Multnomah County Oregon

Board of Commissioners & Agenda

connecting citizens with information and services

BOARD OF COMMISSIONERS

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501 SE Hawthorne Boulevard, Suite 600
Portland, Or 97214
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Email: mult.chair@co.multnomah.or.us

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REVISED
OCTOBER 2, 2003
BOARD MEETING

FASTLOOK AGENDA ITEMS OF INTEREST

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:

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or: http://www.mctv.org

Thursday, October 2, 2003 - **8:30 AM**
Multnomah Building, Sixth Floor Commissioners Conference Room 635
501 SE Hawthorne Boulevard, Portland

EXECUTIVE SESSION

E-1 The Multnomah County Board of Commissioners Will Meet in Executive Session Pursuant to Pursuant to ORS 192.660(1)(h) for Consultation with Counsel Concerning Current Litigation or Litigation Likely to be Filed; and Pursuant to ORS 192.660(1)(d) for Labor Negotiator Consultation Concerning Labor Negotiations. Only Representatives of the News Media and Designated Staff are allowed to Attend. Representatives of the News Media and All Other Attendees are Specifically Directed Not to Disclose Information that is the Subject of the Executive Session. No Final Decision will be made in the Executive Session. Presented by Agnes Sowle, Carol Brown and Invited Others. 1 HOUR REQUESTED.

Thursday, October 2, 2003 - **9:30 AM**
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

REGULAR MEETING

CONSENT CALENDAR - 9:30 AM
NON-DEPARTMENTAL

C-1 Appointment of Basil Panaretos, Jr., Sharon Cowley, Robert L. Correll, Robert Heimbucher, Joan Lamirande, William L. Gibbs, Michael Mace, William N. Ross, Harvey Rice, Calleen M. Collver-Holm, Janice Williams and Richard Farance to the 2003-2004 BOARD OF PROPERTY TAX APPEALS POOLS

C-2 Appointment of Donna Sather to the MULTNOMAH COUNTY COMMUNITY HEALTH COUNCIL

SHERIFF'S OFFICE

C-3 RESOLUTION Authorizing Annual Designation of a Portion of Compensation as a Housing Allowance for Chaplains Serving Inmates and Employees at the Multnomah County Jails

REGULAR AGENDA - 9:30 AM
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.

DEPARTMENT OF BUSINESS AND COMMUNITY SERVICES - 9:30 AM

R-1 Amendment to the 2001-2004 Agreement Between Multnomah County, Oregon and Multnomah County Employee Union Local 88, AFSCME, AFL-CIO [Subject: Seniority and Layoff (Article 21)]

R-2 Amendment 1 to Government Expenditure Contract (190 agreement) 4600003470 with the Oregon Bureau of Labor and Industries, for Enforcement of Multnomah County's Civil Rights Ordinance

R-3 Budget Modification BCS 04-02 Requesting $25,000 General Fund Contingency Transfer for Enforcement of the County's Civil Rights Ordinance for Fiscal Year 2004

NON-DEPARTMENTAL - 9:45 AM

R-4 PROCLAMATION Proclaiming October 5 through 11, 2003 Mental Illness Awareness Week in Multnomah County, Oregon

R-5 PROCLAMATION Proclaiming October 2003 Domestic Violence Awareness Month in Multnomah County, Oregon

DEPARTMENT OF HEALTH - 10:05 AM

R-6 Report on the Environmental Health of Multnomah County. Presented by Lillian Shirley and Jon Duckart. 30 MINUTES REQUESTED.

R-7 Funds Allocation Agreement with Multnomah County, CareOregon, Inc., Oregon Community Health Information Network, Inc. (OCHIN) Clackamas County Public Health Division, Virginia Garcia Memorial Health Center, and Klamath Open Door Clinic, Providing for OCHIN to Obtain and Operate the Practice Management System on a Not-for-Profit Basis

NON-DEPARTMENTAL - 10:50 AM

R-8 Special Needs Committee Report and Consideration of a RESOLUTION Accepting the Report of the Special Needs Committee of the Housing and Community Development Commission, and Implementing the Recommendations Therein. Presented by Diane Luther, Linda Kaeser, Beth Kaye and Invited Guests. 90 MINUTES REQUESTED.

Multnomah County Oregon

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Thursday, October 2, 2003 - 9:30 AM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

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CONSENT CALENDAR - 9:30 AM
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SHERIFF'S OFFICE

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NON-DEPARTMENTAL - 9:45 AM

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R-6 Report on the Environmental Health of Multnomah County. Presented by Lillian Shirley and Jon Duckart. 30 MINUTES REQUESTED.

R-7 Funds Allocation Agreement with Multnomah County, CareOregon, Inc., Oregon Community Health Information Network, Inc. (OCHIN) Clackamas County Public Health Division, Virginia Garcia Memorial Health Center, and Klamath Open Door Clinic, Providing for OCHIN to Obtain and Operate the Practice Management System on a Not-for-Profit Basis

NON-DEPARTMENTAL - 10:50 AM

R-8 Special Needs Committee Report and Consideration of a RESOLUTION Accepting the Report of the Special Needs Committee of the Housing and Community Development Commission, and Implementing the Recommendations Therein. Presented by Diane Luther, Linda Kaeser, Beth Kaye and Invited Guests. 90 MINUTES REQUESTED.

Maria Rojo de Steffey
Multnomah County Commissioner, District 1

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Portland, Oregon 97214

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MEMORANDUM

TO: Chair Diane Linn
Commissioner Serena Cruz
Commissioner Lisa Naito
Commissioner Lonnie Roberts
Clerk of the Board Deb Bogstad

FROM: Matthew Lashua - Staff Assistant to Commissioner Maria Rojo de Steffey

DATE: September 16, 2003

RE: Board Meeting Absence

Commissioner Maria Rojo de Steffey will be out of town and will be unable to attend the October 2nd Board Meeting.

Thursday, October 2, 2003 - **8:30 AM**
Multnomah Building, Sixth Floor Commissioners Conference Room 635
501 SE Hawthorne Boulevard, Portland

EXECUTIVE SESSION

Chair Diane Linn convenes the meeting at 8:30 a.m., with Commissioners Lisa Naito and Serena Cruz present, and Commissioner Lonnie Roberts and Vice-Chair Maria Rojo de Steffey excused.[He's attending an Worksystems Inc. executive meeting and she's on a plane to New York].

E-1 The Multnomah County Board of Commissioners Will Meet in Executive Session Pursuant to Pursuant to ORS 192.660(1)(h) for Consultation with Counsel Concerning Current Litigation or Litigation Likely to be Filed; and Pursuant to ORS 192.660(1)(d) for Labor Negotiator Consultation Concerning Labor Negotiations. Only Representatives of the News Media and Designated Staff are allowed to Attend. Representatives of the News Media and All Other Attendees are Specifically Directed Not to Disclose Information that is the Subject of the Executive Session. No Final Decision will be made in the Executive Session. **Presented by Agnes Sowle, Carol Brown and Invited Others.** **1 HOUR REQUESTED.**

THERE BEING NO FURTHER BUSINESS, THE EXECUTIVE SESSION IS ADJOURNED. THE BOARD WILL RECONVENE IN OPEN SESSION IN THE BOARDROOM AT 9:30 AM

Thursday, October 2, 2003 - **9:30 AM**
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

REGULAR MEETING

Chair Diane Linn convenes the meeting at 9:30 a.m., with Commissioners Lisa Naito, Serena Cruz and Lonnie Roberts present, and Vice-Chair Maria Rojo de Steffey excused [in New York].

CONSENT CALENDAR - 9:30 AM

MAY I HAVE A MOTION ON THE CONSENT CALENDAR?

COMMISSIONER _____ MOVES
COMMISSIONER _____ SECONDS
APPROVAL OF THE CONSENT CALENDAR

ALL IN FAVOR, VOTE AYE, OPPOSED____?
THE MOTION FAILS
OR
THE CONSENT CALENDAR IS APPROVED

ACKNOWLEDGE AND THANK APPOINTEES TO FOLLOWING BOARDS:

NON-DEPARTMENTAL

C-1 Appointment of **Basil Panaretos, Jr., Sharon Cowley, Robert L. Correll, Robert Heimbucher, Joan Lamirande, William L. Gibbs, Michael Mace, William N. Ross, Harvey Rice, Calleen M. Collver-Holm, Janice Williams and Richard Farance to the 2003-2004 BOARD OF PROPERTY TAX APPEALS POOLS**

C-2 Appointment of **Donna Sather to the MULTNOMAH COUNTY COMMUNITY HEALTH COUNCIL**

SHERIFF'S OFFICE

C-3 RESOLUTION Authorizing Annual Designation of a Portion of Compensation as a Housing Allowance for Chaplains Serving Inmates and Employees at the Multnomah County Jails

REGULAR AGENDA - 9:30 AM
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.

DEPARTMENT OF BUSINESS AND COMMUNITY SERVICES - 9:30 AM

R-1 Amendment to the 2001-2004 Agreement Between Multnomah County, Oregon and Multnomah County Employee Union Local 88, AFSCME, AFL-CIO [Subject: Seniority and Layoff (Article 21)]

COMMISSIONER _____ MOVES
COMMISSIONER _____ SECONDS
APPROVAL OF R-1

GAIL PARNELL EXPLANATION AND RESPONSE TO QUESTIONS

OPPORTUNITY FOR PUBLIC TESTIMONY
OPPORTUNITY FOR BOARD COMMENTS

ALL IN FAVOR, VOTE AYE, OPPOSED____?

THE MOTION FAILS
OR
THE AMENDMENT TO THE 2001-2004 LOCAL 88 AFSCME AGREEMENT IS APPROVED

R-2 Amendment 1 to Government Expenditure Contract (190 agreement) 4600003470 with the Oregon Bureau of Labor and Industries, for Enforcement of Multnomah County's Civil Rights Ordinance

COMMISSIONER _____ MOVES
COMMISSIONER _____ SECONDS
APPROVAL OF R-2

APRIL LEWIS AND ASSISTANT COUNTY ATTORNEY DAVID BLANKFELD EXPLANATION AND RESPONSE TO QUESTIONS

OPPORTUNITY FOR PUBLIC TESTIMONY
OPPORTUNITY FOR BOARD COMMENTS

ALL IN FAVOR, VOTE AYE, OPPOSED____?
THE MOTION FAILS
OR
THE CONTRACT AMENDMENT IS APPROVED

R-3 Budget Modification BCS 04-02 Requesting $25,000 General Fund Contingency Transfer for Enforcement of the County's Civil Rights Ordinance for Fiscal Year 2004

COMMISSIONER _____ MOVES
COMMISSIONER _____ SECONDS
APPROVAL OF R-3

COMMISSIONER _____ MOVES
COMMISSIONER _____ SECONDS
APPROVAL OF AN AMENDMENT REDUCING THE AMOUNT OF GENERAL FUND CONTINGENCY TRANSFER FROM $25,000 TO $10,000

ALL IN FAVOR, VOTE AYE, OPPOSED____?

THE MOTION FAILS
OR
THE CONTINGENCY TRANSFER AMOUNT IS REDUCED TO $10,000

APRIL LEWIS AND ASSISTANT COUNTY ATTORNEY DAVID BLANKFELD EXPLANATION, RESPONSE TO QUESTIONS

OPPORTUNITY FOR PUBLIC TESTIMONY

OPPORTUNITY FOR BOARD COMMENTS

ALL IN FAVOR, VOTE AYE, OPPOSED____?

THE MOTION FAILS
OR
THE CONTINGENCY TRANSFER BUDGET MODIFICATION IS APPROVED, AS AMENDED

NON-DEPARTMENTAL - 9:45 AM

R-4 PROCLAMATION Proclaiming October 5 through 11, 2003 Mental Illness Awareness Week in Multnomah County, Oregon

COMMISSIONER _____ MOVES
COMMISSIONER _____ SECONDS
APPROVAL OF R-4

COMMISSIONER LISA NAITO, JOHN HOLMES, INVITED OTHERS, EXPLANATION, READ PROCLAMATION, RESPONSE TO QUESTIONS

OPPORTUNITY FOR PUBLIC TESTIMONY

OPPORTUNITY FOR BOARD COMMENTS

ALL IN FAVOR, VOTE AYE, OPPOSED____?

THE MOTION FAILS
OR
THE PROCLAMATION IS ADOPTED

R-5 PROCLAMATION Proclaiming October 2003 Domestic Violence Awareness Month in Multnomah County, Oregon

COMMISSIONER _____ MOVES
COMMISSIONER _____ SECONDS
APPROVAL OF R-5

COMMISSIONER LISA NAITO, ROBIN SELIG, JOHN RICHMOND AND KRIS BILLHARDT EXPLANATION, READ PROCLAMATION, RESPONSE TO QUESTIONS

OPPORTUNITY FOR PUBLIC TESTIMONY

OPPORTUNITY FOR BOARD COMMENTS

ALL IN FAVOR, VOTE AYE, OPPOSED____?

THE MOTION FAILS
OR
THE PROCLAMATION IS ADOPTED

DEPARTMENT OF HEALTH - 10:05 AM

R-6 Report on the Environmental Health of Multnomah County. Presented by Lillian Shirley and Jon Duckart. 30 MINUTES REQUESTED.

NON-VOTING ITEM. LILLIAN SHIRLEY AND JON DUCKART POWERPOINT PRESENTATION AND RESPONSE TO BOARD QUESTIONS AND DISCUSSION.

R-7 Funds Allocation Agreement with Multnomah County, CareOregon, Inc., Oregon Community Health Information Network, Inc. (OCHIN) Clackamas County Public Health Division, Virginia Garcia Memorial Health Center, and Klamath Open Door Clinic, Providing for OCHIN to Obtain and Operate the Practice Management System on a Not-for-Profit Basis

COMMISSIONER _____ MOVES
COMMISSIONER _____ SECONDS
APPROVAL OF R-7

DAN KAPLAN AND CAROL FORD EXPLANATION AND RESPONSE TO QUESTIONS

OPPORTUNITY FOR PUBLIC TESTIMONY
OPPORTUNITY FOR BOARD COMMENTS

ALL IN FAVOR, VOTE AYE, OPPOSED____?

THE MOTION FAILS
OR
THE AGREEMENT IS APPROVED

NON-DEPARTMENTAL - 10:50 AM

R-8 Special Needs Committee Report and Consideration of a RESOLUTION Accepting the Report of the Special Needs Committee of the Housing and Community Development Commission, and Implementing the

Recommendations Therein. Presented by Diane Luther, Linda Kaeser, Beth Kaye and Invited Guests. 90 MINUTES REQUESTED.

COMMISSIONER _____ MOVES
COMMISSIONER _____ SECONDS
APPROVAL OF R-8

DIANE LUTHER INTRODUCTIONS, SET CONTEXT PRESENTATION/EXPLANATION AND REQUEST FOR AMENDMENTS TO THE RESOLUTION FINDING F., ADDING THE FOLLOWING SENTENCE AFTER THE FIRST SENTENCE: "THE COUNTY DOES NOT INTEND TO DECREASE CURRENT FUNDING IN EXISTING POVERTY PROGRAMS TO FUND THIS EFFORT." AND ADDING LANGUAGE TO THE END OF RESOLVE 8 SO IT READS: "THE BOARD REQUESTS THAT THE SPECIAL NEEDS COMMITTEE OVERSEE IMPLEMENTATION OF RECOMMENDATIONS CONTAINED IN THE REPORT, INCLUDING HOW TO IDENTIFY SPECIAL NEEDS FAMILIES AND IMPROVE THEIR ACCESS TO SERVICES AND HOUSING."

COMMISSIONER _____ MOVES
COMMISSIONER _____ SECONDS
APPROVAL OF AMENDMENT TO F., ADDING THE FOLLOWING SENTENCE AFTER THE FIRST SENTENCE: "THE COUNTY DOES NOT INTEND TO DECREASE CURRENT FUNDING IN EXISTING POVERTY PROGRAMS TO FUND THIS EFFORT." AND ADDING LANGUAGE TO THE END OF RESOLVE 8 SO IT READS: "THE BOARD REQUESTS THAT THE SPECIAL NEEDS COMMITTEE OVERSEE IMPLEMENTATION OF RECOMMENDATIONS CONTAINED IN THE REPORT, INCLUDING HOW TO IDENTIFY SPECIAL NEEDS FAMILIES AND IMPROVE THEIR ACCESS TO SERVICES AND HOUSING."

ALL IN FAVOR, VOTE AYE, OPPOSED____?

THE MOTION FAILS

AGENDA PLACEMENT REQUEST

BUD MOD #:

Board Clerk Use Only:

Meeting Date: October 2, 2003
Agenda Item #: C-1
Est. Start Time: 9:30 AM
Date Submitted: 09/15/03

Requested Date: 10/02/2003 **Time Requested:** N/A

Department: Non-Departmental **Division:** Chair's Office

Contact/s: Chair Diane Linn, Delma Farrell

Phone: 503.988.3308 **Ext.:** 83953 **I/O Address:** 503/600

Presenters: Consent Calendar

Agenda Title: Appointment of Basil Panaretos, Jr., Sharon Cowley, Robert L. Correll, Robert Heimbucher, Joan Lamirande, William L. Gibbs, Michael Mace, William N. Ross, Harvey Rice, Calleen M. Collver-Holm, Janice Williams and Richard Farance to the 2003-2004 Board of Property Tax Appeals Pools

NOTE: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide clearly written title.

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1. **What action are you requesting from the Board? What is the department/agency recommendation?** Request approval of appointment of Basil Panaretos, Jr., Sharon Cowley, Robert L. Correll, Robert Heimbucher, Joan Lamirande, William L. Gibbs, Michael Mace, William N. Ross, Harvey Rice, Calleen M. Collver-Holm, Janice Williams and Richard Farance to the 2003-2004 Board of Property Tax Appeals pools.

2. **Please provide sufficient background information for the Board and the public to understand this issue.** The Board of Property Tax Appeals hears petitions for reductions for real market or assessed value of property (as specified in ORS 309.026). Consider applications to excuse liability for penalty imposed under ORS 308.295. Membership consists of a pool of members of the County governing body or non-office holding County residents to serve in their place; a pool of non-office holding residents of the County who are not employees of the County or of any taxing district within the County; a pool of members of the governing body of a school district within the County. Appointed annually on or before October 15th. Pat Thompson of the Department of Business & Community Services, Assessment & Taxation Division is the Clerk of the Board of Property Tax Appeals.

3. **Explain the fiscal impact (current year and ongoing).** No current year or ongoing fiscal impact.

NOTE: If a Budget Modification or a Contingency Request attach a Budget Modification Expense & Revenues Worksheet and/or a Budget Modification Personnel Worksheet.

If a budget modification, explain:

- **What revenue is being changed and why?**
- **What budgets are increased/decreased?**
- **What do the changes accomplish?**
- **Do any personnel actions result from this budget modification? Explain.**
- **Is the revenue one-time-only in nature?**
- **If a grant, what period does the grant cover?**
- **When the grant expires, what are funding plans?**

NOTE: Attach Bud Mod spreadsheet (FORM FROM BUDGET)

If a contingency request, explain:

- **Why was the expenditure not included in the annual budget process?**
- **What efforts have been made to identify funds from other sources within the Department/Agency to cover this expenditure?**
- **Why are no other department/agency fund sources available?**
- **Describe any new revenue this expenditure will produce, any cost savings that will result, and any anticipated payback to the contingency account.**
- **Has this request been made before? When? What was the outcome?**

If grant application/notice of intent, explain:

- **Who is the granting agency?**
- **Specify grant requirements and goals.**
- **Explain grant funding detail – is this a one time only or long term commitment?**
- **What are the estimated filing timelines?**
- **If a grant, what period does the grant cover?**
- **When the grant expires, what are funding plans?**
- **How will the county indirect and departmental overhead costs be covered?**

4. **Explain any legal and/or policy issues involved.** No legal and/or policy issues.

5. **Explain any citizen and/or other government participation that has or will take place.** N/A

Required Signatures:

Department/Agency Director: _____ **Date: 09/15/03**

AGENDA PLACEMENT REQUEST

BUD MOD #:

Board Clerk Use Only:

Meeting Date: October 2, 2003
Agenda Item #: C-2
Est. Start Time: 9:30 AM
Date Submitted: 09/15/03

Requested Date: 10/02/2003 **Time Requested:** N/A

Department: Non-Departmental **Division:** Chair's Office

Contact/s: Chair Diane Linn, Delma Farrell

Phone: 503.988.3308 **Ext.:** 83953 **I/O Address:** 503/600

Presenters: Consent Calendar

Agenda Title: Appointment of Donna Sather to the Multnomah County Community Health Council

NOTE: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide clearly written title.

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1. **What action are you requesting from the Board? What is the department/agency recommendation?** Request approval of appointment of Donna Sather to the Multnomah County Community Health Council.

2. **Please provide sufficient background information for the Board and the public to understand this issue.** The purpose of the Multnomah County Community Health Council (CHC) is to assist and advise the County Health Department in promoting its vision of healthy people in healthy communities. The CHC supports and guides the Health Department in its mission to provide comprehensive health care that is quality drive, affordable and culturally competent to the people of Multnomah County. CHC provides input and feedback to generally advise the development, implementation and evaluation of Health Department programs including, but not limited to all programs funded through the Federal Bureau of Primary Health Care. The CHC also serves as the Citizen Budget Advisory Committee for the County Health Department. Members can range from 9 to 25 members. Consumers of County health programs constitute the majority; remaining members are health care providers and representatives of the community. Members are appointed to 3-year terms by the County Chair from nominees selected by the current Council with approval of the Board of County Commissioners. Sonia Manhas of the Health Department is the Community Health Council Manager.

3. **Explain the fiscal impact (current year and ongoing).** No current year or ongoing fiscal impact.

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If a budget modification, explain:

- **What revenue is being changed and why?**
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- **Explain grant funding detail – is this a one time only or long term commitment?**
- **What are the estimated filing timelines?**
- **If a grant, what period does the grant cover?**
- **When the grant expires, what are funding plans?**
- **How will the county indirect and departmental overhead costs be covered?**

4. **Explain any legal and/or policy issues involved.** None.

5. **Explain any citizen and/or other government participation that has or will take place.** N/A

Required Signatures:

Department/Agency Director: _____ **Date: 09/15/03**

AGENDA PLACEMENT REQUEST

BUD MOD #:

Board Clerk Use Only:

Meeting Date: October 2, 2003
Agenda Item #: C-3
Est. Start Time: 9:30 AM
Date Submitted: 09/23/03

Requested Date: 2 October 2003 **Time Requested:** N/A

Department: Sheriff's Office **Division:** Enforcement

Contact/s: Sharie Lewis

Phone: 503- 988-4813 **Ext.:** 84813 **I/O Address:** 503/350

Presenters: Consent Calendar

Agenda Title: Resolution recognizing the Annual Authorization for Designation of a Portion of Compensation as a Housing Allowance for Chaplains Serving Inmates and Employees at Multnomah County Jails

NOTE: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide clearly written title.

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1. **What action are you requesting from the Board? What is the department/agency recommendation?**
   MCSO recommends the adoption of a resolution designating a portion of the compensation received by two of its Chaplains to be used as a Housing Allowance.

2. **Please provide sufficient background information for the Board and the public to understand this issue.**
   The Multnomah County Sheriff's Office employs Edward Stelle and Lewis Kyle as Chaplains serving inmates and employees at the county jails. The Sheriff's Office does not provide housing to either Chaplain. Based on 26 USC § 107(2) allows clergy to exclude from the calculation of their gross income, the housing allowance paid as part of their compensation, to the extent used by them to rent or provide a home.

3. **Explain the fiscal impact (current year and ongoing).**
The following Chaplains are allowed to designate the following amounts of their compensation as a housing allowance for calendar year 2004, subject to the requirements and limitations of internal revenue law:

Chaplain	Housing Allowance Amount Per Annum
Edward Stelle	$10,000
Lewis Kyle	$19,000

4. **Explain any legal and/or policy issues.**
Allowance is in accordance with (US Code) 26 USC § 107(2).

5. **Explain any citizen and/or other government participation that has or will take place.**
None.

Required Signatures:

Department/Agency Director:  **Date: 9/23/03**

Budget Analyst

By: **Date:**

Dept/Countywide HR

By: **Date:**

BEFORE THE BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

RESOLUTION NO. _____

Annual Authorization for Designation of a Portion of Compensation as a Housing Allowance for Chaplains Serving Inmates and Employees at the Multnomah County Jails

The Multnomah County Board of Commissioners Finds:

a. The Multnomah County Sheriff's Office employs Edward Stelle and Lewis Kyle as chaplains serving inmates and employees at the county jails.

b. The Sheriff's Office does not provide housing to either chaplain.

c. 26 USC §107(2) allows clergy to exclude from the calculation of their gross income the housing allowance paid as part of their compensation, to the extent used by them to rent or provide a home.

The Multnomah County Board of Commissioners Resolves:

The following chaplains are allowed to designate the following amounts of their compensation as a housing allowance for calendar year 2004, subject to the requirements and limitations of internal revenue law:

Chaplain	Housing Allowance Amount Per Annum
Edward Stelle	$10,000
Lewis Kyle	$19,000

ADOPTED this 2nd day of October 2003.

BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

_____
Diane M. Linn, Chair

REVIEWED:

AGNES A. SOWLE, COUNTY ATTORNEY
FOR MULTNOMAH COUNTY, OREGON

By _____
Scott E. Asphaug, Deputy County Attorney

BEFORE THE BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

RESOLUTION NO. 03-136

Annual Authorization for Designation of a Portion of Compensation as a Housing Allowance for Chaplains Serving Inmates and Employees at the Multnomah County Jails

The Multnomah County Board of Commissioners Finds:

a. The Multnomah County Sheriff's Office employs Edward Stelle and Lewis Kyle as chaplains serving inmates and employees at the county jails.

b. The Sheriff's Office does not provide housing to either chaplain.

c. 26 USC §107(2) allows clergy to exclude from the calculation of their gross income the housing allowance paid as part of their compensation, to the extent used by them to rent or provide a home.

The Multnomah County Board of Commissioners Resolves:

The following chaplains are allowed to designate the following amounts of their compensation as a housing allowance for calendar year 2004, subject to the requirements and limitations of internal revenue law:

Chaplain	Housing Allowance Amount Per Annum
Edward Stelle	$10,000
Lewis Kyle	$19,000

ADOPTED this 2nd day of October 2003.

BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

Diane M. Linn, Chair

REVIEWED:

AGNES A. SOWLE, COUNTY ATTORNEY
FOR MULTNOMAH COUNTY, OREGON

By _____
Scott E. Asphaug, Deputy County Attorney

AGENDA PLACEMENT REQUEST

BUD MOD #:

Board Clerk Use Only:	
Meeting Date:	**October 2, 2003**
Agenda Item #:	**R-1**
Est. Start Time:	**9:30 AM**
Date Submitted:	**09/24/03**

Requested Date: October 2, 2003

Time Requested: 5 minutes

Department: Business Services

Division: Central Human Resources/Labor Relations

Contact/s: Gail Parnell

Phone: 988-5015 **Ext.:** 22595 **I/O Address:** 503/4

Presenters: Gail Parnell

Agenda Title: Amendment to the 2001-2004 Agreement between Multnomah County, Oregon and Multnomah County Employee Union Local 88, AFSCME, AFL-CIO. Subject: Seniority and Layoff (Article 21).

NOTE: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide clearly written title.

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1. **What action are you requesting from the Board? What is the department/agency recommendation?** Approval of Memorandum of Agreement with AFSCME Local 88 to modify bumping provisions in Article 21 of the Local 88 Agreement for 2001-2004. The Department recommends approval. I am asking for this to be expedited because Local 88 has already ratified the agreement and would like to implement as soon as possible.

2. **Please provide sufficient background information for the Board and the public to understand this issue.** Currently, the Local 88 Agreement allows employees only to bump within their assigned departments, based on their seniority in job classification. Over the past two years, the County has undergone a number of organizational changes affecting the structure of County Departments. These changes in County organizational structure directly impact employees' retention rights in the event of layoff, in that their bumping options may be more limited as a result of these changes. This modification will allow employees to bump countywide, thereby eliminating any negative impact on employee bumping rights resulting from changes in County Deparment structure.

3. **Explain the fiscal impact (current year and ongoing).** There is no direct fiscal impact. Changes will require an increase in administrative staff time needed to calculate employee bumping rights.

NOTE: If a Budget Modification or a Contingency Request attach a Budget Modification Expense & Revenues Worksheet and/or a Budget Modification Personnel Worksheet.

If a budget modification, explain: N/A

- **What revenue is being changed and why?**
- **What budgets are increased/decreased?**
- **What do the changes accomplish?**
- **Do any personnel actions result from this budget modification? Explain.**

- **Is the revenue one-time-only in nature?**
- **If a grant, what period does the grant cover?**
- **When the grant expires, what are funding plans?**

NOTE: Attach Bud Mod spreadsheet (FORM FROM BUDGET)

If a contingency request, explain: N/A

- **Why was the expenditure not included in the annual budget process?**

- **What efforts have been made to identify funds from other sources within the Department/Agency to cover this expenditure?**
- **Why are no other department/agency fund sources available?**
- **Describe any new revenue this expenditure will produce, any cost savings that will result, and any anticipated payback to the contingency account.**

- **Has this request been made before? When? What was the outcome?**

If grant application/notice of intent, explain: N/A

- **Who is the granting agency?**
- **Specify grant requirements and goals.**
- **Explain grant funding detail – is this a one time only or long term commitment?**
- **What are the estimated filing timelines?**
- **If a grant, what period does the grant cover?**
- **When the grant expires, what are funding plans?**
- **How will the county indirect and departmental overhead costs be covered?**

4. **Explain any legal and/or policy issues involved.** None

5. **Explain any citizen and/or other government participation that has or will take place.** AFSCME Local 88 members have voted to approve this amendment.

Required Signatures:

Department/Agency Director: _____ **Date:** 9/24/03

Budget Analyst

By: _____ **Date:** 9/24/03

Dept/Countywide HR

By: _____ **Date:** 9-24-03

MEMORANDUM OF AGREEMENT
(County Wide - Classification Seniority Rights)

I.
Parties to the Agreement

The parties to this Agreement are Multnomah County, Oregon, hereinafter referred to as the County, and Local 88, of the American Federation of State, County and Municipal Employees, AFL-CIO, hereinafter referred to as the Union.

II.
Background

WHEREAS, the County is a fluid public sector organization that adjusts its department organization structure by adding, deleting or combining departments in order to meet economic challenges and community needs; and

WHEREAS, County's addition, deletion or combining of departments has impacts on employees seniority options that were not anticipated when the parties negotiated the current collective bargaining agreement; and

WHEREAS, the Union has proposed changes to Article 21 that would enhance employee bumping options; and

WHEREAS, the County recognizes employee seniority concerns in a changing environment and wants to ensure employees that they don't suffer a disadvantage as a result of County reorganization changes;

NOW, therefore, the parties mutually agree to modify Article 21 as follows:

III.
Agreement

Effective with the signing of this agreement Article 21 is modified as follows:

ARTICLE 21
SENIORITY AND LAYOFF

I. Definitions

A. Layoff:

A reduction in force in classification for reasons of lack of funds, lack of work, efficiency or reorganization. Reductions in force are identified by classification within the affected department.

B. Continuous Service:

Means uninterrupted employment with Multnomah County subject to the following provisions:

1. Continuous service shall include uninterrupted employment with another governmental agency accomplished in accordance with and subject to ORS 236.610 through 236.650.

2. Continuous service is terminated by voluntary termination, involuntary termination due to expiration of a recall list, removal from a recall list after layoff pursuant to "Section IV.D" of this article, or discharge for cause.

C. Bumping:

The displacement of the least senior regular employee by another regular employee within the department with more seniority within the classification or if there is not a less senior employee in the classification in the department, then the displacement of the least senior regular employee in the classification in the County.

D. Equivalent Classification:

Refers to matching by the County HR Director or his/her designee of an abolished classification with a current classification that has substantially the same

duties, authority, and responsibility.

E. Classification Previously Held:

Refers to a classification or its equivalent in which the employee gained regular status and for which he or she continues to qualify.

F. Regular Employee:

Refers to the status a classified employee acquires after successful completion of the probationary period for the classification to which the employee was appointed.

G. Lateral Classification:

Refers to a classification or its equivalent which has the same top step as the employee's current classification.

H. Affected by Layoff:

Refers to an employee who was demoted, laid off, or reassigned as a result of a layoff process under the provisions of this article.

I. Permanent Appointment:

Refers to the appointment of an employee to a budgeted position from a certified list of eligibles.

II. Seniority

A. Seniority will be determined as follows:

1. The total length of continuous service within the affected job classification and its equivalent within the County; if a tie occurs, then

2. Total length of continuous service within the County; if a tie occurs, then

3. Test score on the Civil Service Examination, if available, for the classification; if a tie occurs or if the test scores are not available, then

4. It shall be broken by lot in a manner to be determined by the Central Human Resources.

B. In computing seniority for regular employees, the following factors will be taken into account:

1. Part-time work within the same or equivalent classification will count on a full-time basis.

2. Time spent in an abolished classification that has a current equivalent will count toward seniority in the equivalent classification.

3. Time on authorized leave taken with pay will count.

4. When an authorized leave without pay exceeds 30 days, no time spent on that leave will count.

5. Time spent in unclassified appointment status will not count, except for purposes of vacation accrual.

6. Time spent in on-call status will not count.

7. Temporary time, limited duration time and working out of class time that exceeds thirty (30) days shall be taken into account in the following manner:

a. Prior to permanent appointment

All continuous, contiguous service that meets the following guidelines shall count:

1. Service in a position which has been classified or formally labeled the same as the classification to which the employee is appointed; or

2. Service with duties substantially the same as the classification to which the employee is appointed. The determination of whether the duties were "substantially the same" must be a reasonable one on the part of the County.

b. After permanent appointment

All continuous, contiguous service on a temporary promotion shall count toward seniority in the immediately previous classification, except in cases in which the promotion becomes permanent immediately following the temporary appointment; in these cases the time will be counted toward the classification to which the employee is promoted.

8. When a layoff exceeds 30 days, no time spent on layoff will count.

9. Time spent in a trainee capacity, e.g., in state or federal trainee programs, will not count.

10. Time spent working for another government in an equivalent classification will count if the employee was transferred to Multnomah County pursuant to ORS 236.610 through 236.650.

11. Seniority shall be forfeited by discharge for cause, voluntary termination, or, after layoff, by removal from all recall lists pursuant to "Section IV" of this article.

12. Time spent on a probationary period that is not completed will count toward the employee's previous classification, if any unless such probationary period was in a classification outside the Local 88 bargaining unit, then such time will not count if such period is in excess of six months. Time spent on a trial service period after lateral transfer that is not completed will be counted toward the previous classification.

13. Current rules for calculation of seniority as contained in this article do not alter seniority determinations under prior Local 88 contracts.

III. Layoff Rules

The County will notify regular employees affected by layoff of their reassignment or layoff, according to the provisions of this section.

A. Reassignment of Regular Employees During a Layoff

Layoffs will be identified by classification within the affected department and County. Employees holding positions that perform functions to be discontinued will be subject to the following in order of seniority:

1. Reassignment to a position in the same classification and within the employee's current department, or if the employee does not have enough seniority, then

2. Reassignment to a position County wide, in the following order:

a. Reassignment to a position in the same classification; or, if the employee does not have enough seniority, then

b. Reassignment to a position in a lower or equivalent classification previously held, or if the employee does not have enough seniority, then

c. Change of status between full-time and part-time, or if the employee does not have enough seniority, then

3. Layoff.

B. Non-Regular Employees During a Layoff

1. Within an affected classification and department, temporary, non-regular probationary, and other employees who do not have classified status and who are occupying budgeted positions will be terminated before employees with classified status are affected by layoff. Employees without status who are terminated will not be placed on recall lists and do not have bumping rights.

2. An employee who has not completed a probationary period following promotion to a classified position and is affected by layoff shall be returned to the position previously held.

3. Probationary employees terminated or demoted in accordance with "Subsection 1" and "Subsection 2" above will be placed on reinstatement lists for one year from the date of their termination or demotion. They may, at the County's discretion, be reinstated to their former classification if there are no regular employees who are on a recall list for that classification. Probationary employees who are reinstated will be treated as if they have been on a leave of absence from the classification for purposes of computing seniority and length of probationary period.

C. Layoff Processing for Employees on a Leave of Absence Without Pay

1. Employee notification

Employees who are on a leave of absence without pay which is scheduled to continue after the layoff effective date and whose classifications are

expected by the County to be affected by an upcoming layoff process will be notified in writing and given an option to return from leave.

2. Use of positions during the layoff process

If no response is received by the County within five days of written notification, or if the employee declines to return from leave of absence, or if the employee is unable to return from leave of absence, the position from which the employee is on leave of absence will be treated as a vacant position during the layoff process and will be available to be filled by another employee who is affected by the layoff process, according to the provisions of this article.

3. Return from family medical leave without pay

After a layoff process affecting the employee's classification has occurred, employees who are on Family Medical Leave without pay immediately prior to returning to work will return to the position formerly held, and the employee occupying that position will be reassigned according to seniority pursuant to this article.

4. Return from other leave without pay

After a layoff process affecting the employee's classification has occurred, employees not on Family Medical Leave without pay immediately prior to returning to work will be reassigned according to seniority pursuant to this article.

5. Recalculation of seniority after leave of absence without pay

All employees on leave of absence without pay that exceeds thirty (30) days will have their seniority recalculated upon their return from leave so that none of the time on the leave of absence without pay counts toward seniority per "Section II.B.4" of this article.

D. The Bumping Process

Vacancies that are created and approved by the Board of County Commissioners to be effective the day following the layoff date shall be treated as vacancies available during a layoff process.

1. Bumping process shall occur in the following order:

a. Reassignment of employees to vacant positions within the

employees current department, if available, will always take precedence over their bumping another employee; where multiple vacancies are available within the employees current department, the County will reassign the employee to one.

b. If bumping is necessary, the least senior employee in the affected classification in the department will be bumped. If there is no employee with less seniority in the classification in the department, then assignment to a vacant position in the County in the affected classification, if no vacant position, then the least senior employee in the affected classification in the County will be bumped.

c. If there is no employee in the classification in the County with less seniority then the employee will be bumped to a classification previously held. If the employee held more than one previous classification, order shall be to the previous class held and so forth. Employee bumping rights includes right to bump into a previous classification with a higher maximum salary only if the higher salary rate of the previously held class is due to a salary adjustment for that class resulting from a classification /compensation study and the employee moved from the class as a result of a lateral transfer, promotion or reclass. If an employee bumps to a classification previously held and did not complete the probationary period in the class, employee will be required to complete probation according to the terms of Article 2, Section VIII.

d. Full time employees will be reassigned only to full time positions and part time employees will be reassigned only to part time positions, unless reassignment to the other status is the only available option other than layoff.

2. Shift assignment will not have an effect on the layoff process.

3. Employees who are reassigned to a position pursuant to these provisions and do not accept that position will be deemed to have resigned.

4. Employees may not be reassigned to positions under this article unless qualified to perform the duties of that position. Employees may be denied rights otherwise available under these provisions only if they lack knowledge, skills or abilities required for the position that are not easily learned on the job within ninety days. Employees may be required to take and pass qualifying examinations in order to

establish their rights to specific positions.

IV. Notice and Recall List

A. Employees who are subject to reassignment, demotion, or layoff pursuant to the provisions of this article shall receive a notice in writing at least fifteen days prior to such action. The notice shall state the reason for the action and shall further state that the action does not reflect discredit on the employee. The Union will be provided a copy of the notice.

B. Employees who are laid off, demoted, or reassigned to a lateral classification and/or reassigned between full-time and part-time status will be placed on the recall lists, according to seniority. Employees will be placed on all the recall lists that meet the criteria below. (For example, employees who are demoted and reassigned from full-time to part-time will be placed on the recall lists for full-time appointment in the current classification, for part-time appointment in the higher classification, and for full-time appointment in the higher classification):

1. Employees who are laid off will be placed on the recall list for the classification held by the employee at the beginning of the layoff process .

2. Employees who are demoted will be placed on the recall list for all the classifications held by the employee at the beginning of the layoff process to, but not including, the one the employee demoted to.

3. Employees who are reassigned to a lateral classification or to a classification previously held will be placed on the recall list for the classification held by the employee at the beginning of the layoff process.

4. Employees who are reassigned from full-time to part-time will be placed on the list for recall to full-time assignment.

5. Employees who are reassigned from part-time to full-time will be placed on the list for recall to part-time assignment.

C. Employees who are reassigned to positions in the same classification,

resign, or elect to retire will not be placed on recall lists.

D. Employees will remain on a recall list for twenty-four months from the date of placement on the list. Within that time period, employees will be removed from the recall list only under the following circumstances:

1. Upon written request of the employee; or
2. Upon their retirement; or
3. Upon acceptance of permanent recall from the list; or
4. Upon declining an offer of permanent recall; or
5. Upon the employee's failure to respond to a certified letter sent to the employee's last known address within fourteen days of mailing; or
6. Disciplinary termination for cause.

E. Employees who are laid off and are on recall list(s) and return to permanent County employment for any reason will be treated as if they have been on a leave of absence without pay for the purpose of computing seniority.

F. To ensure that data about vacancies and employee work assignments are reliable and that bumping options are accurate, the County HR Director may freeze all personnel transactions as determined appropriate beginning 4 weeks prior to the date a layoff is implemented and ending the day immediately following the effective date of the layoff.

V. Recall

A. Employees on a recall list will be certified in order of seniority, before applicants who qualify through examination, provided they are qualified to perform the duties of the position. Employees on a recall list shall be offered appointment to vacancies, in order of seniority, except when they lack knowledge, skills or abilities required for the position that are not easily learned on the job within ninety days. Employees may be required to take and pass qualifying examinations in order to establish their rights to specific positions. The hiring manager is required to state in

writing what qualification(s) the employee lacks that the position requires. The employee will remain on the recall list for certification to other vacancies during his or her term of eligibility.

B. Failure to recall an employee, except as provided above, will be deemed a dismissal of that employee for cause and will be reviewed and processed according to the provisions of Article 17, Disciplinary Action.

VI. Seniority Application

A. The above terms for determination of seniority shall apply not only to the layoff process, but also to other situations in which seniority is applied, including total service for the purpose of vacation accrual rates.

B. For purposes of vacation bidding, the employee's original date of hire with the County pursuant to "Section II.B" of this article, shall be used to determine vacation selection in accordance with Article 8, Vacation Leave, "Section V".

C. Seniority determinations shall have no application to retirement matters.

D. The County agrees to make available to the Union upon request copies of any personnel list the County maintains regarding seniority or classification changes.

VII. Posting Process

A. Seniority List Posting

Lists showing seniority within the County and seniority within classification shall be provided to the Union and posted on all Union bulletin boards on or about March 1 of each year or anytime an employee or employees are notified that their position(s) is being eliminated..

B. Seniority List Appeal Process

1. Errors on new lists

Employees who have concerns about the calculation of their

seniority shall notify Central Human Resources with a copy to the Union. If an employee's concems remain unresolved, the Union may file a formal written grievance at Step 3 of the grievance procedure within thirty (30) days of his or her initial consultation with Central Human Resources. If no grievance is filed within that time, the seniority calculation is deemed correct. A grievance may be filed only with respect to seniority accrued since July 1, 1998.

VIII. Seniority of and Bumping by Non-Bargaining Unit Employees and Other Bargaining Units

A. The only non-bargaining unit employees, confidential employees or members of other bargaining units, who may bump into the bargaining unit are those who are in the Classified service and who have previously been a member of the Bargaining Unit or in a classification which subsequently became part of these units .

B. Only time served in the bargaining unit shall apply for bumping purposes.

X. Special Provisions to Save Employees From Layoff

It is recognized by the parties that employees who are to be laid off or involuntarily demoted because of their seniority within a classification within a department face difficult circumstances in being placed in alternative employment within the County. Any such employee who is placed in a classification not previously held shall be subject to a trial service period of ninety days to demonstrate his or her ability to perform or fulfill the requirements of the new classification. Employees who, in the opinion of the County, are unsuccessful during this ninety day trial service period will be removed from their new classification and placed on the appropriate recall list. Such employees shall continue to be eligible for placement under the provisions of this section as long as alternative employment opportunities are being explored by management for affected employees.

Agreed to this date, _____, 2003.

For the Union:

Marla Rosenberger
President, Local 88

Claude Piller
Council Representative
AFSCME Council 75

For the County:

Diane Linn, County Chair

Maria Rojo de Steffey, Commissioner

Serena Cruz, Commissioner

Lisa Naito, Commissioner

Lonnie Roberts, Commissioner

Negotiated By:

Gail Parnell
Central HR Director

Reviewed: Agnes Sowle, County Attorney For Multnomah County, Oregon

Agnes Sowle
County Attorney

APPROVED : MULTNOMAH COUNTY
BOARD OF COMMISSIONERS
AGENDA # R-1 DATE 10-02-03
DEBORAH L. BOGSTAD, BOARD CLERK

AGENDA PLACEMENT REQUEST

BUD MOD #:

Board Clerk Use Only:

Meeting Date: October 2, 2003
Agenda Item #: R-2
Est. Start Time: 9:35 AM
Date Submitted: 09/22/03

Requested Date: 10/02/03 **Time Requested:** 5 minutes

Department: Business & Community Services **Division:** Human Resources

Contact/s: April Lewis

Phone: 503-988-5015 **Ext.:** 28869 **I/O Address:** 503/4

Presenters: April Lewis and David Blankfeld

Agenda Title: Amendment 1 to Government Expenditure Contract (190 agreement) 4600003470 with the Oregon Bureau of Labor and Industries, for Enforcement of Multnomah County's Civil Rights Ordinance

NOTE: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide clearly written title.

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1. **What action are you requesting from the Board? What is the department/agency recommendation**? The Department of Business & Community Services (DBCS) recommends the renewal of the contract between the county and Bureau of Labor and Industries (BOLI) for enforcement of the County's Civil Rights Ordinance.

2. **Please provide sufficient background information for the Board and the public to understand this issue.** On November 29th, 2001, the Board of County Commissioners approved Multnomah County Ordinance #969 which bans discrimination on the basis of sexual orientation, gender identity, and source of income in housing, employment, and public accommodations for all Multnomah County residents. In FY 2002 and FY 2003, the County (through DBCS) contracted with the Bureau of Labor and Industries (BOLI) to enforce civil rights protections included in Ordinance 969.

When complaints are filed that require investigation, the County pays BOLI for work performed and services rendered in investigating and, if necessary, settling the complaint. In FY 2002, the Board of County Commissioners approved this contract and it now requires renewal for FY 2003-04.

3. **Explain the fiscal impact (current year and ongoing)**. Associated with this contract is a request to reduce the General Fund contingency by $25,000 in FY 2004. Actual expenditures for investigation of civil rights complaints will not be known until the end of the fiscal year; however, expenditures for this purpose in FY 2003 did not exceed $3,000. The Budget Office has made a note to include this item in DBCS' FY 2005 budget request.

4. **Explain any legal and/or policy issues**. There are none.

5. **Explain any citizen and/or other government participation that has or will take place**. The County attorney's office has worked with the City of Portland attorneys to ensure that both agencies' contracts are in agreement and alignment with each other.

Required Signatures:

Department/Agency Director: *Tony Mounts* **Date: 09/18/03**

Budget Analyst
By: **Date:**

Dept/Countywide HR
By: **Date:**

MULTNOMAH COUNTY CONTRACT APPROVAL FORM

Contract #: 4600003470

Pre-approved Contract Boilerplate (with County Attorney signature) ☐Attached ☒Not Attached Amendment #: 1

CLASS I	CLASS II	CLASS III A
Contracts $75,000 and less per 12 month period	Contracts over $75,000 per 12 month period	☒ Government Contracts (190 Agreement)
☐ Professional Services Contracts ☐ PCRB Contracts ☐ Maintenance Agreements ☐ Licensing Agreements ☐ Public Works Construction Contracts ☐ Architectural & Engineering Contracts ☐ Revenue Contracts ☐ Grant Contracts ☐ Non-Expenditure Contracts	☐ Professional Services Contracts ☐ PCRB Contracts ☐ Maintenance Agreements ☐ Licensing Agreements ☐ Public Works Construction Contracts ☐ Architectural & Engineering Contracts ☐ Revenue Contracts ☐ Grant Contracts ☐ Non-Expenditure Contracts	☒ Expenditure ☐ Non-Expenditure ☐ Revenue **CLASS III B** ☐ Government Contracts (Non-190 Agreement) ☐ Expenditure ☐ Non-Expenditure ☐ Revenue ☐ Interdepartmental Contracts

Department: DBCS Division: DIVERSITY Date: 6/27/2003
Originator: APRIL LEWIS Phone: 503-988-5015 Bldg/Rm: 503/4
Contact: SANDRA VILLENEUVE Phone: 503-988-5015 Bldg/Rm: 503/4
Description of Contract: PROVIDE ADMINISTRATIVE ENFORCEMENT OF COMPLAINTS FILED UNDER MULTNOMAH COUNTY CODE MCC15.340 TO 15.347.

RENEWAL: ☒ PREVIOUS CONTRACT #(S): 4600002830
RFP/BID: RFP/BID DATE:
EXEMPTION #: ORS/AR #:
Effective DATE: EXPIRATION DATE:
CONTRACTOR IS: ☐ MBE ☐ WBE ☐ ESB ☐ QRF State Cert# or ☐ Self Cert ☐ Non-Profit ☐ N/A (*Check all boxes that apply*)

Contractor: OREGON BUREAU OF LABOR & INDUSTRIES
Address: 800 NE OREGON ST.
City/State: PORTLAND OR
ZIP Code: 97232-2162
Phone: 503-731-4873
Employer ID# or SS#: 93-6001771
Contract Effective Date: 01/20/02 Term Date: 06/30/02
Amendment Effect Date: 07/01/03 New Term: 06/30/04

Original Contract Amount: $25,000
Total Amt of Previous Amendments: $0
Amount of Amendment: $0
Total Amount of Agreement $: $25,000

Remittance address
(If different)

Payment Schedule / Terms
☐ Lump Sum $ ☐ Due on Receipt
☐ Monthly $ ☐ Net 30
☒ Other $ ☐ Other

☐ Requirements Funding Info:
Original Requirements Amount $
Total Amt of Previous Amendments $
Requirements Amount Amendment: $
Total Amount of Requirements $

REQUIRED SIGNATURES:

Department Manager: [signature] DATE 9/18/03
Purchasing Manager: DATE
County Attorney: [signature] DATE 9.18.03
County Chair: [signature] DATE 10.2.03
Sheriff: DATE
Contract Administration: DATE

APPROVED: MULTNOMAH COUNTY BOARD OF COMMISSIONERS
AGENDA # R-2 DATE 10.02.03
DEBORAH L. BOGSTAD, BOARD CLERK

COMMENTS: COST CENTER 707000/60170

INTERGOVERNMENTAL AGREEMENT BETWEEN THE MULTNOMAH COUNTY AND THE STATE OF OREGON, BUREAU OF LABOR AND INDUSTRIES (BOLI) FOR ENFORCEMENT OF MULTNOMAH COUNTY'S CIVIL RIGHTS ORDINANCE

This Agreement is entered into by and between the Multnomah County, Oregon, (County), and the Oregon Bureau of Labor and Industries (Contractor) pursuant to ORS 190.110.

RECITALS:

1. On November 29, 2001, the Board of County Commissioners of Multnomah County by Ordinance No. 969 adopted amendments to the County Code to prohibit discrimination in Multnomah County in employment, housing, and public accommodations on the basis of race, religion, color, sex, marital status, political affiliation, national origin, familial status, mental or physical disability, sexual orientation, gender identity and source of income.

2. BOLI already enforces the anti-discrimination provisions contained in ORS Chapter 659A and in the City of Portland Code and has substantial expertise in such enforcement.

3. The County wishes BOLI to enforce those provisions of County Code §§ 15.340 to 15.347 which are not currently covered by ORS Chapter 659A. The Board of County Commissioners has provided for funding for this activity through an allocation of General Funds for the FY 2003-04 in the amount of $25,000.

4. BOLI desires to be the enforcement agent for the County.

5. The County and BOLI agree that BOLI will enforce gender identity claims that are also covered under state law without charge to the County.

TERMS:

1. Scope of BOLI Services

   BOLI shall provide those services set out in Exhibit A hereto.

   ✓ Handle up to 20 cases depending upon complaint filings

- ✓ Complainants will be interviewed by an investigator within 20 days of the filing date
- ✓ Complaints will be processed within 90 days of filing
- ✓ 100% of the complaints will meet the Division's quality characteristics

2. Reimbursement of Expenses

The County shall pay BOLI for work performed under this Agreement as set out in Exhibit B hereto. The payment shall be full reimbursement for work performed, for services rendered, and for all labor, materials, supplies, equipment, and incidentals necessary to perform the work and services. Payment shall be made upon submission of a detailed invoice of expenses.

It is agreed that total reimbursement under this Agreement shall not exceed TWENTY FIVE THOUSAND DOLLARS ($25,000).

3. Term

a) Effective Date: This Agreement shall be effective when signed by both parties and shall cover expenses incurred by BOLI after the effective date.

b) Termination Date - New Case Intake: This Agreement will remain in effect as to intake of new cases until June 30, 2004 unless terminated as provided in paragraph 5.

c) Termination Date - Disposition of Cases Filed With BOLI: With respect to cases initiated with BOLI prior to June 30, 2003, or the date of early termination pursuant to paragraph 4, this Agreement shall remain in effect through completion of BOLI's administrative processing of such cases.

d) Renewal: This contract shall automatically renew on the contract anniversary each year unless either party mails or delivers to the other not less than 30 days prior to such date a notice of termination. All contract terms shall apply during any renewal period unless BOLI shall have submitted in writing to County not less than 60 days prior to the contract anniversary a list of price adjustments that will apply to the upcoming renewal period. County shall be deemed to have accepted such price adjustments if the contract is renewed.

4. Early Termination

   a) The County and BOLI, by mutual written agreement, may terminate the intake of new cases under this Agreement at any time.

   b) Either party may terminate the intake of new cases under this Agreement upon thirty (30) days written notice to the other party.

   c) Nothing herein shall operate as a bar to termination of the Agreement in the event that either party is found to lack the legal capacity to perform under the Agreement.

5. Contract Managers

   a) For the County, the Contract Manager shall be April Lewis or such other employee named at the discretion of the County.

   b) For BOLI, the Contract Manager shall be the CRD Administrator, or such other employee named at the discretion of BOLI.

   c) Contract Managers shall have the authority to approve invoices for payment and minor changes to the Scope of Work. Any changes will be communicated in writing.

6. Breach of Agreement

   a) BOLI or the County shall breach this Agreement if it fails to perform any substantial obligation under the Agreement, except as provided in subsection b of this section.

   b) Neither BOLI nor the County shall have breached this agreement by reason of any failure to perform a substantial obligation under the Agreement if the failure arises out of causes beyond its control and without its fault or negligence. Should either BOLI or the County fail to perform because of circumstances described in this subsection, BOLI and the County shall make a mutually acceptable revision in the scope of services or compensation sections of this Agreement.

7. Legal Services

   BOLI shall be solely responsible to bear any legal costs or fees arising out of this Agreement, except that where BOLI requires outside legal services for

enforcement of claims arising solely under the County ordinance against the County as respondent or in relation to records confidentiality under ORS 192.001-.505, the County shall be liable for BOLI's expense.

8. General Contract Provisions

A. TERMINATION FOR CAUSE. If, through any cause, the Contractor shall fail to fulfill in timely and proper manner his/her obligations under this Contract, or if the Contractor shall violate any of the covenants, agreements, or stipulations of this Contract, the County shall have the right to terminate this Contract by giving written notice to the Contractor of such termination and specifying the effective date thereof at least 30 days before the effective date of such termination. In such event, all finished or unfinished documents, data, studies, and reports prepared by the Contractor under this Contract shall, at the option of the County, become the property of the County and the Contractor shall be entitled to receive just and equitable compensation for any satisfactory work completed on such documents.

Notwithstanding the above, the Contractor shall not be relieved of liability to the County for damages sustained by the County by virtue of any breach of the Contract by the Contractor, and the County may withhold any payments to the Contractor for the purpose of setoff until such time as the exact amount of damages due the County from the Contractor is determined.

B. TERMINATION FOR CONVENIENCE. The County and Contractor may terminate this Contract at any time by mutual written agreement. If the Contract is terminated by the County as provided herein, the Contractor will be paid an amount which bears the same ratio to the total compensation as the services actually performed bear to the total services of the Contractor covered by this Contract less payments of compensation previously made.

The County, upon thirty (30) days written notice to the Contractor, may terminate this Agreement for any reason deemed appropriate at its sole discretion.

C. REMEDIES. In the event of termination under Section A hereof by the County due to a breach by the Contractor, then the County may complete the work either itself or by agreement with another contractor, or by a combination thereof. In the event the cost of completing the work exceeds the amount actually paid to the Contractor hereunder plus the remaining unpaid balance of the compensation provided herein, then the Contractor shall pay to the County the amount of excess.

The remedies provided to the County under sections A and C hereof for a breach by the Contractor shall not be exclusive. The County also shall be entitled to any other equitable and legal remedies that are available.

In the event of breach of this contract by the County, then the Contractor's remedy shall be limited to termination of the contract and receipt of payment as provided in section B hereof.

In the event of termination under Section A, the County shall provide the Contractor an opportunity for an administrative appeal to the Bureau Director.

D. CHANGES. The County may, from time to time, request changes in the scope of the services or terms and conditions hereunder. Such changes, including any increase or decrease in the amount of the Contractor's compensation, shall be incorporated in written amendments to this Contract.

E. NONDISCRIMINATION. In carrying out activities under this contract, the Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, age, familial status, national origin, gender identity, source of income, political affiliation, sexual orientation, marital status, and physical or mental disability. The Contractor shall take affirmative actions to insure that applicants for employment are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, age, handicap, familial status, national origin, gender identity, source of income, political affiliation, sexual orientation, marital status, and physical or mental disability. Such action shall include but not be limited to, the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship.

F. ACCESS TO RECORDS. The County, or their duly authorized representatives, shall have access to any books, general organizational and administrative information, documents, papers, and records of the Contractor that are directly pertinent to this contract, for the purpose of making audit examination, excerpts, and transcriptions. All required records must be maintained by the Contractor for three years after the County makes final payment and all other pending matters are closed.

G. MAINTENANCE OF RECORDS. The Contractor shall maintain records on a current basis to support its billings to the County. The County or its authorized representative shall have the authority to inspect, audit, and copy on reasonable notice and from time to time any records of the Contractor

regarding its billings or its work hereunder. The Contractor shall retain these records for inspection, audit, and copying for 3 years from the date of completion or termination of this contract.

H. AUDIT OF PAYMENTS. The County, either directly or through a designated representative, may audit the records of the Contractor at any time during the 3-year period established by Section G above.

If an audit discloses that payments to the Contractor were in excess of the amount to which the Contractor was entitled, then the Contractor shall repay the amount of the excess to the County.

I. INDEMNIFICATION. The County and the Contractor each shall be responsible, to the extent required by the Oregon Tort Claims Act (ORS 30.260-30.3000), only for the acts, omissions or negligence of its own officers, employees or agents.

J. WORKERS' COMPENSATION INSURANCE.

(a) The Contractor, its subcontractors, if any, and all employers working under this Agreement, are subject employers under the Oregon Worker's Compensation law and shall comply with ORS 656.017, which requires them to provide workers' compensation coverage for all their subject workers. A certificate of insurance, or copy thereof, shall be attached to this Agreement and shall be incorporated herein and made a term and part of this Agreement. The Contractor further agrees to maintain worker's compensation insurance coverage for the duration of this Agreement.

(b) In the event the Contractor's worker's compensation insurance coverage is due to expire during the term of this Agreement, the Contractor agrees to timely renew its insurance, either as a carrier-insured employer or a self-insured employer as provided by Chapter 656 of the Oregon Revised Statutes, before its expiration, and the Contractor agrees to provide the County such further certification of worker's compensation insurance a renewals of said insurance occur.

K. LIABILITY INSURANCE.

(a) The Contractor shall maintain public liability and property damage insurance that protects the Contractor and the County and its officers, agents, and employees from any and all claims, demands, actions, and suits for damage to property or personal injury, including death, arising from the Contractor's work under this contract. The insurance shall

provide coverage for not less than $200,000 for personal injury to each person, $500,000 for each occurrence, and $500,000 for each occurrence involving property damages; or a single limit policy of not less than $500,000 covering all claims per occurrence. The limits of the insurance shall be subject to statutory changes as to maximum limits of liability imposed on municipalities of the state of Oregon during the term of the agreement. The insurance shall be without prejudice to coverage otherwise existing and shall name as additional insureds the County and its officers, agents, and employees. Notwithstanding the naming of additional insureds, the insurance shall protect each insured in the same manner as though a separate policy had been issued to each, but nothing herein shall operate to increase the insurer's liability as set forth elsewhere in the policy beyond the amount or amounts for which the insurer would have been liable if only one person or interest had been named as insured. The coverage must apply as to claims between insureds on the policy. The insurance shall provide that it shall not terminate or be canceled without 30 days written notice first being given to the County Auditor. If the insurance is canceled or terminated prior to completion of the contract, Contractor shall provide a new policy with the same terms. Contractor agrees to maintain continuous, uninterrupted coverage for the duration of the contract. The insurance shall include coverage for any damages or injuries arising out of the use of automobiles or other motor vehicles by Contractor.

(b) The Contractor shall maintain on file with the County a certificate of insurance certifying the coverage required under subsection (a). The adequacy of the insurance shall be subject to the approval of the County Attorney. Failure to maintain liability insurance shall be cause for immediate termination of this agreement by the County.

In lieu of filing the certificate of insurance required herein, Contractor shall furnish a declaration that Contractor is self-insured for public liability and property damage for a minimum of the amounts set forth in ORS 30.270.

L. SUBCONTRACTING AND ASSIGNMENT. The Contractor shall not subcontract its work under this contact, in whole or in part, without the written approval of the County. The Contractor shall require any approved subcontractor to agree, as to the portion subcontracted, to fulfill all obligations of the Contract as specified in this contract. Notwithstanding County approval of a subcontractor, the Contractor shall remain obligated for full performance hereunder, and the County shall incur no obligation other than its obligations to the Contractor hereunder. The Contractor agrees that if subcontractors are

employed in the performance of this contract, the Contractor and its subcontractors are subject to the requirements and sanctions of ORS Chapter 656, Workers' Compensation. The Contractor shall not assign this contract in whole or in part or any right or obligation hereunder, without prior written approval of the County. Subcontractors shall be responsible for adhering to all regulations cited within this contract.

M. INDEPENDENT CONTRACTOR STATUS. The Contractor is engaged as an independent contractor and will be responsible for any federal, state, or local taxes and fees applicable to payments hereunder.

The Contractor and its subcontractors and employees are not employees of the County and are not eligible for any benefits through the County, including without limitation, federal social security, health benefits, workers' compensation, unemployment compensation, and retirement benefits.

N. REPORTING REQUIREMENTS. The Contractor shall report on its activities in a format and by such times as prescribed by the County.

O. CONFLICTS OF INTEREST. No County officer or employee, during his or her tenure or for one year thereafter, shall have any interest, direct or indirect, in this contact or the proceeds thereof.

No County officer or employees who participated in the award of this contract shall be employed by the Contractor during the period of the contract.

P. OREGON LAW AND FORUM. This contract shall be construed according to the law of the State of Oregon.

Any litigation between the County and the Contractor arising under this contract or out of work performed under this contract shall occur, if in the state courts, in the Multnomah County court having jurisdiction thereof, and if in the federal courts, in the United States District Court for the State of Oregon.

Q. COMPLIANCE WITH LAWS. In connection with its activities under this contract, the Contractor shall comply with all applicable federal, state, and local laws and regulations.

R. SEVERABILITY. If any provision of this agreement is found to be illegal or unenforceable, this agreement nevertheless shall remain in full force and effect and the provision shall be stricken.

S. INTEGRATION. This agreement contains the entire agreement between the County and the Contractor and supercedes all prior written or oral discussions or agreements.

T. PROGRAM AND FISCAL MONITORING. The County shall monitor on a regular basis to assure contract compliance. Such monitoring may include, but are not limited to, on site visits, telephone interviews, and review of required reports and will cover both programmatic and fiscal aspects of the contract. The frequency and level of monitoring will be determined by the County.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by duly authorized representatives as of the date of their signatures.

MULTNOMAH COUNTY

Diane M. Linn
Chair

Date: 10.2.03

OREGON BUREAU OF LABOR AND INDUSTRIES

Dan Gardner
Commissioner

Date: _____

Reviewed

AGNES SOWLE, COUNTY ATTORNEY
FOR MULTNOMAH COUNTY, OREGON

By _____
David N. Blankfeld
Assistant County Attorney

APPROVED : MULTNOMAH COUNTY
BOARD OF COMMISSIONERS
AGENDA # R-2 DATE 10.02.03
DEBORAH L. BOGSTAD, BOARD CLERK

EXHIBIT A

DESCRIPTION OF ENFORCEMENT SERVICES TO BE RENDERED BY THE BUREAU OF LABOR AND INDUSTRIES ("BOLI")

I. GENERAL DESCRIPTION OF SERVICES

BOLI shall provide administrative enforcement of complaints filed under Multnomah County Code ("MCC") §§ 15.340 to 15.347. This includes enforcement of claims filed against the County itself.

II. ENFORCEMENT STEPS

A. Filing a Complaint

1. Immediately upon receipt of a complaint alleging a violation of MCC 15.343 B., 15.344 B., or 15.345 B., BOLI shall commence processing of the complaint.

2. The procedures for filing a complaint are as follows:

   a. An individual makes an inquiry to the BOLI Civil Rights Division (CRD).

   b. An intake officer talks with the individual to determine whether he/she has a potential basis for filing a complaint under MCC §§ 15.340 to 15.347.

   c. If the intake officer determines that the individual has a basis for filing a complaint, one of the following two steps will be taken:

      (1) If the complaint involves potential violation of MCC 15.344 B (discrimination in housing) the complainant will be referred to the Fair Housing Council of Oregon which may schedule testing and referral to the private bar, or back to BOLI;

      (2) If the complaint involves a potential violation of MCC 15.343 B (discrimination in employment) or 15.345 B. (discrimination in public accommodations), an interview will be scheduled at BOLI.

   d. The intake officer will draw up a complaint which the individual will review and sign. The signature must be notarized. CRD will provide notary service if needed.

e. The notarized charge will be forwarded to a lead worker investigator for assignment to a senior civil rights investigator responsible for in-depth Complainant interviews and prompt charge assessment.

f. A complaint must be filed with BOLI within one year of the alleged unlawful practice. If the alleged unlawful practice is of a continuing nature, the right to file a complaint exists so long as the complaint is filed within one (1) year from any date of occurrence.

B. Notice of Filing

1. Notification letters will be sent to Respondent requesting a position statement within 14 days of filing. The Respondent's position statement will consist of the proper identification of the Respondent and a response to the specific allegations in the complaint.

2. Notification letters will be sent to the Complainant requiring that he/she contact the investigator within 14 days to schedule a complainant interview.

C. Charge Assessment

1. Complainants will be given an in-depth interview within 30 days from the date the complaint is filed with the Division. The interview will cover each specific harm suffered by the Complainant and the dates of occurrence. For each harm suffered, the Complainant must be able to specify relevant incidents to show specific intent or disparate treatment. The Complainant must be able to articulate linkages or causal connection between the harm and the protected class. Witnesses and comparators must be identified if the Complainant was in a position to have access to such information.

2. If the Complainant states that missing evidence exists, they will be given 14 days to provide the evidence upon request of the investigator. Failure to provide the required information will result in a dismissal.

3. Investigators will utilize the Civil Rights Division's screening criteria to separate the cases into A, B, or C categories.

a. **"A" CASES** are those which more likely than not will result in substantial evidence cases. Full investigation will be conducted until the investigator is able to write a substantial evidence administrative determination or a dismissal memo.

b. **"B" CASES** are those which need more information in order to determine whether it is an A or C case. The investigator may utilize the investigative tools of FFC, specific interrogatory, and witness/Respondent interviews as appropriate.

c. **"C" CASES** are those which are dismissed because the evidence gathered would not be sufficient to result in a substantial evidence finding. In most cases, Complainants will have been interviewed and a Respondent position statement will be in the case file.

Some examples of cases that can be resolved under C category dismissal are: nonjurisdictional, charges unsupported by any direct or circumstantial evidence of discrimination, and the Complainant was in a position to have access to such evidence, the Complainant was not credible.

4. When a dismissal has been determined, the Complainant will be informed that he/she may pursue their case through the courts and will receive a state notice of complainant's right to file a civil suit. The investigator who is responsible for deciding a dismissal must explain in the notice why the action to dismiss was taken.

5. Dismissal cases require the investigator to write a brief memo to the case file which must be signed by a second investigator and which states the reason why the case has been dismissed. A letter will be sent to the Complainant and Respondent advising them of the dismissal.

6. Cases that have not been dismissed after the Complainant interview will be assigned to a B team investigator who will continue the investigation on B cases. Cases in B category can be dismissed if it is determined that there are insufficient evidence to demonstrate that the case will not result in a cause finding.

D. Pre-Determination Settlement (PDS)

1. BOLI encourages complainants and respondents to resolve complaints by mutual agreement at any time before an Administrative Determination is made. CRD will notify both parties of this option in the notice of filing and during its initial contacts with them. CRD will mediate between the parties to aid such a settlement. CRD will not, however, permit these negotiations to become so lengthy that they defeat the overall purpose of the ordinance enforced by BOLI.

2. If, before an Administrative Determination is made, the parties agree upon settlement, a CRD representative will draft a PDS agreement. The agreement will state:

   a. That a "no-fault" settlement has been reached;

   b. That the complainant and respondent accept the terms of the agreement as a resolution of the complaint;

   c. The specific action(s) the respondent and/or complainant will take in settlement of the complaint and the time within which the action(s) will be taken; and

   d. That BOLI may investigate any alleged breaches of the agreement.

3. The complainant, respondent and CRD representative will sign the PDS agreement. Upon execution of the PDS agreement, CRD will close the complaint and notify the complainant and respondent.

E. Fact-Finding Conference

1. At such times as it deems appropriate, CRD may hold a fact-finding conference. When appropriate, the conference will occur within thirty (30) days of the filing of a complaint. Such a conference is part of CRD's investigation of the complaint. The purpose of the conference will be:

   a. To identify the undisputed elements of the complaint;

   b. To define and, if possible, resolve the disputed elements of the complaint; and

   c. To attempt to settle the complaint.

2. A representative of CRD will schedule the conference, notifying both the complainant and the respondent of the date, time and place. The CRD representative may require the complainant and/or respondent to provide information and documents for use at the conference and will make such request at least ten (10) days prior to the conference.

3. The complainant and the respondent may be accompanied by counsel, but counsel's role is advisory only. The conference will be informal and cross-examination will not be allowed. A complainant's failure to appear shall not result in administrative closure of the case through dismissal of charges

against the respondent, unless such failure is part of a sustained pattern of non-cooperation, making enforcement of the case unreasonable.

4. If the conference does not result in settlement, the CRD representative will either:

   a. Issue an Administrative Determination stating that there is substantial evidence of unlawful discrimination in support of the complainant's allegations; or

   b. Determine that there is insufficient evidence to issue an Administrative Determination and issue a dismissal memo or refer the case to an investigator to conduct a complete investigation.

F. Investigation

1. If a complaint is not resolved through pre-determination settlement or otherwise dismissed, CRD will investigate the allegations contained in the complaint. The purpose of the investigation is to determine objectively whether there is substantial evidence of unlawful discrimination.

2. The investigation will include interviews with the complainant, respondent and anyone else who may be a source of evidence. The investigation may also involve the examination and analysis of written documents.

3. Except at the request of a witness, neither the respondent nor the respondent's representative will be present during interviews of witnesses who are the respondent's nonsupervisory employees or former employees. Upon request, CRD will provide the complainant, respondent or witness with a copy of any existing written transcript or summary of his/her own testimony.

4. The investigator will make written requests to the respondent for documents, records, files or other sources of evidence. The respondent will be required to provide such information within twenty-one (21) days of the date of the investigator's written request. If the respondent is unable to provide the information within that time, he/she will notify the investigator within ten (10) days of the date of receipt of the investigator's request. The notification will be in writing and will state the specific time, not to exceed fourteen (14) days beyond the original due date, when the information will be provided.

5. The investigator will make all reasonable efforts to obtain the respondent's voluntary consent for access to the respondent's business premises, relevant evidence and sources of evidence when the nature of the complaint requires

such access. With the respondent's consent, the investigator, while on the respondent's business premises, may examine records and copy such materials and may take the statements of such employees as are relevant to the allegations of the complaint. If the respondent does not give voluntary consent, BOLI will exercise its vested authority to obtain the necessary information.

G. Administrative Determination/Dismissal

1. Upon completion of the investigation, CRD will issue an Administrative Determination based on the statements of the complainant, respondent and witnesses and the analysis of records and other relevant evidence. A copy of the Administrative Determination will be provided to the complainant and respondent.

2. If CRD finds no substantial evidence of unlawful discrimination, BOLI will close the complaint and notify the complainant and respondent of the closure. It will notify the complainant of his/her right, if any, to file a civil suit. If CRD finds substantial evidence of unlawful discrimination, BOLI will notify the complainant and respondent. The complaint will be assigned to a CRD representative for conciliation. However, the Commissioner may proceed directly to a contested case hearing if the interests of justice so require.

3. BOLI will process all cases from perfected charges through Administrative Determination within 90 days.

4. The Administrative Determination will be final.

H. Conciliation

1. If CRD finds substantial evidence of unlawful discrimination, a representative of CRD will seek to eliminate the effects of the unlawful discriminatory act(s) by conference, conciliation and persuasion. BOLI will not allow such negotiations to be so lengthy that they defeat the purposes of the ordinance enforced by BOLI. If an agreement is reached which is satisfactory to the complainant and respondent, CRD's representative will draft a conciliation agreement. The agreement will state:

   a. That the complainant and respondent accept the terms of the agreement as a resolution of the complaint;

b. The specific action(s) the respondent and/or complainant will take in settlement of the complaint and the time within which the action(s) will be taken; and

c. That CRD will investigate any alleged breaches of the agreement.

2. Upon execution of the agreement (signed by both parties), CRD will close the complaint and notify the complainant and respondent.

3. BOLI will complete the investigation and conciliation activities within 150 days after receipt of the complaint.

I. Failed Conciliation -- Contested Case Hearing

1. When CRD is unable to obtain voluntary compliance through conference, conciliation or persuasion, CRD will refer the complaint to its hearing presenter to be prepared for a contested case hearing.

III. TRAINING

BOLI will provide its investigators with training on enforcing the County's Civil Rights Ordinance.

IV. RECORDS CONFIDENTIALITY

ORS 192.501 (8) conditionally exempts investigatory information relating to any complaint filed under ORS 659A.040 or 659A.045, until such time as the complaint is resolved under ORS 659A.050, or a final administrative determination is made under ORS 659A.060. This exemption may not govern records filed with BOLI under County Code §§ 15.340 to 15.347. BOLI will therefore ensure that to the extent possible, records submitted to it meet the requirements detailed in ORS 192.502 (3) "Confidential Disclosures by Citizens."

V. ACCESS TO RECORDS BY THE COUNTY

BOLI will provide the County Attorney's Office and the Contract Manager with full access to open and closed case files, unless the County is the respondent. On-site inspection will be arranged at least two working days in advance with the Civil Rights Division.

VI. STATUS CONFERENCES AND QUARTERLY REPORTS

A. BOLI and the County shall schedule meetings of respective staff when requested by either party to discuss how enforcement of County Code §§ 15.340 to 15.347 is proceeding. The failure to schedule or complete any status conference shall not affect BOLI's obligation to provide written reports as required by this section.

B. BOLI shall prepare quarterly statistics showing the status of claims filed under this Agreement and shall provide such reports to the Contract Manager, on or before October 30, January 30, April 30 and July 30. Such BOLI reports shall contain a breakdown of all complaints made to BOLI, categorized by references to County Code §§ 15.340 to 15.347. Where complaints include claims of discrimination under federal or state discrimination laws, that information should be included. The report shall indicate at what broad stage of the BOLI administrative process the complaints are currently to be found. (e.g., prior to or post-fact finding conference, prior to or post-investigative stages, prior to or post-Administrative Determination, etc.)

EXHIBIT B

CONTRACT CHARGES

Detailed Quarterly Billing Statements:

BOLI shall prepare a detailed quarterly statement of charges specifying the individual cases for which payment is sought, with a breakdown of charges.

Contract Charges

BOLI will charge $1000.00 per case for the processing of complaints from II. A. "Filing a Complaint" to II. G. "Consultation" as described in Exhibit A. This charge includes administrative closures (due to lack of jurisdiction, uncooperative complainant, bankruptcy of respondent, etc.). Administrative closures run fewer than 25 percent of caseload. This practice of charging for administrative closures is consistent with current BOLI contracts with other entities.

Contested Case Hearings

BOLI will charge actual costs for case preparation and hearings. Although costs vary with difficulty per hearing, costs average $1,000. The Division projects to process 1 case through administrative hearings.

Post-hearing administrative expenses

BOLI will charge actual costs for such expenses. Examples include testimony transcription, settling and receiving supersedeas bonds and holding money in trust pending appeal.

AGENDA PLACEMENT REQUEST

BUD MOD #: **BCS 04-02, AS AMENDED**

APPROVED : MULTNOMAH COUNTY
BOARD OF COMMISSIONERS
AGENDA # R-3 DATE 10·02·03
DEBORAH L. BOGSTAD, BOARD CLERK

Board Clerk Use Only:

Meeting Date: **October 2, 2003**
Agenda Item #: **R-3**
Est. Start Time: **9:40 AM**
Date Submitted: **09/24/03**

Requested Date: 10/02/03 **Time Requested:** 5 minutes

Department: Business & Community Services **Division:** Human Resources

Contact/s: April Lewis

Phone: 503-988-5015 **Ext.:** 28869 **I/O Address:** 503/4

Presenters: April Lewis and David Blankfeld

Agenda Title: Budget Modification BCS 04-02 Requesting ~~$25,000~~ $10,000 General Fund Contingency Transfer for Enforcement of the County's Civil Rights Ordinance for Fiscal Year 2004

NOTE: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide clearly written title.

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1. **What action are you requesting from the Board? What is the department/agency recommendation**? The Department of Business & Community Services (DBCS) recommends the transfer of ~~$25,000~~ $10,000 from General Fund contingency and requests authorization to spend up to that amount in payments for enforcement of the County's Civil Rights Ordinance.

2. **Please provide sufficient background information for the Board and the public to understand this issue**. On November 29th, 2001, the Board of County Commissioners approved Multnomah County Ordinance #969 which bans discrimination on the basis of sexual orientation, gender identity, and source of income in housing, employment, and public accommodations for all Multnomah County residents. In FY 2002 and FY 2003, the County (through DBCS) contracted with the Bureau of Labor and Industries (BOLI) to enforce civil rights protections included in Ordinance 969.

When complaints are filed that require investigation, the County pays BOLI for work performed and services rendered in investigating and, if necessary, settling the complaint. In FY 2002, the Board of County Commissioners appropriated $25,000 from the General Fund contingency to investigate and settle complaints, and in FY 2003 this item was included in the DBCS budget. It was inadvertently omitted from the FY 2004 budget.

3. **Explain the fiscal impact (current year and ongoing).** This action would reduce the General Fund contingency by ~~$25,000~~ $10,000 in FY 2004. Actual expenditures for investigation of civil rights complaints will not be known until the end of the fiscal year. The Budget Office has made a note to include this item in DBCS' FY 2005 budget request.

If a budget modification, explain:

- **What revenue is being changed and why**? No revenue impact.
- **What budgets are increased/decreased**? General Fund contingency is reduced by ~~$25,000~~ $10,000; and DBCS-Human Resources budget is increased by ~~$25,000~~ $10,000.
- **What do the changes accomplish**? The change will appropriate funds to enable the County to contract with BOLI for civil rights violation investigations.
- **Do any personnel actions result from this budget modification? Explain.** None.
- **Is the revenue one-time-only in nature**? NA
- **If a grant, what period does the grant cover**? N/A
- **When the grant expires, what are funding plans**? N/A

NOTE: Attach Bud Mod spreadsheet (FORM FROM BUDGET)

If a contingency request, explain:

- **Why was the expenditure not included in the annual budget process**? It was inadvertently omitted from the department's request.
- **What efforts have been made to identify funds from other sources within the Department/Agency to cover this expenditure**? Professional Services was looked at as a source, but none is available.
- **Why are no other department/agency fund sources available**? Professional Services funds were cut during the budget process and none is available to support this.
- **Describe any new revenue this expenditure will produce, any cost savings that will result, and any anticipated payback to the contingency account.** N/A
- **Has this request been made before**? **When**? **What was the outcome**? This request was made in FY 2002 as the result of a budget note identifying contingency as an appropriate place to seek funding for the (then) anticipated County civil rights ordinance.

4. **Explain any legal and/or policy issues.**
The County is required to enforce its Board Adopted non-discrimination policies Countywide.

5. **Explain any citizen and/or other government participation that has or will take place.** The County attorney's office has worked with the City of Portland attorneys to ensure that both agencies' contracts are in agreement and alignment with each other.

Required Signatures:

Department/Agency Director: *Tony Mounts* **Date: 09/24/03**

Budget Analyst

By: *Ching Hay* **Date: 09/24/03**

Dept/Countywide HR

By: *Gail Parnell* **Date: 09/24/03**

Budget Modification: **BCS 04-02**

EXPENDITURES & REVENUES

lease show an increase in revenue as a negative value and a decrease as a positive value for consistency with MERLIN.

ine No.	Fund Center	Fund Code	Accounting Unit: *Internal Order*	Accounting Unit: *Cost Center*	Accounting Unit: *WBS Element*	Cost Element	Current Amount	Revised Amount	Change Increase/ (Decrease)	Subtotal	Description
1	70-01	1000		707000		60170	-	10,000	10,000		Professional Services
2	19	1000		9500001000		60470		(10,000)	(10,000)		General Fund Contingency
3								0			
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									0	**0**	**Total - Page 1**
									0	**0**	**GRAND TOTAL**

MULTNOMAH COUNTY, OREGON

BUDGET & QUALITY
MULTNOMAH BUILDING
501 SE HAWTHORNE BLVD, 4TH FLOOR
P. O. BOX 14700
PORTLAND, OR 97214
PHONE (503) 988-3883

TO: Board of County Commissioners

FROM: Julie Neburka, Budget Office

DATE: September 24, 2003

RE: Bud Mod DBCS 04-02

The Department of Business & Community Services (DBCS) is requesting ~~$25,000~~ $10,000 from the General Fund Contingency in order to cover costs associated with the County's civil rights ordinance. This ordinance requires some amount of complaint processing, investigation, mediation, negotiation, and preparation for and representation at administrative hearings. The Bureau of Labor & Industries (BOLI) has provided these services annually since FY 2002 for a cost not to exceed $25,000 per year. DBCS administers and monitors the performance of this small contract.

It should be noted that costs associated with the County's civil rights ordinance to date have averaged about $3,000 per year since the ordinance was approved in November of 2001. Any appropriation not used for expenses related to the contract will revert to the General Fund at the end of the fiscal year, and the Budget Office has made a note to ensure that this contract is included as an ongoing expense in the department's FY 2005 budget. The Budget Office recommends approval of this bud mod, which will reduce the General Fund contingency by ~~$25,000~~ $10,000.

BOGSTAD Deborah L

From: BELL Iris D
Sent: Wednesday, October 01, 2003 3:51 PM
To: LEWIS April D; BLANKFELD David N
Cc: LINN Diane M; COMITO Charlotte A; CARROLL Mary P; BROWN Carol L; NEBURKA Julie Z; BOGSTAD Deborah L
Subject: R-3 BUD MOD
Importance: High

April/David-

We have agreed to amend the BUD MOD to a $10,000 general fund contingency request. Commissioner Cruz or Naito will call for the Amendment with the understanding that any unused portion of these funds be returned to the general fund. A discussion of the need to monitor and track the use of these funds will take place along with a request that the Office of Diversity, Equity and Affirmative Action produce for the FY 2005 a proposed budget to be used solely for the purpose of responding to Civil Rights complaints. We would also like updates from the Office on how these complaints are proceeding and the amount of money that is being expended; these updates can be made to the Chair and Commissioners on a monthly or quarterly basis, which ever is most practical.

Thank you all for helping to resolve this matter. I look forward to working with you on other mutual efforts of this type as they are very rewarding once resolved.

iris

Iris M.D. Bell
Deputy Chief of Staff
Multnomah County Chair's Office
(503) 988-4034

AGENDA PLACEMENT REQUEST

BUD MOD #: **BCS 04-02**

Board Clerk Use Only:

Meeting Date: **October 2, 2003**
Agenda Item #: **R-3**
Est. Start Time: **9:40 AM**
Date Submitted: **09/24/03**

Requested Date: 10/02/03 **Time Requested:** 5 minutes

Department: Business & Community Services **Division:** Human Resources

Contact/s: April Lewis

Phone: 503-988-5015 **Ext.:** 28869 **I/O Address:** 503/4

Presenters: April Lewis and David Blankfeld

Agenda Title: Budget Modification BCS 04-02 Requesting $25,000 General Fund Contingency Transfer for Enforcement of the County's Civil Rights Ordinance for Fiscal Year 2004

NOTE: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide clearly written title.

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1. **What action are you requesting from the Board? What is the department/agency recommendation**? The Department of Business & Community Services (DBCS) recommends the transfer of $25,000 from General Fund contingency and requests authorization to spend up to that amount in payments for enforcement of the County's Civil Rights Ordinance.

2. **Please provide sufficient background information for the Board and the public to understand this issue.** On November 29th, 2001, the Board of County Commissioners approved Multnomah County Ordinance #969 which bans discrimination on the basis of sexual orientation, gender identity, and source of income in housing, employment, and public accommodations for all Multnomah County residents. In FY 2002 and FY 2003, the County (through DBCS) contracted with the Bureau of Labor and Industries (BOLI) to enforce civil rights protections included in Ordinance 969.

When complaints are filed that require investigation, the County pays BOLI for work performed and services rendered in investigating and, if necessary, settling the complaint. In FY 2002, the Board of County Commissioners appropriated $25,000 from the General Fund contingency to investigate and settle complaints, and in FY 2003 this item was included in the DBCS budget. It was inadvertently omitted from the FY 2004 budget.

3. **Explain the fiscal impact (current year and ongoing).** This action would reduce the General Fund contingency by $25,000 in FY 2004. Actual expenditures for investigation of civil rights complaints will not be known until the end of the fiscal year. The Budget Office has made a note to include this item in DBCS' FY 2005 budget request.

If a budget modification, explain:

- **What revenue is being changed and why**? No revenue impact.
- **What budgets are increased/decreased**? General Fund contingency is reduced by $25,000; and DBCS-Human Resources budget is increased by $25,000.
- **What do the changes accomplish**? The change will appropriate funds to enable the County to contract with BOLI for civil rights violation investigations.
- **Do any personnel actions result from this budget modification? Explain.** None.
- **Is the revenue one-time-only in nature**? NA
- **If a grant, what period does the grant cover**? N/A
- **When the grant expires, what are funding plans**? N/A

NOTE: Attach Bud Mod spreadsheet (FORM FROM BUDGET)

If a contingency request, explain:

- **Why was the expenditure not included in the annual budget process**? It was inadvertently omitted from the department's request.
- **What efforts have been made to identify funds from other sources within the Department/Agency to cover this expenditure**? Professional Services was looked at as a source, but none is available.
- **Why are no other department/agency fund sources available**? Professional Services funds were cut during the budget process and none is available to support this.
- **Describe any new revenue this expenditure will produce, any cost savings that will result, and any anticipated payback to the contingency account.** N/A
- **Has this request been made before**? **When**? **What was the outcome**? This request was made in FY 2002 as the result of a budget note identifying contingency as an appropriate place to seek funding for the (then) anticipated County civil rights ordinance.

4. **Explain any legal and/or policy issues.**
The County is required to enforce its Board Adopted non-discrimination policies Countywide.

5. **Explain any citizen and/or other government participation that has or will take place**. The County attorney's office has worked with the City of Portland attorneys to ensure that both agencies' contracts are in agreement and alignment with each other.

Required Signatures:

Department/Agency Director: *Tony Mounts* **Date: 09/24/03**

Budget Analyst

By: *Ching Hay* **Date: 09/24/03**

Dept/Countywide HR

By: *Gail Parnell* **Date: 09/24/03**

Budget Modification: **BCS 04-02**

EXPENDITURES & REVENUES

Please show an increase in revenue as a negative value and a decrease as a positive value for consistency with MERLIN.

Line No.	Fund Center	Fund Code	Accounting Unit *Internal Order*	Accounting Unit *Cost Center*	Accounting Unit *WBS Element*	Cost Element	Current Amount	Revised Amount	Change Increase/ (Decrease)	Subtotal	Description
1	70-01	1000		707000		60170	-	25,000	25,000		Professional Services
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									0	**0**	**GRAND TOTAL**

MULTNOMAH COUNTY, OREGON

BUDGET & QUALITY
MULTNOMAH BUILDING
501 SE HAWTHORNE BLVD, 4TH FLOOR
P. O. BOX 14700
PORTLAND, OR 97214
PHONE (503) 988-3883

TO: Board of County Commissioners

FROM: Julie Neburka, Budget Office

DATE: September 24, 2003

RE: Bud Mod DBCS 04-02

The Department of Business & Community Services (DBCS) is requesting $25,000 from the General Fund Contingency in order to cover costs associated with the County's civil rights ordinance. This ordinance requires some amount of complaint processing, investigation, mediation, negotiation, and preparation for and representation at administrative hearings. The Bureau of Labor & Industries (BOLI) has provided these services annually since FY 2002 for a cost not to exceed $25,000 per year. DBCS administers and monitors the performance of this small contract.

It should be noted that costs associated with the County's civil rights ordinance to date have averaged about $3,000 per year since the ordinance was approved in November of 2001. Any appropriation not used for expenses related to the contract will revert to the General Fund at the end of the fiscal year, and the Budget Office has made a note to ensure that this contract is included as an ongoing expense in the department's FY 2005 budget. The Budget Office recommends approval of this bud mod, which will reduce the General Fund contingency by $25,000.

AGENDA PLACEMENT REQUEST

BUD MOD #:

Board Clerk Use Only:

Meeting Date: October 2, 2003
Agenda Item #: R-4
Est. Start Time: 9:45 AM
Date Submitted: 09/24/03

Requested Date: October 2, 2003 **Time Requested:** 10 minutes

Department: Non-Departmental **Division:** Commission District 3

Contact/s: Charlotte Comito

Phone: 503.988-5217 **Ext.:** 85217 **I/O Address:** 503/600

Presenters: Commissioner Lisa Naito, John Holmes, Invited Others

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Agenda Title: PROCLAMATION Proclaiming October 5 through 11, 2003 Mental Illness Awareness Week in Multnomah County, Oregon

NOTE: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide clearly written title.

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1. **What action are you requesting from the Board? What is the department/agency recommendation?** Approval

2. **Please provide sufficient background information for the Board and the public to understand this issue.**

3. **Explain the fiscal impact (current year and ongoing).**

   NOTE: If a Budget Modification or a Contingency Request attach a Budget Modification Expense & Revenues Worksheet and/or a Budget Modification Personnel Worksheet.

   If a budget modification, explain:
   - **What revenue is being changed and why?**
   - **What budgets are increased/decreased?**

- ❖ What do the changes accomplish?
- ❖ Do any personnel actions result from this budget modification? Explain.
- ❖ Is the revenue one-time-only in nature?
- ❖ If a grant, what period does the grant cover?
- ❖ When the grant expires, what are funding plans?

NOTE: Attach Bud Mod spreadsheet (FORM FROM BUDGET)

If a contingency request, explain:

- ❖ Why was the expenditure not included in the annual budget process?
- ❖ What efforts have been made to identify funds from other sources within the Department/Agency to cover this expenditure?
- ❖ Why are no other department/agency fund sources available?
- ❖ Describe any new revenue this expenditure will produce, any cost savings that will result, and any anticipated payback to the contingency account.
- ❖ Has this request been made before? When? What was the outcome?

If grant application/notice of intent, explain:

- ❖ Who is the granting agency?
- ❖ Specify grant requirements and goals.
- ❖ Explain grant funding detail – is this a one time only or long term commitment?
- ❖ What are the estimated filing timelines?
- ❖ If a grant, what period does the grant cover?
- ❖ When the grant expires, what are funding plans?
- ❖ How will the county indirect and departmental overhead costs be covered?

4. Explain any legal and/or policy issues.

5. Explain any citizen and/or other government participation that has or will take place.

Required Signatures:

Department/Agency Director: Date: September 24, 2003

Budget Analyst
By: Date:

Dept/Countywide HR
By: Date:

BEFORE THE BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

PROCLAMATION NO. _____

Proclaiming October 5 through 11, 2003 Mental Illness Awareness Week in Multnomah County, Oregon

The Multnomah County Board of Commissioners Finds:

a) Mental Health is essential to health, every individual, family and community must understand that mental health is an essential part of overall health and we must increase suicide prevention by reducing the stigma of seeking care;

b) It is essential to eliminate disparities in mental health by promoting well-being for all, regardless of race, ethnicity, language, place of residence or age and ensure equity of access, delivery of services and improvement of outcomes, through public and private partnership to ensure culturally competent care to all;

c) Consumers and families must have the necessary information and the opportunity to exercise choice over their care decisions, including individualized plans of care, expanded supported employment, enhanced rights protections, better criminal and juvenile justice diversion and re-entry programs, improve access to housing, and end chronic homelessness;

d) Every individual must have the opportunity for early and appropriate mental health screening, assessment and referral to treatment;

e) Adults and children with mental illness must have ready access to evidence-based best treatments, services and supports leading to recovery

f) The mental health system must inform consumers, providers and public policy with quality, accessible and accountable information supporting improved care and information dissemination

The Multnomah County Board of Commissioners Proclaims:

1. October 5 through 11, 2003, as Mental Illness Awareness Week in Multnomah County, Oregon, to increase public awareness of severe mental illness and in so doing to promote greater access to effective treatments for those who suffer from the potentially disabling symptoms of these disorders.

ADOPTED this 2nd day of October, 2003.

BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

_____
Diane M. Linn, County Chair

_____
Maria Rojo de Steffey,
Commissioner Dist 1

_____
Serena Cruz,
Commissioner Dist 2

_____
Lisa Naito,
Commissioner Dist 3

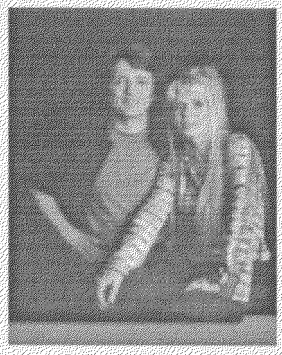
_____
Lonnie Roberts,
Commissioner District 4

Mental Illness Awareness Week
October 5-11, 2003

NAMI-MC has scheduled two exciting, FREE events for Mental Illness Awareness Week. We hope to see you at both events!!

James Gordon and Sandy Horne in Concert

When: Wednesday, October 8; 7-9 pm
Laurelhurst Presbyterian Church, 935 NE 33rd, 97232



James Gordon, a renowned Canadian Folksinger-Songwriter and Sandy Horne, will perform songs from his newly released CD about mental health issues entitled "1 in 5." Songs from "1 in 5" were written using the poems and stories of people with personal mental health experiences. This concert will be a moving experience for consumers and family members. To hear samples of James Gordon's music, please go to www.jamesgordon.ca.

Breakfast Talk with Dr. Barbara Limandri from OHSU

When: Friday, October 10; 8-10 am
Topic: The Brain and Medications Helping the Client and the Family
Oregon State Office Building, 800 NE Oregon St, Room 120-B, 97232

Dr. Limandri will speak about psychopharmacology and the impact of medication on brain physiology. Her talk will present helpful scientific information in lay-terms and will help families and consumers struggling with mental illness better understand the importance and impact of medications.

For more information, please call
the NAMI-MC office at (503) 228-5692.

MENTAL ILLNESS AWARENESS WEEK MAY 2003

NAMI Multnomah Reporter

NATIONAL ALLIANCE FOR THE MENTALLY ILL OF MULTNOMAH COUNTY

NAMI-PORTLAND'S VOICE ON MENTAL ILLNESS—MC

Volume 28, Issue 10 • October 2003

MENTAL ILLNESS AWARENESS WEEK (MIAW)

OCTOBER 5-11, 2003

12th Annual Rondeau Lecture

Dr. Robert Drake, M.D., Ph.D.

Supportive Employment for Clients with Psychiatric Disabilities

Thursday, October 16
5:30 pm reception, 6:30 pm lecture
Doernbecher Children's Hospital,
3181 SW Sam Jackson Park Rd,
Marion Miller Auditorium, 11th Fl

Dr. Drake is the Andrew Thomson Professor of Psychiatry and Community Family Medicine at Dartmouth Medical School and the Director of New Hampshire-Dartmouth Psychiatric Research Center. In addition to working actively as a clinician in community mental health centers for the past 20 years, he has been developing and evaluating innovative community programs for persons with severe mental disorders.

He is well known for his work in co-occurring substance use disorder and severe mental illness. Some of his recent work has focused on vocational rehabilitation. His over 200 publications cover diverse aspects of adjustment and quality of life among persons with severe mental disorders and those in their support systems.

Virtual Hallucination Machine Comes to Multnomah County

NAMI-MC, thanks to Janssen Pharmaceutica, has the privilege of exhibiting one of the few Virtual Hallucination Machines in the country for two days during MIAW. The Virtual Hallucination Machine is an educational experience designed to create empathy for those with schizophrenia. A portable laptop unit runs the computer program, allowing the machine to travel to medical and advocacy meetings, academic settings and even physician offices.

The machine simulates the experiences of someone suffering from severe and persistent mental illness. By using the machine, family members and health care professionals gain insight into the nature of mental illness. By creating auditory and visual hallucinations the machine gives the user an an eye-opening, and sometimes harrowing, first-hand experience of mental illness.

An early version of the machine was developed in 1998 as a cassette tape that simulated schizophrenic auditory hallucinations. A number of individuals with the disease, as well as psychiatrists, were interviewed about their own experiences or that of their patients'. In the resulting tape, voices were recorded that sought to re-create a composite of these experiences - both in tonality and content.

With the increasing sophistication of computers, the simulation was made even more realistic by expanding it to include visual as well as auditory hallucinations. A panel of experts helped to visualize the images and delusions most likely to haunt individuals with schizophrenia. The next improvement was made by creating a lightweight earphones-and-goggles unit - complete with full-motion tracking capabilities, a 360-degree field of vision and surround sound - that allows participants to experience both sight and sound.

MENTAL ILLNESS AWARENESS WEEK Oct 5-11 2003

NAMI-MC will have the machine available for the public to try during several events on Monday, October 6 and Tuesday, October 7. See the schedule on page 3 for more details.

Our General Meeting for this month will provide a a wonderful opportunity for members to try the machine. The General Meeting is on Monday, October 6 from 6-7 pm at Providence Medical Center, 4805 NE Glisan, Room HCC8. Food will be served at 6 pm. Support groups will start at 7 pm. Please join us for this truly unique experience and help us kick-off MIAW.

NAMI MULTNOMAH REPORTER

A monthly publication of
NAMI of Multnomah County

Our mission is to improve the quality of life for people with mental illnesses and their families through support groups, education classes and advocacy.

524 NE 52nd Avenue
Portland, OR 97213
phone: (503) 228-5692
www.nami.org/multnomah

From Education to Advocacy Conference

How to Work with the Mental Health System

Hosted by NAMI-Oregon

When: Saturday, October 11
Location: Salem Hospital Auditorium, 665 Winter St SE, 97309
Time: 9:30am - 4:30pm
Cost: Free

This conference is designed to give consumers, family members, advocates, and professionals a broad, yet intensive, look at how to partner effectively with the mental health system.

Registration is free, but space is limited. Please reserve your spot by calling NAMI-Oregon at (503) 370-7774 or (800) 343-6264. Refreshments and lunch included.

14th Saward Lecture

Understanding and Treating Emotional and Behavioral Disorders in Children

By Peter S. Jensen, MD

Monday, October 13
7:30-9 pm
Newmark Theater
Portland Center for the Performing Arts
1111 SW Broadway

A reception will follow the lecture.

Tickets to the Saward Lecture are free but required. You may order tickets by calling (503) 335-2466. Tickets will be given out on a first-come, first-serve basis.

Peter S. Jensen, MD, is the Director of the *Center for the Advancement of CHildren's Mental Health-Putting Science to Work*, and Ruane Professor of Child Psychiatry at the Columbia College of Physicians and Surgeons. Before his appointment to Columbia University in 2000, Dr. Jensen was the Associate Director of Child and Adolescent Research at the National Institute of Mental Health (NIMH).

Dr. Jensen is the author of more than 200 scientific articles and book chapters, has written or co-edited nine books on children's mental health, and serves on many editorial and scientific advisory boards. Dr. Jensen's current research focuses on translating scientifically valid assessment and intervention methods into "real-world" settings.

NAMI–MC Calendar of Events

October 2003

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2 **VFT Education Class** 6:30-8:30 pm Albertina Kerr Centers, 722 NE 162nd Ave Portland, OR	3	4
5	6 **General Meeting**, 6 pm PMC, HCC8 4805 NE Glisan St **F-to-F Support Group**, 7 pm PMC, Social Room **VFT Support Group**, 7 pm NAMI-MC Office	7	8 **F-to-F Support Group** 11 am Jeanne Maze, (503) 239-0292	9	10	11 **NAMI-Oregon From Education to Advocacy Conference** 9:30-4:30 pm Salem Hospital Auditorium, 665 Winter St SE
12	13 **F-to-F Support Group** 2130 SW 5th, Ste 201 Carol Slegers, (503) 645-7978 **14th Saward Lecture** Dr. Peter Jensen, 7:30-9 pm Newmark Theater, 1111 SW Broadway	14	15 **Board Meeting** 6:30-8 pm John Holmes, (503) 228-5692	16 **Rondeau Lecture** Dr. Robert Drake Reception, 5:30 pm Lecture, 6:30 pm Doernbecher Children's Hospital Marion Miller Auditorium, 11th Floor	17	18
19	20 **F-to-F Support Group**, 7 pm NAMI-MC Office **VFT Support Group**, 7 pm PMC, HCC6 4805 NE Glisan St	21	22 **F-to-F Support Group** 11 am Jeanne Maze, (503) 239-0292	23 **Mood Disorders Public Forum** Movie Night: "About Schmidt" 5:30-8 pm Portland VA Auditorium (503) 220-3483	24	25
26	27 **F-to-F Support Group** 7 pm Cascadia Business Building 2130 SW 5th, Ste 201 Carol Slegers, (503) 645-7978	28	29	30	31	

Mental Illness Awareness Week-See page 3 for event details

Community Groups

Anxiety/Agoraphobia/Panic Attack
When: 2nd Saturday; 2:30—4:30 PM
Location: Mt. Hood Medical Center, 24800 SE Stark
Contact: Patricia L. Brost RN, (503) 674-1287

Asperger's Syndrome Support
Contact: Roger Meyer, (503) 666-2776
www.aspergersnet.org

Borderline Personality Disorder Peer Support Group
When: Thursdays, 1-2:30 pm
Location: Wise Counsel & Comfort Building, 1305 NE Fremont
Contact: Jeanne Clawson, (503) 231-1334

Brain Injury Support
Contact: Joan Brown, (503) 413-8918

Children and Adults with ADD
Contact: (503) 294-9504

Cascadia Family Support
When: 4th Tuesday; 5:30—7 PM
Location: 2415 SE 43rd Ave, 1st Fl Lobby
Contact: Jennifer Wilcox, (503) 238-0705

When: 2nd Tuesday; 5:30—7 PM
Location: Cascadia-Gresham, 400 NE 7th
Contact: Carol Laine, (503) 661-5455

Depression and Bipolar Support Alliance (DBSA)
When: Tuesdays; 7 PM
Location: OHSU, 3rd Fl Cafeteria Area
Contact: Glenda Westin, (503) 245-2311

Location: Hillsboro
Contact: Gen Horlacher, (503) 357-6331
www.dbsalliance.org

Dual Diagnosis Anonymous (DePaul Center)
Contact: (503) 535-1174

Emotions Anonymous
When: Wednesdays; 7:30 PM
Location: Portland Mennonite Church, 1312 SE 35th Ave.
Contact: (503) 240-6064

Friends of Forensics
When: Sept 10, Nov 12; 12:30-2 PM
Location: Oregon State Hospital, Salem
Contact: Dale Rector, (503) 492-2658

Healing from Depression and Anxiety Support
When: Mon, Wed, Thurs; 7-10 PM; or Tues; 4-7 PM
Contact: Douglas Bloch, (503) 284-2848
www.healingfromdepression.com

Latina Sexual Assault Support Group
When: Mondays
Location: Portland/ Gresham Area
Contact: Diane Camarillo, Volunteers of America–Family Center, (503) 771-5503 for screening/intake

Mood Disorders Center Public Forum
When: 4th Thursday; 5:30—7 PM
Location: Portland VA Medical Center Auditorium
Contact: (503) 220-3483

Obsessive Compulsive Disorder Support
Contact: (503) 494-6167

Recovery, Inc.
Support group for various mood disorders.
Contact: Jeanne Clawson, (503) 231-1334
www.recovery-inc.org

Suicide Bereavement Support
When: 3rd Monday; 7 PM
Location: Peace House, 2116 NE 18th
Contact: Claire Meyer, (503) 236-8444

Suicide Support Groups-Various
Location: The Dougy Center, 3909 SE 52nd
Contact: Joan Schweizerhoff, (503) 775-5683

Catholic Families with a Disabled Family Member
Contact: Molly, (503) 233-8319

Tourette's Syndrome
When: Last Sunday; 3—5 PM (quarterly)
Location: Bethal Congregational Church, Beaverton

Drop-in Centers

David's Harp
11261 NE Knott; (503) 253-8883
Mon, Fri 10:30—2 pm; Wed 1:30—5 pm

FolkTime
4837 NE Couch Street; (503) 238-6428
Mondays & Wednesday

Renaissance
2415 SE 43rd Avenue; (503) 232-8503
Mon-Fri 9—9 pm; Sat 1—5 pm

Safe Haven
12015 SE 22nd, Milwaukee; (503) 238-6428
Tuesdays & Thursdays

Places to Contact

NAMI National Hotline
(800) 950-6264

Multnomah County Crisis Hotline
(800) 716-9769; (503) 988-4888

Verity Membership Services
(503) 988-5887

Multnomah Medicaid Enrollment Team
(503) 988-3816
www.mchealth.org/medicaid/whoarewe.html

State Department of Mental Health
(503) 945-9700

Oregon Advocacy Center
(503) 243-2081

Mood Disorders Center
(503) 220-3483

Youthline
1-(877) 553-TEEN

United Way Information and Referral Line
(503) 222-5555, Mon-Fri 8-6

PhRMA Prescription Assistance
www.healthyoregon.org

Mental Illness Awareness Week Events

(all events are free unless otherwise noted)

Monday, October 6

Virtual Hallucination Machine Presentation, Noon-1 pm

Cascadia Business Building, 2130 SW 5th, Ste 201

Mental Health Fair, 3-5 pm

Providence Medical Center, 4805 NE Glisan St, Main Hospital Lobby

The major feature of the fair will be a Virtual Hallucination Machine that simulates schizophrenia. Mental health care providers, clinics, pharmaceutical companies and other community partners will be present.

NAMI-MC General Meeting-Topic: Virtual Hallucination Machine, 6-7 pm

Providence Medical Center, 4805 NE Glisan St, HCC8

Come try the machine and help us kick-off MIAW. Food will be served at 6 pm. Support groups will follow at 7 pm.

Tuesday, October 7

Virtual Hallucination Machine Presentation, Noon-2 pm

Cascadia Plaza Building, 2415 SE 43rd (near Division), 97206

Mental Health Fair, 3-5 pm

Legacy Emanuel Hospital, 2801 N. Gantenbein Avenue, 97227, Atrium

The major feature of the fair will be a Virtual Hallucination Machine that simulates schizophrenia. Mental health care providers, clinics, pharmaceutical companies and other community partners will be present.

Wednesday, October 8

James Gordon and Sandy Horne in Concert, 7-9 pm

Laurelhurst Presbyterian Church, 935 NE 33rd, 97232

James Gordon, a renowned Canadian Folksinger-Songwriter and Sandy Horne, will perform songs from his newly released CD about mental health issues entitled "1 in 5." Songs from "1 in 5" were written using the poems and stories of people with personal mental health experiences. This concert will be a moving experience for consumers and family members. To hear samples of James Gordon's music, please go to www.jamesgordon.ca.

Thursday, October 9

Healing From Depression and Anxiety Workshop with Douglas Bloch, 7-9 pm

Adventist Medical Center, Amphitheater C, 1023 SE Market St, 97216

Cost: $12

Contact: Call 503-256-4000 to pre-register

Friday, October 10

Breakfast Talk with Dr. Barbara Limandri from OHSU, 8-10 am

Topic: The Brain and Medications Helping the Client and the Family

Oregon State Office Building, 800 NE Oregon St, Room 120-B, 97232

Dr. Limandri will speak about psychopharmacology and the impact of medication on brain physiology. Her talk will present helpful scientific information in lay-terms and will help families and consumers struggling with mental illness better understand the importance and impact of medications.

NAMI Multnomah Reporter

National Alliance For The Mentally Ill of Multnomah County

NAMI—Portland's Voice on Mental Illness

Volume 28, Issue 10 • October 2003

NAMI In Nearby Counties

Oregon-Salem
(800) 343-6264
namior@comcast.net
www.namioregon.org

Clackamas County
Oak Grove
(503) 656-4367

Clark County
Vancouver, WA
(360) 695-2823
namicc1@aol.com

Washington County
Aloha
(503) 356-6835
www.namiwash.org

Borderline Personality Disorder Support Group

When: Thursdays, 1-2:30 pm
Location: Wise Counsel & Comfort Bldg, 1305 NE Fremont

A peer support group has been created to assist people with borderline personality disorder maintain stability and gain new strategies for managing life's stresses. Participants must have a diagnosis of borderline personality disorder and be 18 or older.

For information call Jeanne Clawson at (503) 666-8790.

NAMI of Multnomah County
524 NE 52nd Avenue
Portland, OR 97213

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BEFORE THE BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

PROCLAMATION NO. 03-137

Proclaiming October 5 through 11, 2003 Mental Illness Awareness Week in Multnomah County, Oregon

The Multnomah County Board of Commissioners Finds:

a) Mental Health is essential to health, every individual, family and community must understand that mental health is an essential part of overall health and we must increase suicide prevention by reducing the stigma of seeking care;

b) It is essential to eliminate disparities in mental health by promoting well-being for all, regardless of race, ethnicity, language, place of residence or age and ensure equity of access, delivery of services and improvement of outcomes, through public and private partnership to ensure culturally competent care to all;

c) Consumers and families must have the necessary information and the opportunity to exercise choice over their care decisions, including individualized plans of care, expanded supported employment, enhanced rights protections, better criminal and juvenile justice diversion and re-entry programs, improve access to housing, and end chronic homelessness;

d) Every individual must have the opportunity for early and appropriate mental health screening, assessment and referral to treatment;

e) Adults and children with mental illness must have ready access to evidence-based best treatments, services and supports leading to recovery

f) The mental health system must inform consumers, providers and public policy with quality, accessible and accountable information supporting improved care and information dissemination

The Multnomah County Board of Commissioners Proclaims:

1. October 5 through 11, 2003, as Mental Illness Awareness Week in Multnomah County, Oregon, to increase public awareness of severe mental illness and in so doing to promote greater access to effective treatments for those who suffer from the potentially disabling symptoms of these disorders.

ADOPTED this 2nd day of October, 2003.

BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

Diane M. Linn, County Chair

Maria Rojo de Steffey,
Commissioner Dist 1

Serena Cruz,
Commissioner Dist 2

Lisa Naito,
Commissioner Dist 3

Lonnie Roberts,
Commissioner District 4

AGENDA PLACEMENT REQUEST

BUD MOD #:

Board Clerk Use Only:

Meeting Date: October 2, 2003
Agenda Item #: R-5
Est. Start Time: 9:55 AM
Date Submitted: 09/24/03

Requested Date: October 2, 2003 **Time Requested:** 10 minutes

Department: Non-Departmental **Division:** Commission District 3

Contact/s: Charlotte Comito

Phone: 503.988-5217 **Ext.:** 85217 **I/O Address:** 503/600

Presenters: Commissioner Lisa Naito, Chiquita Rollins

Agenda Title: PROCLAMATION Proclaiming October 2003 Domestic Violence Awareness Month in Multnomah County, Oregon

NOTE: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide clearly written title.)

---

1. **What action are you requesting from the Board? What is the department/agency recommendation**? approval

2. **Please provide sufficient background information for the Board and the public to understand this issue.**

3. **Explain the fiscal impact (current year and ongoing).**

   NOTE: If a Budget Modification or a Contingency Request attach a Budget Modification Expense & Revenues Worksheet and/or a Budget Modification Personnel Worksheet.

   If a budget modification, explain:
   - **What revenue is being changed and why**?
   - **What budgets are increased/decreased**?

- ❖ What do the changes accomplish?
- ❖ Do any personnel actions result from this budget modification? Explain.
- ❖ Is the revenue one-time-only in nature?
- ❖ If a grant, what period does the grant cover?
- ❖ When the grant expires, what are funding plans?

NOTE: Attach Bud Mod spreadsheet (FORM FROM BUDGET)

If a contingency request, explain:

- ❖ Why was the expenditure not included in the annual budget process?
- ❖ What efforts have been made to identify funds from other sources within the Department/Agency to cover this expenditure?
- ❖ Why are no other department/agency fund sources available?
- ❖ Describe any new revenue this expenditure will produce, any cost savings that will result, and any anticipated payback to the contingency account.
- ❖ Has this request been made before? When? What was the outcome?

If grant application/notice of intent, explain:

- ❖ Who is the granting agency?
- ❖ Specify grant requirements and goals.
- ❖ Explain grant funding detail – is this a one time only or long term commitment?
- ❖ What are the estimated filing timelines?
- ❖ If a grant, what period does the grant cover?
- ❖ When the grant expires, what are funding plans?
- ❖ How will the county indirect and departmental overhead costs be covered?

4. Explain any legal and/or policy issues.

5. Explain any citizen and/or other government participation that has or will take place.

Department/Agency Director: Date: September 24, 2003

Budget Analyst
By: Date:

Dept/Countywide HR
By: Date:

BEFORE THE BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

PROCLAMATION NO. _____

Proclaiming October 2003 Domestic Violence Awareness Month in Multnomah County, Oregon

The Multnomah County Board of Commissioners Finds:

a. Multnomah County and its partner agencies have developed model programs to address domestic violence in our community. These include:

- mandatory arrest with no matrix or census release of domestic violence offenders;
- police/community partnerships to provide victims with outreach services;
- efforts in partnership with the US Attorney to reduce firearm use in domestic violence;
- increased funding for services to children who witness domestic violence through the City of Portland Children's Initiative;
- county funding of over $2 million in victim services contracts, including emergency shelter, culturally specific services, and court advocacy;
- The Local Public Safety Coordinating Council's Domestic Violence Pre-adjudication Release Work Group work to assure domestic violence victims are notified prior to the release of a defendant booked with domestic violence charges.

b. Despite our community's best efforts, domestic violence continues to be a pervasive and serious problem in Multnomah County.

c. Twenty-two percent of adult women have been physically assaulted by a current or former intimate partner in their lifetime.

d. Each year, fifteen percent of children witness domestic violence; most are under 5 years old.

e. Young women, 18 to 24 are particularly at risk of assault by their young male partners.

f. Domestic violence accounts for 40% of all reported violent crimes in Multnomah County and 23% of all reported felony person crimes; domestic violence calls make up to 40-50% of all reported chronic calls in the City of Portland.

g. Domestic violence shelters and crisis lines are receiving about 30,000 crisis calls a year with requests for shelter for over 15,000 women and children.

h. On average, domestic violence homicides make up one-quarter of all homicides in the County, usually exceeding the number of gang-or drug-related homicides. In 2002, domestic violence related homicides made up 6 of the 23 homicides in the City of Portland.

i. While most other crime continues to decrease in our community, domestic violence reports have remained constant.

The Multnomah County Board of Commissioners Proclaims:

The month of October 2003 to be Domestic Violence Awareness Month in Multnomah County, Oregon. In so doing, we commit to providing leadership in addressing this issue and working with community partners to reduce the harm caused to children and families by domestic violence.

ADOPTED this 2nd day of October, 2003.

BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

_____
Diane M. Linn, County Chair

_____
Maria Rojo de Steffey,
Commissioner Dist 1

_____
Serena Cruz,
Commissioner Dist 2

_____
Lisa Naito,
Commissioner Dist 3

_____
Lonnie Roberts,
Commissioner District 4

BOGSTAD Deborah L

From: ROLLINS Chiquita M
Sent: Friday, September 26, 2003 3:51 PM
To: BOGSTAD Deborah L
Cc: COMITO Charlotte A
Subject: October 2 Proclamation

Deb

3 people from the Family Violence Coordinating Council will be at the Board meeting to present info re: the proclamation. They are:

Robin Selig, Chair of the Council, works at Legal Aid Services of Oregon
John Richmond, Vice-Chair, works at Oregon DHS Child Welfare
Kris Billhardt, prior Chair, works at Volunteers of America Family Center.

They will be brief, and I don't know which of them will speak after they introduce themselves. I believe they would still like to go at 9:45 instead of 9:55. One of them needs to be downtown at 10.

Chiquita

BEFORE THE BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

PROCLAMATION NO. 03-138

Proclaiming October 2003 Domestic Violence Awareness Month in Multnomah County, Oregon

The Multnomah County Board of Commissioners Finds:

a. Multnomah County and its partner agencies have developed model programs to address domestic violence in our community. These include:

- mandatory arrest with no matrix or census release of domestic violence offenders;
- police/community partnerships to provide victims with outreach services;
- efforts in partnership with the US Attorney to reduce firearm use in domestic violence;
- increased funding for services to children who witness domestic violence through the City of Portland Children's Initiative;
- county funding of over $2 million in victim services contracts, including emergency shelter, culturally specific services, and court advocacy;
- The Local Public Safety Coordinating Council's Domestic Violence Pre-adjudication Release Work Group work to assure domestic violence victims are notified prior to the release of a defendant booked with domestic violence charges.

b. Despite our community's best efforts, domestic violence continues to be a pervasive and serious problem in Multnomah County.

c. Twenty-two percent of adult women have been physically assaulted by a current or former intimate partner in their lifetime.

d. Each year, fifteen percent of children witness domestic violence; most are under 5 years old.

e. Young women, 18 to 24 are particularly at risk of assault by their young male partners.

f. Domestic violence accounts for 40% of all reported violent crimes in Multnomah County and 23% of all reported felony person crimes; domestic violence calls make up to 40-50% of all reported chronic calls in the City of Portland.

g. Domestic violence shelters and crisis lines are receiving about 30,000 crisis calls a year with requests for shelter for over 15,000 women and children.

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i. While most other crime continues to decrease in our community, domestic violence reports have remained constant.

The Multnomah County Board of Commissioners Proclaims:

The month of October 2003 to be Domestic Violence Awareness Month in Multnomah County, Oregon. In so doing, we commit to providing leadership in addressing this issue and working with community partners to reduce the harm caused to children and families by domestic violence.

ADOPTED this 2nd day of October, 2003.

BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

Diane M. Linn, County Chair

Maria Rojo de Steffey,
Commissioner Dist 1

Serena Cruz,
Commissioner Dist 2

Lisa Naito,
Commissioner Dist 3

Lonnie Roberts,
Commissioner District 4

AGENDA PLACEMENT REQUEST

BUD MOD #:

Board Clerk Use Only:

Meeting Date: October 2, 2003
Agenda Item #: R-6
Est. Start Time: 10:05 AM
Date Submitted: 09/08/03

Requested Date: October 2, 2003 **Time Requested:** 30 minutes

Department: Health **Division:** Community Health Promotions and Partnerships

Contact/s: Sandy Johnson

Phone: 503 988-3056 **Ext.:** 28790 **I/O Address:**

Presenters: Lillian Shirley, Jon Duckart

Agenda Title: The Environmental Health of Multnomah County

NOTE: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide clearly written title.

---

1. **What action are you requesting from the Board? What is the department/agency recommendation?**
   Receive report, "The Environmental Health of Multnomah County 2003;" become aware of findings to be released to the public

2. **Please provide sufficient background information for the Board and the public to understand this issue.**
   The quality of the environment is directly related to the health of Multnomah County residents. Public health professionals have long understood this connection and have studied the relationships between human health and the quality of the air we breathe, the water we drink, the food we eat, and many other aspects of our physical world.

   "The Environmental Health of Multnomah County 2003" provides:
   - An assessment of many of the most important local environmental health issues,
   - Identification of local, state and federal agencies responsible for monitoring and protecting the environment, and
   - Comparisons of our community's health to that of the State, the Nation, other counties, and national health targets.

3. **Explain the fiscal impact (current year and ongoing).** N/A

NOTE: If a Budget Modification or a Contingency Request attach a Budget Modification Expense & Revenues Worksheet and/or a Budget Modification Personnel Worksheet.

If a budget modification, explain:

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- **Has this request been made before? When? What was the outcome?**

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- **Who is the granting agency?**
- **Specify grant requirements and goals.**
- **Explain grant funding detail – is this a one time only or long term commitment?**
- **What are the estimated filing timelines?**
- **If a grant, what period does the grant cover?**
- **When the grant expires, what are funding plans?**
- **How will the county indirect and departmental overhead costs be covered?**

4. **Explain any legal and/or policy issues involved.**
No specific policy or legal issue is expected at this time. However, it is expected that this report will be relevant to future policy decisions.

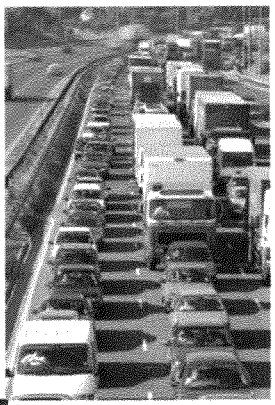
5. **Explain any citizen and/or other government participation that has or will take place.**
Focus groups were conducted with residents and employees from a variety of environmental agencies to obtain feedback on an earlier draft of this report. Presentations of findings from the report will be made to interested community agencies.

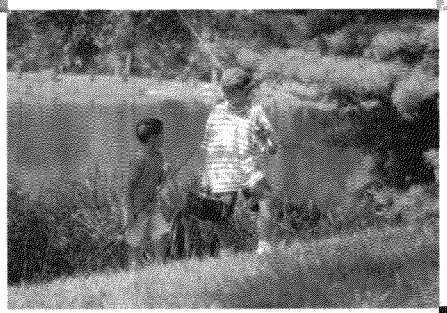
Required Signatures:

Department/Agency Director: Lillian Shirley **Date: 9/08/2003**

The Environmental Health of Multnomah County

2003





MULTNOMAH COUNTY
Health Department

Multnomah County Health Department

Lillian Shirley, RN, MPH, MPA
Director

Board of County Commissioners

Diane Linn	Chair of the Board
Maria Rojo de Steffey	District 1 Commissioner
Serena Cruz	District 2 Commissioner
Lisa Naito	District 3 Commissioner
Lonnie Roberts	District 4 Commissioner

For additional copies, please contact:
Multnomah County Health Department
Office of Planning and Development
Health Research and Assessment
1120 SW 5th Ave., 14th Floor,
Portland, Oregon 97204

Phone 503-988-3663 x29055
Or access this document at the following website:
www.co.multnomah.or.us/health/

June, 2003

Dear Multnomah County Residents,

Our health is tied to our environment's health. Public health professionals have long understood this connection and have studied the relationships between human health and the quality of the air we breathe, the water we drink, the food we eat, the places we work, the houses we live in, the items we purchase, and many other aspects of our physical world.

Over the past century, an increasing number of people have become interested in and advocates for the health of our environment. The early 1900's brought public health movements resulting in laws protecting people from hazardous products and unsafe working conditions. The 1960's saw consumer-driven movements resulting in the protection of air and water quality. And today, as our Country continues to benefit from these and many other accomplishments, we face new occurrences of old challenges along with new threats to the environment's health.

An example of these challenges occurred in 1993, when more than 400,000 residents of Milwaukee, Wisconsin became ill from a pathogen in their drinking water supply. Tragedies like this underscore the need for continual monitoring of the environment as a part of preventing disease and protecting the public's health.

I am pleased to announce the *Environmental Health of Multnomah County*, a report developed to help us monitor the health of our local environment by identifying and discussing environmental factors that can affect human health. This report is a wealth of information that provides:

- An in-depth local assessment of many of the most important environmental health issues;
- Identification of local, state and federal agencies responsible for monitoring and protecting the environment; and
- Comparisons of our community's health to that of the State, the Nation, other counties', and important national health targets.

I would like to acknowledge the Health Department researchers and numerous individuals from local community groups, neighborhood associations, universities and governmental agencies who contributed to this effort. Working together, we continue our history of improving the health of our environment and move closer to our vision of healthy people in healthy communities.

Sincerely,

Lillian Shirley

Lillian Shirley, RN, MPH, MPA

Director Multnomah County
Health Department

Diane M. Linn

Diane M. Linn, Chair

Multnomah County
Board of Commissioners

Acknowledgments

Special thanks to the residents and individuals from organizations and professions around the county who provided valuable feedback to the report:

Madeleine Eno, Jeff Smith, and Martha Richards, *Southeast Neighborhood Association*
Martha Gannett, Sharon Genasci, and Bob Osmunde, *Northwest District Association Air Quality Committee*
Diana Wolford and Jennifer McCormick, *PSU graduate students in Community Health*
Andrew Baker, *PSU graduate student in Health Administration*
Fred Dobson, *Campbell Elementary, North Clackamas District*
Ed Wack, *Portsmouth Middle School, Portland Public Schools*
Sara Tunstall, Marlene Gin, and Jane Gordon, *residents of Multnomah County*
Rick North, *Interfaith Network of Earth Concerns*
Nancy Tannler, *Southeast Examiner*
Rhett Lawrence, *OSPIRG*
Sarah Doll, *Oregon Environmental Council*
Andrew Epstein, *Independent Living Resources, Oregon Center for Environmental Health*
Fred Berman, *Center for Research in Environmental and Occupational Toxicology, OHSU*
Stephanie Farquhar, *Professor, PSU Community Health*
Jeri Sundvall, *Environmental Justice Action Group*
Lance Trainor, *Red Cross of Oregon*
Jane Foreman, *Friends of Trees*
Dawn Burgardt, *Growing Gardens*
Margaret McConnell, *American Lung Association of Oregon*
Larry Tuttle, *Center for Environmental Equity*
Linda Kue, *Asian Family Center, IRCO*
Kelly Caldwell, *Southeast Uplift*
Anthony Barnack, *Oregon Department of Environmental Quality*
Kevin Odell, *PACE, Multnomah County Health Department*
Brenda Keith, *PACE, Multnomah County Health Department*
Tricia Tillman, *Multnomah County Health Department*
Christine Bernsten, *Multnomah County Health Department*
Lila Wickham, *Multnomah County Health Department*
Lisa Morley, *Multnomah County Health Department*

Office of Planning and Development

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Director

Sandy Johnson
Manager, Health Research & Assessment

Prepared and Written by:

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Health Research and Assessment

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Health Research and Assessment

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Health Research and Assessment

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Health Research and Assessment

Scott Schnoor
Health Research and Assessment

Chris Sorvari
Health Research and Assessment

Noelle Dobson
Intern, Health Research and Assessment

Kevin Kitamura
Public Affairs Office

Table of Contents

Executive Summary

The Environmental Health of Multnomah County presents information on the state of Multnomah County's natural and built environment as it relates to public health. It was prepared by the Multnomah County Health Department to address a core public health function, that of assessing and monitoring the health of the community. We have examined the quality of our County's air and water, its waste system, occupational health, food-borne illnesses, unintentional injuries, and other environmental factors. When possible, we have linked these to available public health data. We have also presented trends so that improvements and problems in the environment over time can be highlighted. We anticipate that this report will address a need among community residents and decision-makers for information on this important topic, and hope that it supports the efforts of interested groups to address public health issues stemming from the environment.

This report relies almost exclusively on secondary data, i.e. data collected by other organizations. The availability and quality of the data vary. The data are as current as possible, but many variations exist on the most current year available for both environmental and health measures.

Key Findings

+Strengths **- Challenges** **± Neutral**

Drinking Water

+ Multnomah County has been in compliance with all federal and state drinking water quality standards since 1993. The County meets the Healthy People 2010 drinking water objective calling for 95% of residents to receive water from water systems meeting federal safety standards.

+ Waterborne disease outbreaks were rare in Multnomah County between 1991 and 2000, and waterborne disease rates have remained stable or declined since 1992.

- Five public water systems in Multnomah County, serving 2% of residents, were in violation of health-based standards for drinking water in 2000-2001.

- Multnomah County does not meet the Healthy People 2010 objective calling for at least 75% of community residents to receive optimal levels of fluoridated water. Less than 10% of the population in Multnomah County has access to optimal levels of fluoride in drinking water.

Food Safety

+ Rates of illness caused by unsafe food handling have declined in both Multnomah County and Oregon since the early 1990's.

+ Rates for one important source of food-borne illness – the bacteria E. coli – were consistently lower for Multnomah County than for Oregon between 1995 and 2000.

- However, Multnomah County has not met national objectives in reducing foodborne illness.

Hazardous Waste

+ Since 1989, 143 hazardous waste sites have been cleaned up, and no longer pose an environmental or health threat. In addition, over 6,800 leaking underground storage tanks have been cleaned up over the past 20 years.

± While two Superfund sites in Multnomah County have been cleaned up and have been removed from the National Priorities List, there are currently three listed Superfund sites in Multnomah County. Two additional sites are candidates for the Superfund program.

-There are 155 sites throughout Multnomah County with confirmed hazardous waste contamination.

Housing and Indoor Air Quality

+ Radon levels in Oregon have been designated of moderate or low concern by the EPA.

- In 2000, 1.1% (3,117 units) of housing stock in Multnomah County lacked complete kitchen facilities and 0.8% (2,252 units) lacked complete plumbing facilities.

-The percentage of overcrowding in renter occupied units (8.7%) is higher than in owner occupied units (2.9%).

- Lead-based paint is most prevalent in houses built before 1950. There is a higher percentage of housing built in 1950 or earlier in the inner Northeast and Southeast neighborhoods.

Land Use and Community Design

±While the rate of motor vehicle crash fatalities is consistently lower in Multnomah County than in Oregon and the U.S., motor vehicle accidents were the leading cause of death of Multnomah County and Oregon children age 1 to 17 years for the period 1997-2000.

± While there has been a steady increase in recent years in the proportion of adults in Multnomah County who are at risk of overweight-related health

problems, the proportion in the county is consistently lower than Oregon and the Nation.

- Only one quarter of adults in Multnomah County participate in regular physical activity.

Occupational Health

+ There were a total of 6,115 accepted work-related disabling claims in Multnomah County in 2001, down from a high of 8,366 claims in 1990.
+ As of July 1, 2000, most businesses, including restaurants, are required to be smoke free throughout Multnomah County.

Outdoor Air Quality

+ Multnomah County has been in compliance with federal air quality standards since 1997, and meets Healthy People 2010 objective for criteria air pollutants established by the Clean Air Act. By comparison, eight counties in Oregon are not in compliance, as of July 2002.
- Fourteen air toxics (among 188 air toxics tracked by the EPA) in the County exceed health-based benchmarks, with six pollutants more than 10 times the benchmark.
- Most of the County exceeds the federal cancer risk benchmark for toxic outdoor air pollutants. The highest risk areas are in North and Northeast Portland.

Recreational Water

+ Rates for recreational waterborne disease are low for Multnomah County, and outbreaks are rare. There were two waterborne disease outbreaks in the County in the 1990's.
-Six of seven waterways in Multnomah County examined by the Oregon Department of Environmental Quality are ranked as poor or very poor. Five water bodies are in violation of federal Clean Water standards that protect beneficial uses.
- Current sewer designs in Multnomah County cause three billion gallons of rainwater and raw sewage to flow into the Willamette River every year.

Solid Waste and Wastewater

+ Portland's recycling rate is at 54%, the best in the country.
- St. Johns landfill, located in Portland and closed since 1991, has known leaks of hazardous substances that are polluting nearby waterways.

Vector-Borne Disease

+ Multnomah County experiences less than two cases of vector borne illness a year.
+ In the nine years between 1991 and 2000, only 4 animals tested positive for rabies in the County.
- Although mosquitoes tested in Multnomah County have not been found to carry the West Nile virus, the virus is expected to arrive in 2003.

Introduction

Purpose

The Environmental Health of Multnomah County provides an assessment of our environment, and highlights hazards in the community that may impact human health. It fulfills a core public health service, that of monitoring health status to identify community health problems. This resource document is the second in a series of health assessment reports conducted by the Multnomah County Health Department, and is part of our continuing commitment to provide the community with important health information. We hope that it will bring new depth to a continuing dialogue between the community and health professionals on factors that influence public health, so that together we can establish health priorities and continue to realize our vision of healthy people in healthy communities.

Environmental health "focuses on the relationships between people and their environment, promotes human health and well-being, and fosters a safe and healthy environment."

What is environmental health and why is it important?

Environmental health is a branch of public health that "focuses on the relationships between people and their environment, promotes human health and well-being, and fosters a safe and healthy environment."[1] According to a recent national survey, Americans are very much aware of the link between environment and human health. Ninety percent of Americans believe that environmental pollutants are important causes of disease. Further, 75% feel that they or a close family member live in a community where environmental pollutants such as air and water contaminants, hazardous wastes, and pesticides are a problem.[2] Scientific evidence linking environment to human health supports this belief.* The Centers for Disease Control and Prevention has estimated that 16% of all preventable deaths in the United States can be attributed to environmental factors. Researchers at the World Health Organization estimate that environmental factors may cause up to 33% of diseases worldwide. And one study of pediatric illnesses indicates that environmental pollutants may account for 5% of cancers, 30% of asthma cases, and 10% of neurobehavioral disorders, with costs exceeding $55 billion annually.[3-5]

...75% [of Americans] feel that they or a close family member live in a community where environmental pollutants such as air and water contaminants, hazardous wastes, and pesticides are a problem.

Although many public health departments take seriously the possible health threats coming from the environment, others have noted public health's shortcomings. More than a decade ago, the Institute of Medicine (IOM) presented a report arguing, in part, that environmental health had become disconnected from public health: "The removal of environmental health authority from public health agencies has led to fragmented responsibility, lack of coordination, and inadequate attention to the health dimensions of environmental problems." Among IOM's many recommendations was a call to public health departments to identify, understand and control environmental problems as health hazards.[6]

* *Social environment, biology, behavior, and health care access also play important roles in human health.*

Who is this report for?

This report is for anyone interested in an examination of Multnomah County's environment and its possible impacts on human health. Anyone living within the Portland metropolitan region may find this report of special interest. We anticipate that this report will also appeal as a resource document to community organizations, public agencies, policy makers, public health professionals, and students.

What does this report cover?

This report is a community resource on Multnomah County's environmental health. It provides an in-depth examination of selected environmental factors that influence human health. Each chapter focuses on nationally recognized environmental factors and provides data for several environmental health indicators, along with baseline data from previous years in order to highlight trends. We have examined the quality of our County's air and water, its waste, occupational health, food-borne illnesses, unintentional injuries, and other environmental factors, and we have linked these to human health data- where it exists.

What is not covered?

While this report contains a wealth of information on the County's environmental health, it is not a report of solutions. It does not prioritize issues or direct steps to be taken to address environmental health problems. In most cases, we do not advocate for or against any environmental health policies. We have sought simply to identify and understand factors in the physical and built environment in Multnomah County that may be health hazards. A more focused environmental health assessment is under way to address environmental problems in specific communities within the County (see PACE EH below).

This report addresses many environmental health issues; however, the list of topics is not exhaustive. There are other environmental health issues that do not appear in this report. Examples of topics not covered are radiation, mold and mildew, institutional health, environmental noise, and odors. In some cases, data for these environmental factors were difficult to obtain, inconsistently collected, or nonexistent. In other cases, time and staff resource constraints limited the number of environmental factors we could cover.

Finally, we were not able to show direct links between environmental exposures and human health problems. Measuring the actual health problems stemming from the environment is difficult, especially for chronic diseases such as cancer, birth defects and asthma.[7] Cancer is especially difficult to tie to environmental causes, primarily because the time between exposure and the detection of the cancer can take many years. Therefore, many chapters in this report rely upon environmental health indicators.

What are environmental health indicators?

Environmental health indicators are measures that assess health status or risk as

it relates to the environment. The best indicators, according the Centers for Disease Control and Prevention, are those that "reliably predict the relationship between human health and the environment, are routinely collected, and have well-accepted definitions and data collection standards."[8]

We relied greatly upon environmental health indicators developed by the Washington State Department of Health. Health researchers from this state recognized the need for an environmental health addendum to the Assessment Protocol for Excellence in Public Health (APEX/PH), developed by the National Association of City and County Health Officials (NACCHO) in 1991. These indicators are organized into major environmental topics – air, water, food, etc. – and each topic presents several environmental indicators. Indicators are of two types. Health status indicators measure health outcomes that can reliably be assumed to result from environmental exposure. An example of this is the foodborne illness indicator stemming from contaminated food. Environmental exposure indicators measure conditions or activities with the potential to expose humans to a contaminant or hazardous condition. Examples of these include air contaminant releases and hazardous waste sites.

Sources and Objectives

All data used in this report are secondary data – that is, data collected by other organizations. No primary data – i.e., new data, for the purpose of this project – were collected. The data were obtained from local, state, and federal agencies charged with monitoring a specific environmental factor. We have provided the most currently available data, and present data over several years in order to analyze trends. In many cases, data go back five years or more. We cannot guarantee the quality of the data, and in most cases we are not able to provide an in-depth analysis of data limitations. The availability and quality of the data vary by public agency.

Data by themselves are not very meaningful without something to compare them to. In many cases we compare ourselves to Oregon. In some cases we compare the County to the Nation and to other counties. The most useful comparisons come from national objectives found in **Healthy People 2010**, a resource developed by the U.S. Department of Health and Human Services, with input from more than 350 national organizations and 250 State public health and environmental agencies. It provides 467 10-year health objectives in 28 focus areas to target national health improvement activities for the Nation. Healthy People 2010 includes many health objectives that are relevant to the indicators in this report, including 30 environmental health targets. Environmental health indicators for Multnomah County are compared against Healthy People 2010 objectives whenever possible*.

* *For more information on the development of Healthy People 2010, visit their website at http://www.healthypeople.gov.*

Other Environmental Health Efforts – PACE EH

While environmental health monitoring is an important first step, it is not enough, especially without vital community input. Health professionals and community residents need to work together to identify environmental health issues and address the problems found. That is why Multnomah County Health Department has joined forces with community residents to assess the environmental health of our County. Through a process called the Protocol for Assessing Community Excellence in Environmental Health (PACE EH), a coalition of community residents and health and environmental professionals has emerged to set priorities for local action to address environmental hazards most clearly impacting human health.[6] As this report went to press, the coalition was in the final stages of determining the geographic area upon which to focus its efforts.

We hope that this report, and the efforts of PACE EH, will address a need among community residents to understand the important links between environment and health so that, together, we can set priorities for action.

1. Adapted from: National Association of County and City Health Officials (NACCHO) *Protocol for Assessing Community Excellence in Environmental Health: A Guidebook for Local Health Officials.* Washington, DC. 2000.
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5. Landrigan PJ, Schechter CB, Lipton JM, Fahs MC, Schwartz J. Environmental Pollutants and Disease in American Children: Estimates of Morbidity, Mortality, and Costs for Lead Poisoning, Asthma, Cancer, and Developmental Disabilities. *Environmental Health Perspectives,* 2002:110:7:721-728.
6. Institute of Medicine. *The Future of Public Health.* Washington, DC: National Academy Press. 1988.
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Demographics of Multnomah County

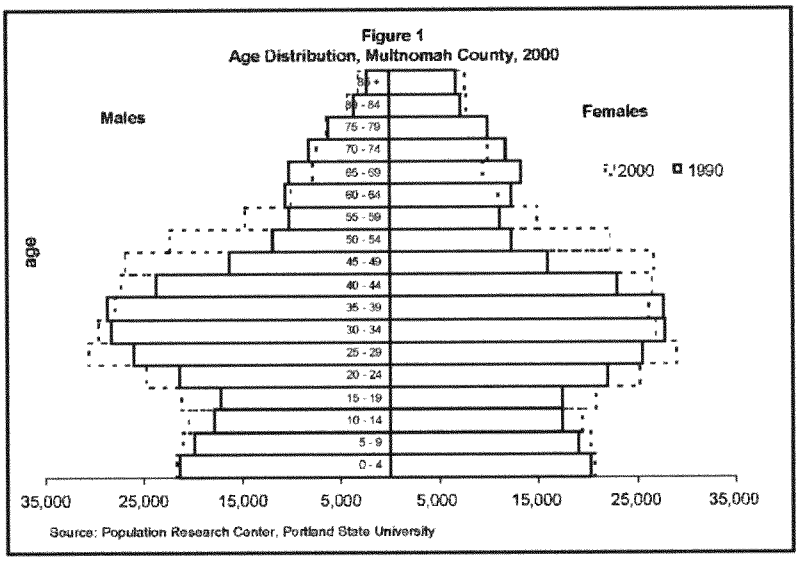
Population

Multnomah County is largely urban, and home to 19.3% of the State's population. The city of Portland comprises 80% of the County's population and is the County seat. The next largest city is Gresham with 14% of the population. The cities of Troutdale, Fairview, and Wood Village comprise the remainder of the population.

Age Distribution

From 1990 to 2000, the population of Multnomah County grew 13%, from 583,887 to 660,486. During the same period, the population of Oregon grew 20%. In 2000, the median age of Multnomah County residents was 35 years. Population growth was not evenly distributed among age groups. Figure 1 shows absolute population growth in the County between 1990 and 2000. The population of adults 74 years and older has remained relatively constant as has the population of very young children (0 to 4). The population of children 5 to 9, adolescents 10 to 19 and young adults 20 to 29 has increased. The largest increase in the adult population from 1990 to 2000 was among 45 to 54 year olds. The County has seen a decrease in the population of 60 to 74 year olds and 35 to 39 year olds.

Figure 1
Age Distribution, Multnomah County, 2000

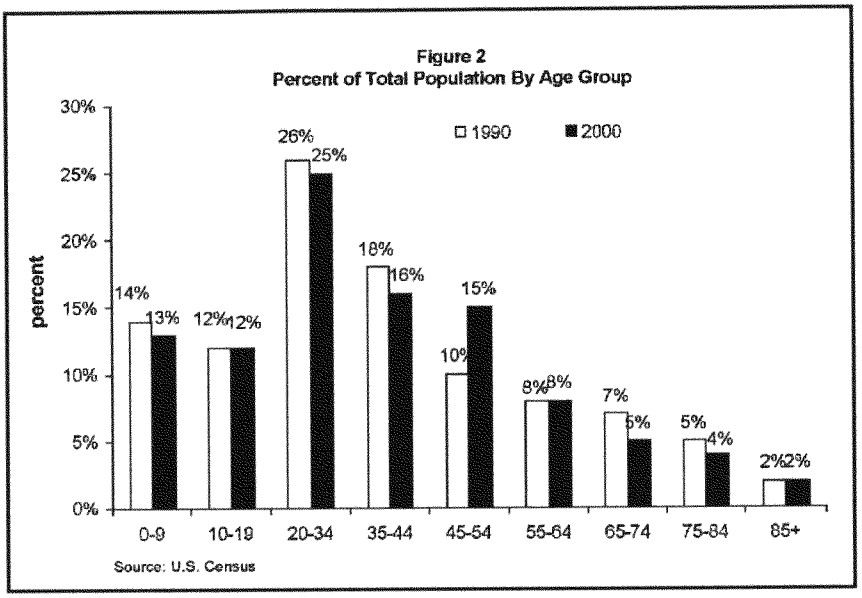


Source: Population Research Center, Portland State University

Figure 2 shows the percent of the population by ten year age groups in 1990 and 2000. The largest change in distribution was in the 45 to 54 year age group, which went from 10% of the population in 1990 to 15% in 2000.

Vulnerable Populations

A safe and healthy environment is important to maintain a physically and emotionally fit life. It is well recognized that vulnerable populations such as children and the elderly suffer greater health effects of poor environmental quality due to



Studies have shown that low-income, racial and ethnic minority individuals are much more likely to be exposed to toxic and hazardous wastes than affluent and white individuals.[1]

higher susceptibilities or higher levels of exposure. For example, **environmental tobacco smoke** is one of the primary causes of poor indoor air quality associated with respiratory health problems in children. The hazards of exposure to lead-based paint poisoning are greatest among children under seven. Very young children, the elderly, and individuals with compromised immune systems are more likely to experience serious effects of food borne illness. Many factors exist in the built environment that contribute to unhealthy communities for vulnerable populations. Among these are lack of safe play areas, unsafe streets and homes, noise, and substantial traffic.

The relationship between prosperity and better health is well established and studies over the last 20 years suggest that there is also a relationship between income and environmental risk factors. Socioeconomically disadvantaged groups such as African Americans, Hispanics, American Indians and Pacific Islanders experience higher rates of cancer, births defects, infant mortality, asthma, diabetes, and cardiovascular disease. Studies have shown that low-income, racial and ethnic minority individuals are much more likely to be exposed to toxic and hazardous wastes than affluent and white individuals. A higher percentage of low-income urban black children have blood lead levels that exceed safe limits compared to urban children with higher family incomes. According to a review of study data, "There is consistent evidence that people who are poorer in the United States are more likely to be exposed to multiple, environmental risks that portend adverse health consequences.[1]"

While Multnomah County is predominately White non-Hispanic, there are proportionately more young people among populations of color than in the White non-Hispanic population. American Indian, African American, and Hispanic populations have the highest percentage of people living at or below the poverty level.

Race and Ethnicity

The 2000 U.S. Census asked individuals to respond to the question of race differently than it had in the past. In 2000, individuals had the opportunity to choose more than one racial category to describe themselves. In addition, the category Asian/Pacific Islander was divided into two categories: Asian and Native Hawaiian or other Pacific Islander. This resulted in racial categories of White, African American, Asian, Native Hawaiian or other Pacific Islander, American Indian, two or more races, and some other race. The question of ethnicity Hispanic or non-Hispanic remained unchanged in 2000. These changes make comparisons to earlier census data on race difficult.

According to the 2000 U.S. Census, White non-Hispanics make up the largest percentage of the population of Multnomah County (Table 1). Among populations of color, Hispanics make up the largest percentage of the population followed by African American and Asian.

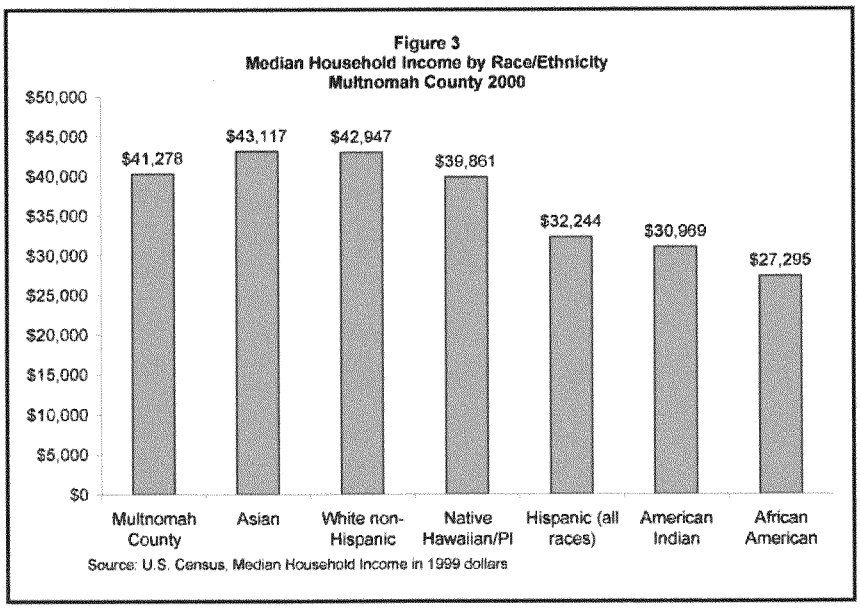
Table 1

Race/Ethnicity	Percent
White non-Hispanic	76.5%
Hispanic (of any race)	7.5%
African American	5.7%
Asian	5.7%
American Indian	1.0%
Native Hawaiian or Pacific Islander	0.4%
Two or more races	4.1%
Some other race	4.0%

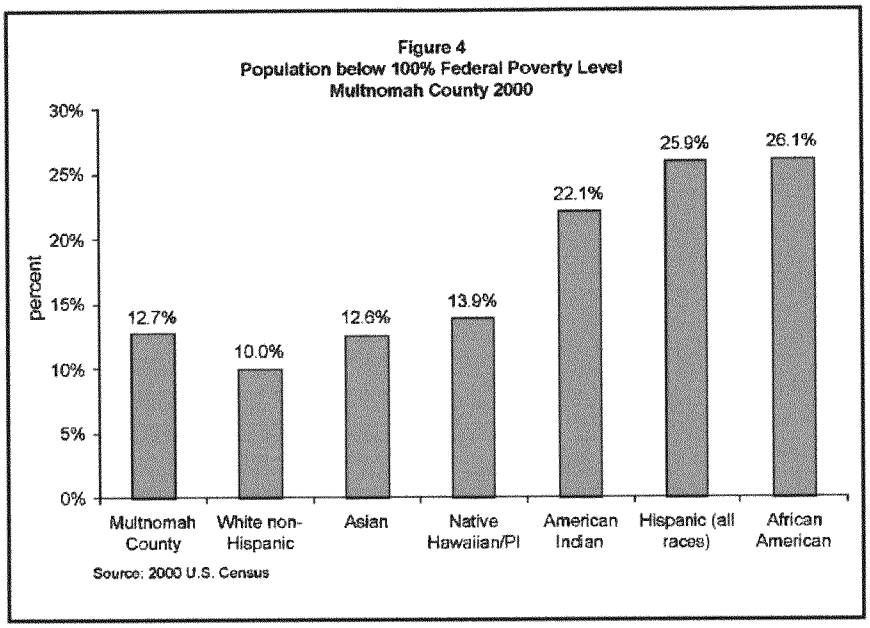
Source: 2000 U.S. Census

Income and Poverty

The 2000 U.S. Census reports that, at $41,278, the median income in Multnomah County was 0.9% higher than median income for Oregon ($40,916) and 1.7% lower than median income for the United States ($41,994). In Multnomah County Hispanic, American Indian and African American populations



have a lower median household income than other racial/ethnic groups (Figure 3). The median household income for African Americans is the lowest of any racial/ethnic group and is 33% lower than the County median household income.



African Americans and Hispanics have higher percentages of individuals at or below 100% of federal poverty level, followed closely by American Indians (Figure 4). The percentage of African Americans in poverty is more than twice as high as for the county as a whole.

Income Inequality

A recent study concludes that Oregon was one of two states in the nation in which the gap between the wealthy and the poor grew the fastest.

A recent study shows that Oregon's wealthiest 1% saw an increase in its average annual income from $374,000 to $741,000, an increase of 98% between 1989 and 2000.[2] In the same period, the State's median income rose from $24,600 to $26,700, an increase of 9%. According to the report, in 1989, the wealthiest 1% comprised 11% of the States' total income, while in 2000 they comprised 17%. The report concludes that Oregon was one of two states with the fastest growing gap between the wealthy and the poor.

1. Evans G, Kantrowitz E. Socioeconomic Status and Health: The Potential role of Environmental Risk Exposure. *Annual Review of Public Health.* 2002; 23:303-331.
2. Leachman M, Thompson J. *Boom, Bust & Beyond: The State of Working Oregon 2002.* Oregon Center for Public Policy. Silverton, OR; 2002.

Drinking Water Quality

Fast Facts

- The Portland Water Bureau - the supplier of almost 90% of the water to County residents - has been in compliance with all federal and State water quality standards since 1993.
- Multnomah County meets the Healthy People 2010 Drinking Water objective calling for 95% of residents to receive water from water systems meeting federal safety standards.
- Five of the 23 public water systems in Multnomah County, serving 1.5% of residents, were in violation of health-based standards for drinking water in 2000-2001.
- Multnomah County does not meet the Healthy People 2010 objective that calls for 75% of residents to receive fluoridated water. Less than 10% of the population has access to optimal levels of fluoride in drinking water.
- 11% of Multnomah County residents have private water systems, which are not required to undergo monitoring, and are therefore more susceptible to contamination.
- Waterborne disease outbreaks were rare in Multnomah County (and Oregon) between 1991 and 1998, and disease rates associated with waterborne disease have remained stable or declined since 1992.

Problem Statement

The link between drinking water quality and human health has been understood for many years. Public concern over safe drinking water has led to strict federal and state standards, and as a result, drinking water in the U.S. is among the safest in the world. In turn, Americans have come to trust the quality of their drinking water. For example, according to the 2000 Oregon Population Survey, 85% of residents believe Oregon is doing a good or very good job of maintaining clean water. Still, drinking water can cause many acute and chronic illnesses from contaminants such as chemicals and **pathogens** (i.e., bacteria, viruses, protozoa). A dramatic example of this occurred in 1993 in Milwaukee, Wisconsin, when over 400,000 became ill from a pathogen in the drinking water supply. There are, on average, 7,600 reported cases of waterborne illness in the U.S. each year, with actual cases estimated as high as 900,000 per year.

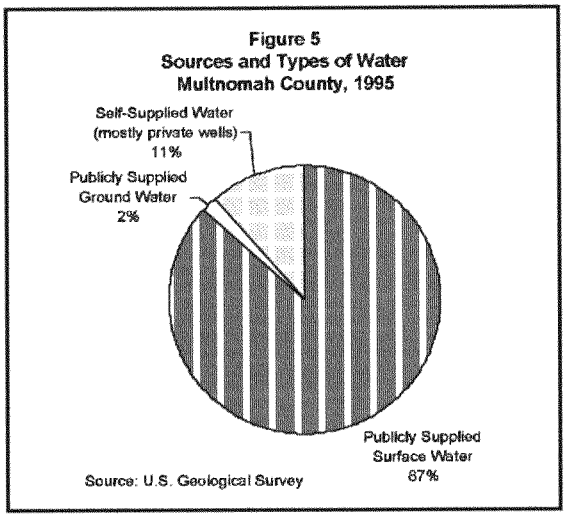
Drinking Water Regulations

Drinking water is regulated through the federal Safe Drinking Water Act and the Oregon Drinking Water Quality Act. The purpose of these acts is to assure safe drinking water free of contaminants to Oregonians using public water supplies. Primary (i.e., legally enforceable) standards for drinking water call for regulation and treatment of water supplies to eliminate pathogens, chemicals, and disinfectants (and their by products) in drinking water. To accomplish this objective, these Acts require that drinking water be tested regularly for 94 contaminants. Seven of these contaminants are pathogens such as Cryptosporidium, Giardia lamblia,

and E. coli, all of which can cause gastrointestinal illness if ingested. Regulations require the disinfection of water to remove or inactivate such organisms so that they do not pose a health threat. Organic and inorganic chemicals are also regulated, especially those that have been linked to chronic illnesses like liver and kidney disease, nervous system problems, and cancer. Nitrate, a chemical mostly linked to fertilizer runoff, is especially dangerous to infants, and can interfere with breathing.

Drinking Water Sources

According to data from the U.S. Geological Survey, 11,540 residents (1.9% of Multnomah County's population) relied upon publicly supplied ground (well) water as their primary source in 1995, whereas 533,000 (87%) relied upon publicly supplied surface water sources (primarily though the Bull Run Watershed and the Portland Water Bureau) (Figure 5). More than 69,500 residents (11%) in the County supplied their own drinking water in 1995, primarily through private wells. By comparison, 32% of residents in Oregon, and 16% nationally, supply their own drinking water. Since private water wells are not regulated under the federal and state drinking water acts, they can be a potential source of contaminants, and pose a greater risk of causing waterborne illnesses.[1]



There are 23 active **community water systems** (CWS) in Multnomah County. Each of these community water systems is publicly operated, and serves a minimum of 15 year-round resident households. The City of Portland Bureau of Water Works, the primary public water supplier of surface water to the County, supplies almost 90% of Multnomah County's CWS drinking water. The Bull Run Watershed, east of the County near Mount Hood, is the largest source of surface water. It has been Portland's primary water source for more than 100 years, and is of such high quality that it is one of the few surface water sources not required by the Environmental Protection Agency to be filtered.[2]

The Portland Water Bureau collects 10,000 water samples each year from throughout the water system, and conducts about 50,000 water analyses on the samples collected. They test for more than 150 contaminants. Of the regulated contaminants for which samples were collected, nearly all were below the maximum level before treatment. Treatment of the water (with chlorine, for example) eliminates risk of pathogen contamination, and all such contaminants were treated

effectively in 2000.[3] Furthermore, no health-based or reporting violations have been reported for the Portland Water bureau since 1993 (the earliest year data is available).[4]

Drinking Water Violations

An analysis of County water systems through the Safe Drinking Water Information System (provided by the EPA) shows that five of the 23 active community water systems in the County in 2000 and 2001 violated health-based standards (i.e., having contaminants exceeding the EPA safety standard, or having water that was not treated properly). These five systems – Corbett Water District, Casselman's Water System, City Bible College, Interlachen Water District, and Rocky Pointe Marina – served approximately 1.5% of Multnomah County residents in 2001. By comparison, statewide there were 177 community water systems violating health-based standards in 2000, serving 6% of Oregon's population.[4] Two water systems in Multnomah County, representing 6,500 residents, violated a maximum contaminant level for pathogens. The rest failed to comply with water treatment reporting. Multnomah County meets the Healthy People 2010 Water Quality objective that 95% of community residents receive drinking water that meets EPA safety standards. Over 98% of County residents using community water systems had safe drinking water in 2001.

Over 98% of Multnomah County residents using community water systems had safe drinking water in 2001.

Water Fluoridation

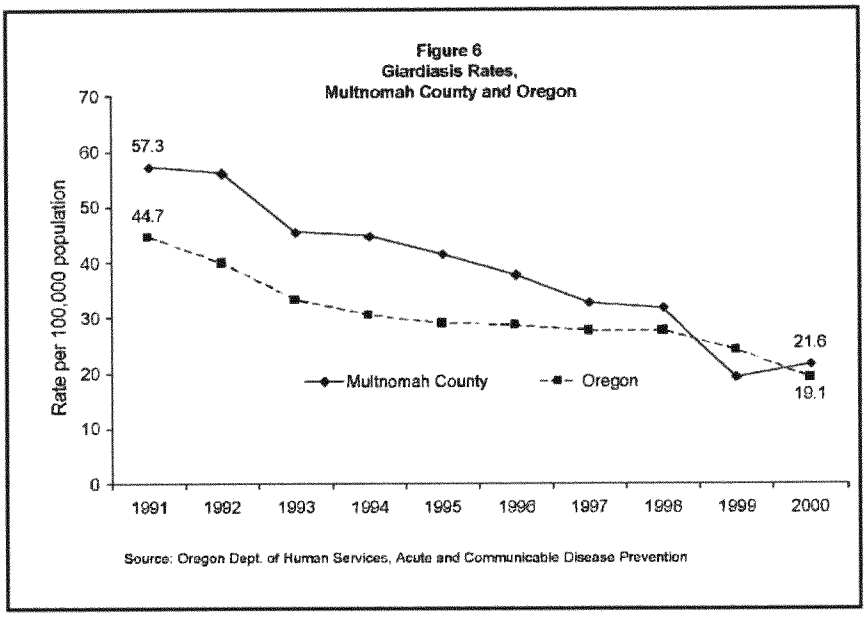
The U.S. Public Health Service recommends that drinking water be treated with optimal levels of fluoride - around one part per million. Optimal levels of fluoride in drinking water can help prevent tooth decay.[5] According to the U.S. Surgeon General, "community water fluoridation continues to be the most cost-effective, practical and safe means for reducing and controlling the occurrence of tooth decay in a community."[6] In 2000, 66% of the U.S. population served by public water systems had drinking water with optimal fluoride levels.

No fluoride was detected in the Portland Bureau's water supply. Portland is one of the few communities in the U.S. that does not fluoridate its water. Though specific statistics regarding fluoridation of public water are not available for Multnomah County, we estimate that less than 10% of County residents live in areas with optimal fluoride levels. Therefore, Multnomah County does not meet the Healthy People 2010 objective calling for at least 75% of community residents to receive optimal levels of fluoridated water. According to the CDC, only 23% of Oregon's population is supplied drinking water with optimal levels of fluoride, the fifth lowest in the nation.[7]

Health Effects of Drinking Water

Drinking water is a potential source of many pathogens and chemicals, and can lead to a variety of acute and chronic illnesses. The most common acute illnesses are gastrointestinal illness, whereas chronic illnesses may include kidney and liver diseases, and many types of cancer, perhaps from chemicals and pathogens in a

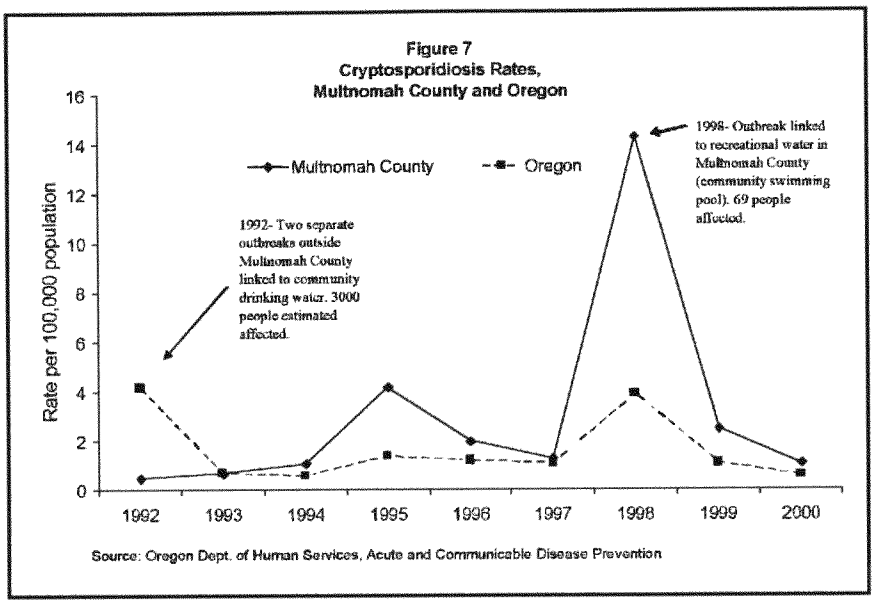
water supply over many years. Data for chronic diseases are difficult to link to water quality and are unavailable for Multnomah County. Data on acute waterborne diseases are available through the Oregon Department of Health Services Acute and Communicable Disease program. It is likely that waterborne disease data are underreported –e.g., not all who become ill from drinking water seek medical treatment. Such data probably underestimate actual water-related illnesses and outbreaks.



Giardiasis, caused by the **giardia** parasite, is considered one of the most common causes of waterborne disease in the U.S.[8] The 1991-2000 average rate for Multnomah County is 34.7 per 100,000, compared to 27.2 for Oregon. Giardia rates from 1992 to 2000 in Multnomah County have declined continually and substantially. Rates declined 65% from 1992 to 2000 (Figure 6). It is not clear to what extent drinking water supplies are responsible for either the incidence of the disease, or in its decline.

Cryptosporidium is another parasite that may be found in a community water supply. Rates for this disease have remained fairly stable since 1992 (Figure 7), and there is no indication that drinking water is contributing to a rise in this disease. There was a fairly large outbreak of about 70 people in 1998, but this has been attributed to a contaminated community swimming pool.

According to the U.S. Centers for Disease Control and Prevention, there were three **waterborne disease outbreaks** of drinking water in Oregon from 1992 to 1998 (the latest for which data is available). Two outbreaks in 1992 were linked to a community water system, and 3,000 people were estimated affected by Cryptosporidium. The third outbreak in 1997 was associated with a campground



water source, and 100 people were affected with Giardia. It is unclear whether any of the outbreaks affected Multnomah County residents.

Conclusion

Stringent requirements for drinking water due to the federal Safe Drinking Water Act, combined with a high-quality surface water source, have provided a safe water supply for Multnomah County residents, with very few contaminants found, and only rare instances of waterborne disease outbreaks associated with drinking water.

Two issues relating to drinking water and health effects have been found. First, fluoride is not in drinking water at an optimal level in Multnomah County. Less than 10% of drinking water in the County has optimal fluoride levels. Second, 11% of Multnomah County residents supply their own water, primarily through private wells. As no testing is required for contaminants in the drinking water of private systems, these residents have an increased risk of drinking unsafe water.

1. *Estimated Water Use in the United States in 1995.* U.S. Geological Survey. Accessed 3/26/2003. http://water.usgs.gov/watuse/.
2. *Water Quality in the Willamette Basin, Oregon, 1991-1995.* U.S. Geological Survey. U.S. Department of the Interior. 1998.
3. Annual Water Quality Report. City of Portland Water Bureau. 2000.
4. *Envirofacts Data Warehouse.* U.S. Environmental Protection Agency. Accessed 9/1/2002. http://oaspub.epa.gov/enviro/ef_home2.water
5. Recommendation for Using Fluoride to Prevent and Control Dental Caries in the United States. *Morbidity and Mortality Weekly Report (MMWR).* Centers for Disease Control and Prevention. 2001;50:RR—14:1-42.
6. *Community Water Fluoridation: Surgeon General's Statement, 2001.* Centers for Disease Control and Prevention. Accessed 3/26/2003. http://www.cdc.gov/OralHealth/factsheets/fl-surgeon2001.htm

7. Populations Receiving Optimally Fluoridated Public Drinking Water – United States. *Morbidity and Mortality Weekly Report (MMWR).* Centers for Disease Control and Prevention. 2002; 51:07:144-7.
8. *Giardiasis.* Acute and Communicable Disease. Oregon Department of Human Services. Accessed 05/01/2002. http://www.ohd.hr.state.or.us/acd/giardiasis/index.cfm

Food Safety

Fast Facts

- Rates of illness caused by unsafe food handling have declined in both Multnomah County and Oregon since the early 1990's. However, Multnomah County has not met national objectives in reducing foodborne illness.
- Rates of Campylobacteriosis in Multnomah County have declined steadily since 1991. The rate in 2000 was 16.0 cases per 100,000 population.
- Incidence of Salmonella fluctuates and does not show a steady trend. The rate in 2000 was 11.7 cases per 100,000.
- Illness rates from E. coli are consistently lower in Multnomah County as compared to the State of Oregon. The rate in Multnomah County in 2000 was 1.7 cases per 100,000.

Problem Statement

Although the food supply in the United States is one of the safest in the world, preventing **foodborne illness** and death continues to be a major public health challenge. The CDC estimates that 76 million people get sick, more than 300,000 are hospitalized, and 5,000 Americans die each year from foodborne illness.[1]

Multnomah County Health Department performs approximately 8,000 inspections of restaurants, special events, street vendors, hotels and motels, child care centers, schools, and adult foster care settings each year. Health inspectors make sure that hot foods are hot, cold foods are cold, hand washing facilities are available and used, and raw meats are not mixed with vegetables. These practices, if improperly performed, can lead to foodborne illness.

Although foodborne illnesses are reported to the local health department, surveillance of exposure and illness is complicated. Foodborne illnesses can be severe or even fatal, yet milder cases are often not detected because individuals do not seek medical care. Further, many diseases that are transmitted through food are also spread through water or from person to person. Thus, the cause of the disease may be difficult to trace.

Foodborne Disease Outbreak: The occurrence of two or more cases of the same illness among people from different households resulting from the ingestion of the same food.

Foodborne Outbreaks

Although most foodborne illness occurs in a private or home setting, occasionally **foodborne disease outbreaks** affect large groups of people. A foodborne disease outbreak is defined as the occurrence of two or more cases of the same clinical illness among people from different households resulting from the ingestion of the same food. A food borne outbreak is an indication that there was a breakdown in the food safety system. Laboratories and clinicians are required to report incidence of foodborne illness to the Multnomah County Health Department. The Health Department then investigates the foodborne illness incident and reports the case(s) to the State Acute and Communicable Disease Office. Public

health epidemiologists investigate outbreaks to control them, and also to learn how similar outbreaks can be prevented in the future.

Outbreaks are identified through citizen complaints or surveillance data from individual counties of identifiable foodborne illnesses. Outbreak data are, however, difficult to quantify. Frequently an individual case of foodborne illness may be identified, and while the case may be part of an outbreak, the cases are not linked. While outbreaks do not represent nearly as many cases of foodborne illness as isolated cases, there is much to learn about foodborne illness from outbreaks. Incubation periods, exposure time, and specific food practices that led to the outbreak can be tracked more definitively in an outbreak than in an isolated case. Table 2 presents the number of outbreaks and the number of cases associated with an outbreak in Multnomah County as reported by the Oregon Department of Human Services. Because outbreaks are difficult to quantify, this is not a complete account of outbreaks occurring in the County.

Table 2
Multnomah County
Foodborne Illness Outbreaks

	1996	1997	1998	1999	2000	2001
Number of outbreaks	2	3	1	5	9	2
Cases associated with an outbreak	N/A	81	24	119	136	26
Rate per 100,000 population	N/A	12.7	3.7	18.4	20.6	3.9

Source: Oregon Department of Human Services, Acute and Communicable Disease Program

Campylobacteriosis: An illness caused by bacteria that lives in the intestines of healthy birds that can make people ill if ingested.

National foodborne illness surveillance data come from FoodNet, a collaboration between the CDC, the U.S. Department of Agriculture, the U.S. Food and Drug Administration, and selected state health departments that began in 1996. FoodNet collects data on laboratory-confirmed cases of foodborne illness in eight states, including Oregon. Data from 1996-2000 show Oregon third behind California and Minnesota for the highest incidence of **Campylobacteriosis** infections and second behind Minnesota for **E. coli** infections.[2] Table 3 shows that in 2000 Oregon and Multnomah County were higher than the eight state sample from 1996-2000 for Campylobacteriosis. Oregon was higher than the eight state sample for E. coli, while Multnomah County was lower; both Oregon and Multnomah County are lower for Salmonella.

Table 3
Food Borne Illness,
Rate per 100,000 population

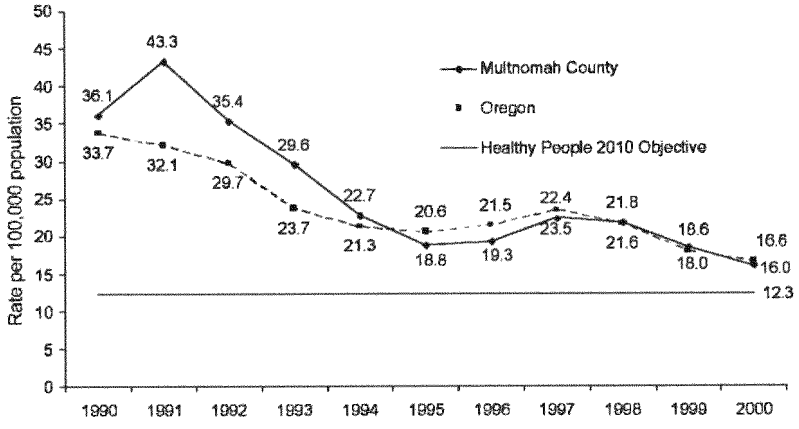
	8 State Sample 1996-2000	Oregon 2000	Multnomah County 2000
Campylobacteriosis	15.7	16.6	16.0
Salmonella	12.0	8.7	11.7
E. coli	2.9	3.9	1.7

Source: FoodNet, Centers for Disease Control and Prevention and Oregon Department of Human Services, Acute and Communicable Disease Program

Campylobacteriosis. Campylobacteriosis is one of the most frequently reported foodborne illnesses in the United States and causes fever and diarrhea. Campylobacter is the bacteria that causes Campylobacteriosis, and it lives in the intestines of healthy birds. Most raw poultry is contaminated with Campylobacter. Eating undercooked poultry, red meats or other food that has been contaminated with juices from raw poultry or red meats is the most frequent source of this infection.

Rates of Campylobacteriosis have declined in both Multnomah County and Oregon since 1991 (Figure 8). In 1991 there was a spike in the rate of Campylobacteriosis in Multnomah County due to increased screening of children with diarrheal illnesses. This screening occurred in association with a Shigella (a bacteria spread by not washing hands) outbreak in children's day care centers.

Figure 8
Campylobacteriosis Rates
Multnomah County and Oregon, 1990-2000



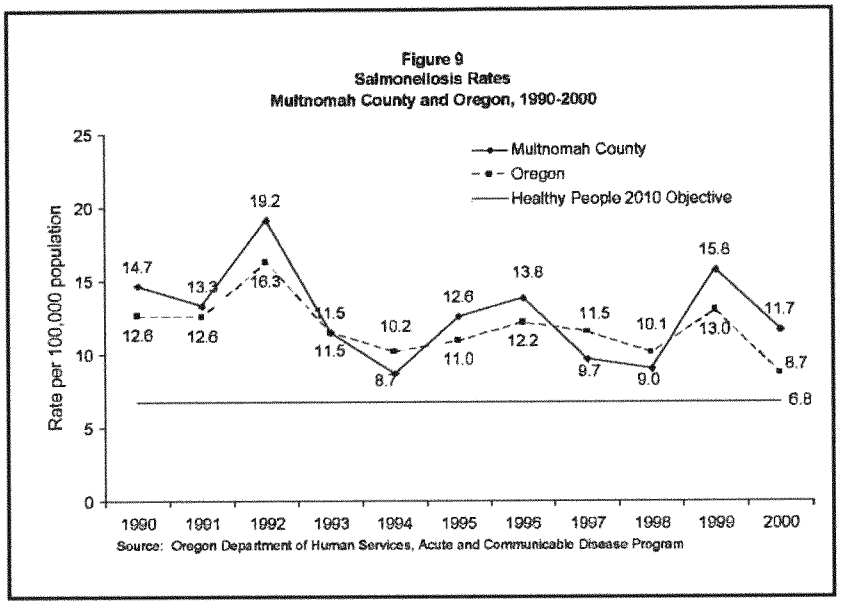
Source: Oregon Department of Human Services, Acute and Communicable Disease Program

Salmonella: Bacteria that are frequently found in birds as well as other animals.

Salmonella. **Salmonella** are bacteria that are widespread in the intestines of birds, reptiles and mammals. The bacteria can spread to humans through a variety of different foods made from animals. Salmonella can get into the blood stream and cause life-threatening infections in persons with poor health or weakened immune systems, especially the very young or elderly. Incidence of Salmonella has fluctuated throughout the 1990's. and do not show a steady trend. The rate in the County in 2000 was 11.7 cases per 100,000 (Figure 9).

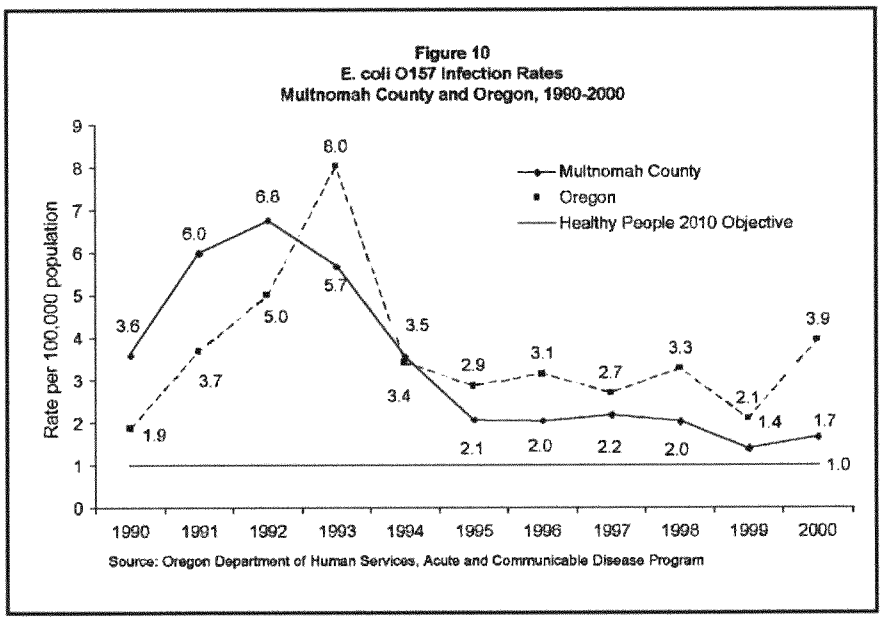
At special risk: Very young children, the elderly, and individuals with compromised immune systems are most likely to experience serious effects of foodborne illness.

E. coli. E. coli is a bacterial pathogen commonly found in cattle. Human illness typically follows consumption of food or water that has been contaminated with microscopic amounts of cow feces and can cause severe and bloody diarrhea and painful abdominal cramps, without fever. E. coli has the potential for causing kidney failure, especially in children.



E. coli:
A bacterial pathogen commonly found in cattle.

Rates of E. coli infection have steadily declined in Multnomah County since 1992 (Figure 10). The increased incidence of E. coli in the State in 1993 was due to an outbreak in three restaurants. The slight increase in the State rate of E. coli in 2000 was due to an outbreak in a restaurant in Marion County.



Health Department inspections

In order to prevent foodborne illness outbreaks, local health departments inspect food service facilities to insure they comply with food safety regulations. In Multnomah County in 2001, there were 2,922 year-round food service facilities requiring two inspections a year. Of the total number of inspections in 2001, six different facilities (0.24%) failed to comply with Oregon Food Sanitation Rules.

In 2001, there were 436 food borne related complaints to the health department, a rate of 0.654 complaints per 100,000 population.

Food handlers' certification training is required for all food service workers. In training sessions food service workers learn how to properly prepare and store food items. As of 2001, 82% of food handlers in Multnomah County had a food handlers card. There were 33,106 food handlers with a food handlers card out of 40,571 food handlers identified from inspection reports.

Fish Advisories

The State Office of Environmental Health and Systems and the Oregon Department of Environmental Quality have issued a number of fish advisories identifying elevated levels of mercury in fish caught in the Willamette River. In Oregon, including the Willamette River, most of the mercury in fish is from volcanic and geothermal mercury minerals rather than from man-made sources, unlike much of the remainder of the U.S.[4] However, human activities that release mercury include burning petroleum and coal, mining, smelting processes, pesticide applications and industrial discharges. Mercury is absorbed by plants and small animal life and when eaten by larger animals the mercury accumulates so that older and larger fish have the highest concentrations of mercury.

Although rates of illness caused by unsafe food handling have declined since the early 1990s, the County has not met national objectives in reducing rates of foodborne illness.

Mercury is poisonous to the human body when it reaches certain concentrations in specific organs. The nervous system (brain, spinal cord and nerves) appears to be the most sensitive to mercury effects. Excessive exposure can result in tremors, loss of sensation in extremities, vision and hearing loss, and developmental and behavioral abnormalities.[4]

Mercury is especially harmful to fetuses and to small children. Women of childbearing age are at special risk because of the effect the level of mercury in their body would have if they were to become pregnant. Babies and small children are at special risk because their organ systems are developing rapidly and are more vulnerable to damage. Limiting consumption of fish is the only way to protect against mercury exposure. Cleaning or cooking techniques do nothing to reduce mercury exposure. The Oregon Department of Human Services recommends the following guidelines for the consumption of fish from the Willamette River:

- Children six years of age and younger should not eat more than one 4-ounce fish meal every seven weeks;
- All women of childbearing age, including pregnant females and breastfeeding mothers, should not eat more than one 8-ounce fish meal per month; and
- Women past the age of childbearing, children older than six years and all other healthy adults may safely consume as much as one 8-ounce fish meal per week.[4]

Conclusion

Although rates of illness caused by unsafe food handling have declined in both Multnomah County and Oregon since the early 1990s, Multnomah County has not met national objectives in reducing rates of foodborne illness. To meet national objectives involves risk reduction activities by individuals, education of food processors, preparers and servers, and adherence to national food manufacturing regulations.

1. *Food Safety Office.* Centers for Disease Control and Prevention. Accessed: 6/28/2002. http://www.cdc.gov/foodsafety/
2. Preliminary FoodNet Data on the Incidence of Foodborne Illnesses: Selected Sites, United States, 2000. *Morbidity and Mortality Weekly Report (MMWR)* Centers for Disease Control and Prevention. April 6, 2001;50:13:241-6.
3. *Population estimates 2001.* Population Research Center. Portland State University. *February 3, 1997 Oregon Health Services Fact Sheet Methylmercury In Sport-caught Fish: How Does Methylmercury Affect Health?* Oregon Department of Human Services. Accessed: 3/36/03. http://www.ohd.hr.state.or.us/esc/docs/fishfact.cfm

Hazardous Waste

Fast Facts

- There are currently three Superfund sites in Multnomah County. Two additional sites are candidates for the Superfund program.
- There are currently 155 sites throughout Multnomah County with confirmed hazardous waste contamination.
- There are close to 3,000 reported or confirmed leaking underground storage tanks in Multnomah County. The vast majority are residential heating oil tanks.
- Since 1989, 143 hazardous waste sites have been cleaned up, and no longer pose an environmental or health threat. In addition, over 6,800 leaking underground storage tanks have been cleaned up over the past 20 years.
- Two Superfund sites in Multnomah County have been cleaned up and have been removed from the National Priorities List.

Hazardous Waste: Potentially harmful substances that have been released or discarded into the environment.

Problem Statement

Hazardous wastes - including acids, solvents, resins, sludge, and heavy metals - are toxic chemicals, primarily generated through commercial and industrial activity. According to the Environmental Protection Agency (EPA), over 40 million tons of hazardous waste is produced in the U.S. each year. Examples of hazardous waste producers include: large industrial facilities such as chemical manufacturers, electroplating companies, and steel mills; and more common businesses such as dry cleaners, auto repair shops, hospitals, exterminators, and photo processing centers. [1]

Long-term exposure to hazardous waste is linked to cancer as well as damage to the brain, kidneys, nervous system and fetal development.

According to a recent national survey, six in ten Americans feel that hazardous wastes pose a very serious health threat.[2] Hazardous wastes that are mishandled or spilled can contaminate the environment and can harm human health. Long-term exposure to hazardous wastes such as benzene are known to cause cancer in humans, and heavy metals such as mercury and lead can damage the brain, kidneys, the nervous system and fetal development.[3]

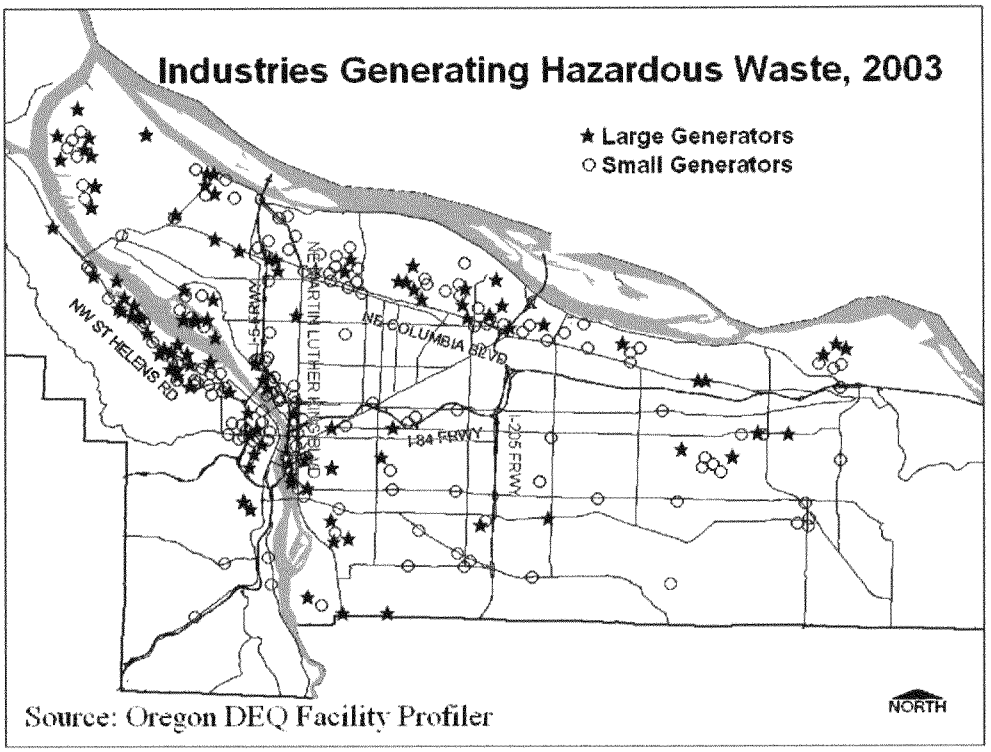
Hazardous Waste Sources and Amounts

Hazardous waste is usually thought to originate at a commercial or industrial facility, such as a dry cleaner or a factory. When industries or commercial properties do not properly contain or dispose of waste, or if a hazardous substance spill occurs, contamination of soil and water can occur. Contamination of the environment can also occur from residential properties, mostly through leaking underground storage tanks. Cleanup is essential in such cases to prevent harm to human health and the environment. Household hazardous wastes probably contribute significant amounts to the overall hazardous waste stream, but no data are currently available for Multnomah County. Such hazardous waste is not examined in this report.

Most Large and Small Quantity Generators are located in the Northwest Industrial, North, and Northeast areas of Portland.

Twenty of the largest 50 waste generators in Oregon are located in Multnomah County.

Generators. Industries that generate hazardous waste are grouped into three separate categories, depending upon the amount they generate. **Large Quantity Generators** produce more than 2,200 pounds per month, **Small Quantity Generators** produce less than 2,200 pounds, and **Conditionally Exempt Generators** (CEGs) produce less than 100 pounds of hazardous waste. CEGs are not required to submit information on their hazardous waste. The Oregon DEQ issues permits to industries that generate hazardous waste. In 2003, there were 119 Large Quantity Generators, 160 Small Quantity Generators, and 1,162 (81% of the total) conditionally exempt generators. Most Large and Small Quantity Generators are located in the Northwest Industrial, North, and Northeast areas of Portland (see map).



Source: Oregon DEQ Facility Profiler

Multnomah County has been home to five Superfund sites over the past twenty years, with cleanup completed on two sites. Superfund sites are uncontrolled or abandoned places where hazardous waste is located.

The total amount of hazardous waste generated in Multnomah County is not available. However, data are available for Large Quantity Generators. According to a 1999 report by the EPA, Oregon generated over 81,000 tons of the total 40 million tons of hazardous waste in the United States that year. Twenty of the largest 50 waste generators in Oregon are located in Multnomah County, and these twenty generated over half - 46,000 tons- of the total Oregon hazardous waste in 1999. The top five hazardous waste generators in Multnomah County generated 43,000 tons, or 53% of the Oregon total (Table 4).[4]

Table 4
Top Five Large Quantity Generators, Multnomah County

Site Name	City	Tons Generated
McCormick & Baxter Superfund Site	Portland	33,792
Oregon Steel Mills, Inc.	Portland	6,112
Reynolds Metal Co.	Troutdale	2,321
Standard Battery	Portland	425
PCC Structurals Inc.	Portland	406
Total		**43,056**

Source: EPA, 1999 National Biennial RCRA Hazardous Waste Report

A **brownfield** is any "abandoned, idled, or under-used industrial and commercial facility where expansion or redevelopment is complicated by real or perceived environmental contamination."[5]

Superfund Sites

The EPA has the authority to cleanup the most hazardous sites in the U.S., and keeps track of over 1,200 sites through the **National Priorities List** (NPL). The **Superfund** program is the cleanup funding source for the NPL. There have been 16 hazardous waste sites in Oregon that have been proposed or listed on the National Priorities List. Multnomah County has seven such sites, five of which were listed on the final NPL. Two sites have been cleaned up and have been removed from the NPL list (Table 5). Three Superfund sites in Multnomah County are currently undergoing cleanup.

Table 5
National Priorities List (Superfund) Sites, Multnomah County

Name	Location	Proposed Listing	Final Listing	Cleanup Completion	Removed from List
Allied Plating, Inc.	North Portland	1/22/87	2/21/90	6/29/93	11/14/93
East Multnomah Co. Ground Water Contam.	Gresham	5/10/93			
Gould Inc.	Northwest Portland	12/30/82	9/08/83	9/28/00	9/30/02
Harbor Oil	North Portland	9/05/02			
McCormick & Baxter Creos. Co.	North Portland	6/23/93	5/31/94		
Portland Harbor	North Portland	7/27/00	12/01/00		
Reynolds Metals Co.	Troutdale	8/23/94	12/16/94		

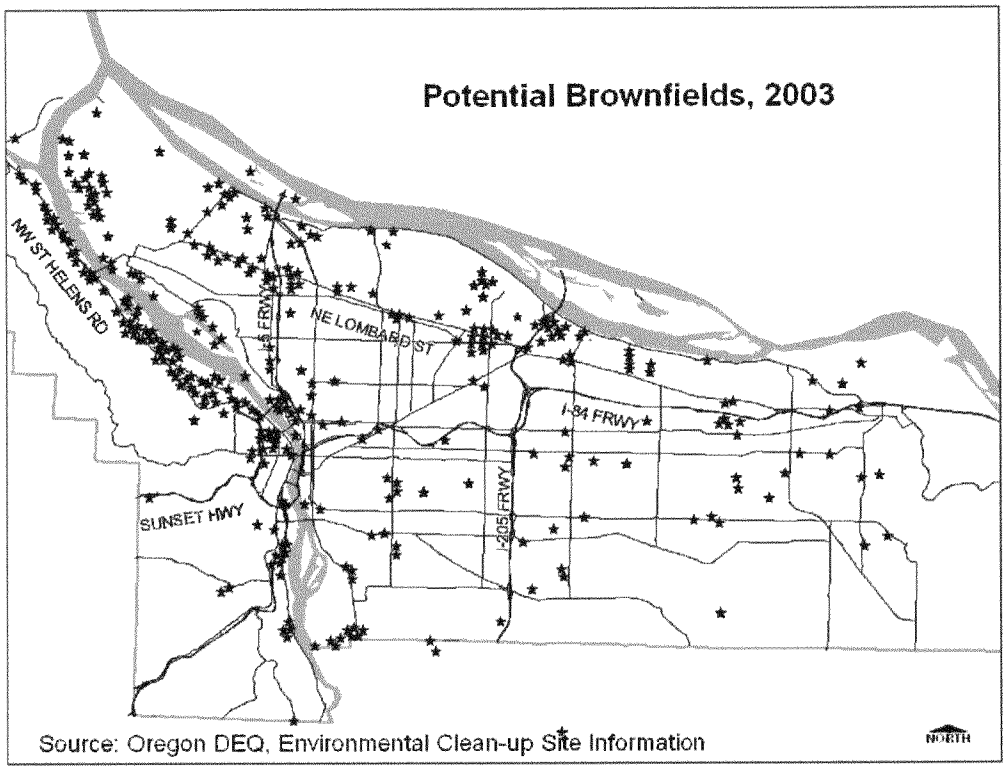
Source: U.S. Environmental Protection Agency, Oregon Department of Environmental Quality

There are currently 155 sites throughout Multnomah County with confirmed hazardous waste contamination.

Brownfields

A brownfield is any "abandoned, idled, or under-used industrial and commercial facility where expansion or redevelopment is complicated by real or perceived environmental contamination."[5] Oregon DEQ keeps track of approximately 2,900 sites throughout Oregon with suspected, confirmed or past hazardous wastes. Although the actual number of brownfields in Multnomah County is unknown, we can approximate the number using DEQ's Environmental Cleanup Site Information (ECSI) database, which tracks contaminated sites from 1989 to 2003. All sites listed, many of which are active businesses, have documented or suspected hazardous substance contamination (from solvents, metals, etc.) in soil, surface

water, groundwater, or sediments. Most sites listed were or are presently commercial or industrial properties that improperly handled hazardous wastes.[6] According to ECSI data, there are currently 155 sites in Multnomah County with confirmed hazardous wastes that may harm human health or the environment. Of these 155, 105 require further investigation and cleanup of the site. In addition, Multnomah County is home to an additional 254 sites suspected to have hazardous wastes. According to ECSI data, 143 sites have been cleaned up, and no further action is required. An examination of potential brownfields (see map) reveals that most sites are in the Northwest industrial, North and Northeast areas of Portland.



In Multnomah County, the majority of leaking underground storage tanks are heating oil tanks located at residential properties.

Leaking Underground Storage Tanks

As of March 2003, the Oregon DEQ had identified over 21,000 leaking underground storage tanks in Oregon that were reported or confirmed to be leaking hazardous wastes. In most cases, the substance was petroleum. In Multnomah County, 9,789 leaking underground storage tanks have been identified over the past 20 years, with cleanup completed on 6,837, or 70%. The vast majority of tanks – 8,344- are heating oil tanks, mostly located at residential properties. Cleanup has been completed on 82% (5,618) of heating oil tanks. About 1,400 regulated leaking storage tanks – mostly from industries and commercial businesses – have been identified, with cleanup completed on 1,165. There are close to 3,000 reported or confirmed leaking underground storage tanks in Multnomah County that have not been cleaned up. Most of these – 2,694 – are heating oil tanks, most likely located at private residences. [7]

Conclusion

There are many hazardous waste sites throughout the County - especially in Northwest Industrial, North, and Northeast Portland - that have contaminated the environment and may be posing human health risks. In many cases, health threats from hazardous waste are being reduced through state and federal programs charged with cleanup of hazardous waste sites. However, many hazardous waste sites remain. The human health impact to Multnomah County residents is unclear.

1. Hazardous Waste. U.S. Environmental Protection Agency. Accessed 04/18/2003. http://www.epa.gov/ebtpages/wasthazardouswaste.html
2. Pew Charitable Trusts. Prepared by Princeton Survey Research Associates. National Survey of Public Perceptions of Environmental Health Risks: Report on the Findings. Washington, DC: Georgetown University. 2000.
3. Canada vs. the OECD: An Environmental Comparison: Hazardous Waste 2001. Organization for Economic Cooperation and Development (OECD). Accessed 04/18/2003. http://www.environmentalindicators.com.
4. National Biennial RCRA Hazardous Waste Report: Based on 1999 Data. U.S. Environmental Protection Agency: Washington, D.C. 2001.
5. Potential Brownfield Sites in Oregon from the Oregon Department of Environmental Quality's Environmental Cleanup Site Information (ECSI) and UST Cleanup Databases. Department of Environmental Quality: Portland, Oregon. 2003.
6. Frequently Asked Questions About ECSI – DEQ's Environmental Cleanup Site Information Database. Department of Environmental Quality: Portland, Oregon. 2003.
7. Oregon DEQ Facility Profiler 2.0. Oregon Department of Environmental Quality. Accessed 04/01/2003. http://deq12.deq.state.or.us/fp20/

Housing and Indoor Air Quality

Fast Facts

- In 2000, 1.1% (3,117 units) of housing stock in Multnomah County lacked complete kitchen facilities and 0.8% (2,252 units) lacked complete plumbing facilities.
- The percentage of overcrowding in renter-occupied units (8.7%) is higher than in owner-occupied units (2.9%).
- Lead-based paint is most prevalent in houses built before 1950. To a lesser extent, housing built between 1950 and 1978 may also have lead-based paint.
- There is a higher percentage of housing built in 1950 or earlier in the inner Northeast and Southeast neighborhoods.
- Radon levels in Oregon, according to the EPA, have been designated as of moderate or low concern.

Problem Statement

Adequate housing and good **indoor air quality** are important in providing a healthy environment for all individuals. People spend much of their time indoors. Some hazards associated with indoor environments include inadequate facilities, poor sanitation, **radon**, indoor tobacco smoke, and lead-based paint.

Radon is a colorless, naturally occurring, radioactive gas which in residential environments can be a potential source of illness for families. Radon has been directly linked to lung cancer and is estimated to cause thousands of deaths nationally each year.[1] Radon comes from the natural decay of uranium, which is found in the soils around a home. Radon can leak into the home through cracks or holes in the foundation.

Lead is poisonous to humans and exposure to lead can affect everyone, but it is especially dangerous for children aged six and younger.

Environmental tobacco smoke is defined as smoke given off by cigarettes, pipes, or cigars to which nonsmokers can be exposed. This type of **secondhand smoke** has been linked to many harmful and fatal diseases. Environmental tobacco smoke causes approximately 3,000 deaths each year among adult nonsmokers, serious lower respiratory tract infections and asthma among children, and has been linked to sudden infant death syndrome (SIDS) among infants.[2]

Lead is also a naturally occurring metallic element that has been mined for centuries for use in a variety of products. Lead is poisonous to humans. Exposure to lead can affect everyone, but it is especially dangerous for children aged six and younger. This is because children's developing brains and nervous systems are more sensitive to the damaging effects of lead. Lead-based paint is the most common source of lead exposure for children. Because they often put their hands and other objects in their mouths, small children are typically lead poisoned by swallowing household dust and soil contaminated with lead from old lead-based paint. The Centers for Disease Control and Prevention estimates that about half

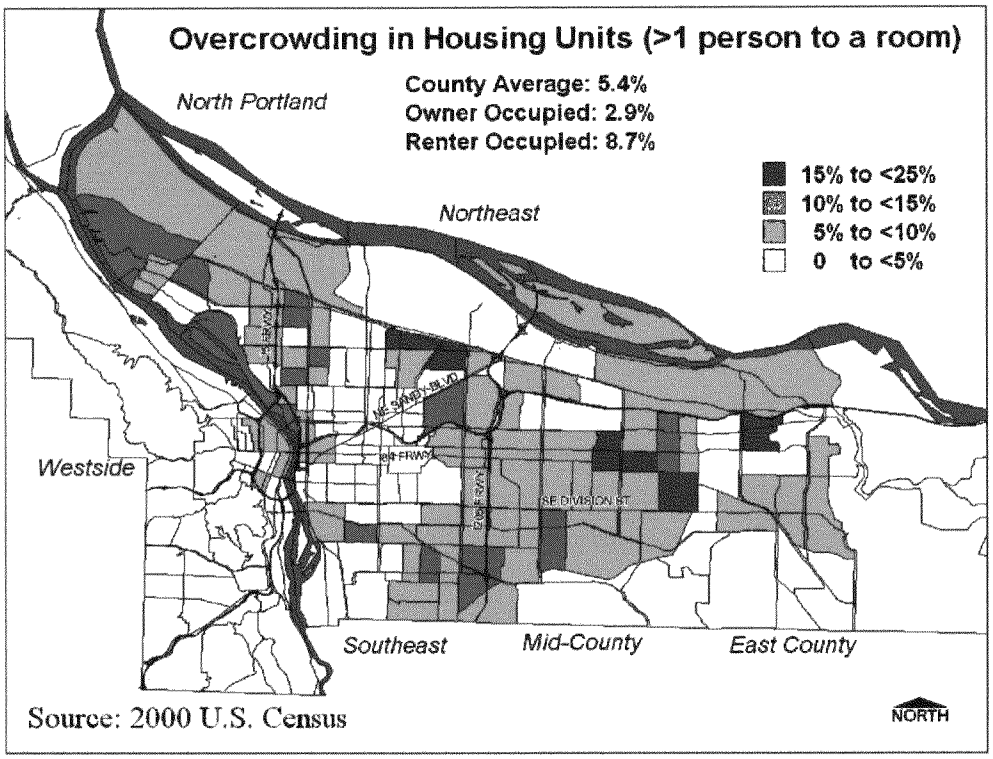
a million American children under the age of six have dangerously elevated levels of lead in their blood and that racial minority and poor children are disproportionately affected.[3]

A housing unit is considered overcrowded if it has more than one person to a room.

Inadequate Housing

Kitchen Facilities, Plumbing Facilities and Overcrowding. Data on housing quality is found in the 2000 U.S. Census. Complete kitchen facilities are defined as a sink with piped water, a range, and a refrigerator. Complete plumbing facilities are defined as hot and cold piped running water, a flush toilet, and a bathtub or shower. A housing unit is considered crowded if it has more than one person to a room.

Within the county, housing units that are considered overcrowded are primarily in North, Northeast and Mid-County. (see map)



Source: 2000 U.S. Census

In 2000, 1.1% (3,117 units) of housing stock in Multnomah County lacked complete kitchen facilities and 0.8% (2,252 units) lacked complete plumbing facilities. The percent of housing units in Multnomah County considered overcrowded is 5.4% (14,793 units). A lack of complete kitchen and plumbing facilities and overcrowding is higher among renters than among home owners. The percentage of housing without complete kitchen and plumbing facilities and those which are overcrowded is similar for Multnomah County, Oregon and the U.S. (Table 6)

Table 6
Measures of Housing Quality, 2000

	Multnomah County			Oregon	U.S.
	Owner Occupied	Renter Occupied	Total	Total	Total
Lack complete kitchen facilities	0.2%	1.9%	1.1%	1.3%	1.3%
Lack complete plumbing facilities	0.3%	1.2%	0.8%	0.9%	1.2%
Overcrowding in housing unit	2.9%	8.7%	5.4%	4.8%	5.7%

Source: Summary File 3, 2000 U.S. Census

Lead Exposure

Although testing for childhood blood lead has increased in the County, the average blood lead levels have shown a decline.

Lead Exposure Testing in Children. Children's blood lead level testing data, both public and private, is reported to the Oregon Department of Human Services Lead-Based Paint Program which provides the data on confirmed childhood lead poisoning cases. Although testing for childhood lead poisoning is available in Multnomah County, many at-risk children are never tested for lead exposure; the actual prevalence of lead poisoning in children in the County is unknown. Blood lead levels of 10 micrograms per deciliter (µg/dL) or more can adversely affect a child's intelligence, behavior and development. Testing for lead exposure in at-risk children is performed through the Multnomah County Health Department's Primary Care Clinics and Immunizations Program. In 2002, 3,184 blood lead tests were conducted through the Health Department. This number is up from 2,886 in 2001 and 1,936 in 2000. Children are also tested through private physicians and community-based screening clinics.

Testing of children through the Multnomah County Health Department indicates 1% of those children who are actually tested have confirmed elevated **blood lead levels.** The Oregon Department of Human Services, Lead-Based Paint Program tracks the number of children county-wide who have tested positive for elevated blood lead levels (Table 7). Although testing for childhood blood lead has increased in the County, the average blood lead levels have shown a decline. The Healthy People 2010 objective is to eliminate elevated blood lead levels in children age one to six.

Table 7
Confirmed Childhood Lead Poisoning Cases*, Multnomah County

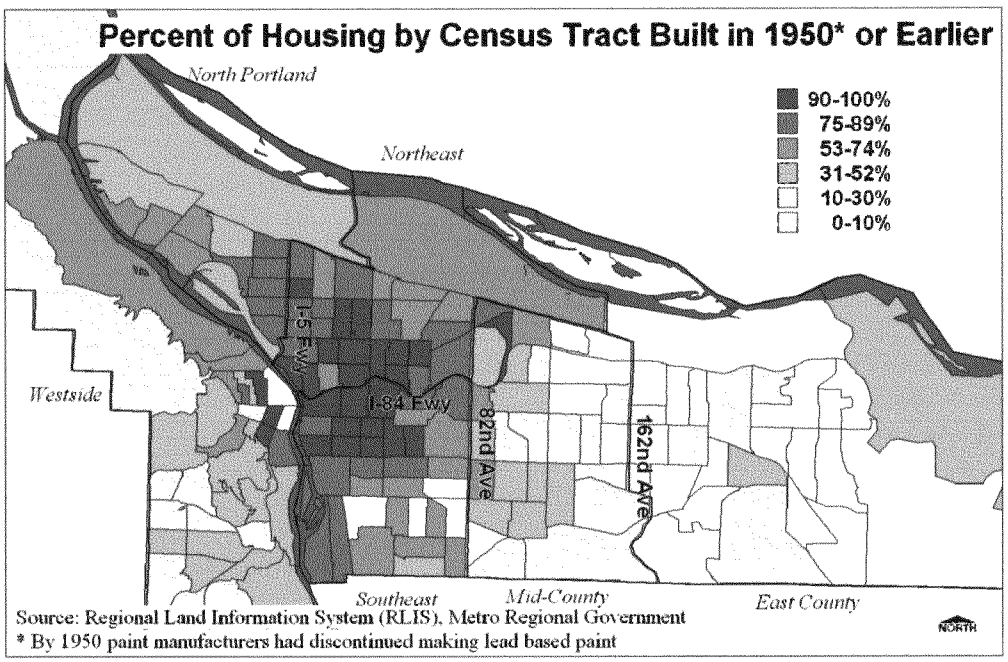
	1993	1994	1995	1996	1997	1998	1999	2000	2001
≥10_g/dL	94	90	63	49	39	58	56	64	44
≥15_g/dL	32	31	20	18	13	21	20	19	17

Source: Oregon Department of Human Services, Lead-Based Paint Program
*70% of the cases were determined to be caused by leaded house paint

Lead-based paint in housing. Lead-based paint is most prevalent in houses built before 1950. To a lesser extent, housing built between 1950 and 1978 may also have lead-based paint. By the early 1950's most paint manufacturers had discontinued producing lead-based paint. However, it was not until 1978 that a ban on manufacturing lead-based paint was enacted. According to the 2000 U.S. Census, 40% of Multnomah County's housing units were built before 1950 and 79.6% were built in 1979 or earlier.

The map below shows the percent of housing built in 1950 or earlier by census tract. In inner Northeast and Southeast neighborhoods there is a higher percentage of housing built in 1950 or earlier.

A February 2001 Multnomah County Health Department (MCHD) study looked at the prevalence of **household lead dust** hazards in North, Northeast and Southeast Portland housing built before 1930. It was found that 71% of homes in the study had lead dust levels that exceeded federal standards. It is important to note also that, at the time the study was conducted, the federal standards were 50% less stringent than they are today. The Healthy People 2010 objective recommends that 50% of people living in pre-1950s housing have their housing tested for the presence of lead-based paint.



Source: Regional Land Information System (RLIS), Metro Regional Government
* By 1950 paint manufacturers had discontinued making lead based paint

MCHD provides environmental lead investigations in those homes where a child has been identified with a confirmed blood lead level of 15 ug/dL or higher. The investigation is designed to assist the family in determining the source or sources of lead exposure, to make recommendations for exposure prevention, and

to identify resources available to the family for lead hazard reduction. MCHD also provides educational materials and resource referrals to families whose children are confirmed at 10 – 14 ug/dL or are unconfirmed at levels of 10 ug/dL or higher. The Health Department, in partnership with the City of Portland, provides lead poisoning prevention education, information, and referral to appropriate assistance programs through the LeadLine.

While childhood blood lead testing in Oregon has increased by approximately 44% between 1999 and 2001, average blood lead levels have shown a decline. However, there are still many at-risk children living in the County who are never tested for lead. Less than 5% of children less than 6 years of age are tested for blood lead.[4] Therefore, the actual prevalence of childhood lead poisoning in the County is unknown.

Indoor Air

Radon. Radon levels in Oregon, according to the EPA, have been designated as of moderate or low concern on a scale from low to moderate to high.[5] The EPA has designated Multnomah County of "Moderate Potential" for radon exposure. This means that the average radon measurements for homes in the region should be in the range of two to four picocuries per liter (pCi/L). Data available from Oregon Department of Human Services, Oregon State Radiation Protection Services show radon levels are within such a range. Of 998 homes tested in Multnomah County, the average level of radon was 3.1 pCi/liter. This is higher than the national average indoor radon level of 1.3 (pCi/L). There were 253 homes (25%) in Multnomah County which tested higher than 4 pCi/liter.[6] The Healthy People 2010 objective is to assure that 20% of the population live in homes that have been tested for radon concentrations and that there is an increase in the number of new homes constructed to be radon resistant.

Environmental Tobacco Smoke. Secondhand smoke has been linked to many harmful and fatal diseases. Children are especially vulnerable, and it has been estimated that 43% of those two months to 10 years live in a home where a tobacco smoker is present. Furthermore, 37% of adults lived in a home with at least one smoker.[7] An analysis by Oregon Public Health Services indicates that 24% of adults in Multnomah County are tobacco smokers. It has also been estimated that in a typical week, 28% of County residents are exposed to secondhand smoke and indoor air housing quality in Multnomah is generally good.[8]

Conclusion

Housing and indoor air quality in Multnomah County is generally good. Renter-occupied housing units have a higher percentage of a lack of complete kitchen and plumbing facilities and a higher percentage of overcrowding than owner-occupied housing. Potential exposure to radon has been deemed moderate for Multnomah County. Exposure to environmental tobacco smoke is of concern for

young children when there is a tobacco smoker in the home. While testing of childhood blood lead levels has increased, the incidence of lead poisoning has decreased. However, less than 5% of children recommended for testing are receiving blood lead testing.

1. *Indoor Air – Radon. A Citizen's Guide to Radon: The Guide to Protecting Yourself and Your Family From Radon (4th ed.).* U.S. Environmental Protection Agency. Accessed: 4/16/2003. http://www.epa.gov/iaq/radon/pubs/citguide.html.
2. *Exposure to Environmental Tobacco Smoke and Cotinine Levels — Fact Sheet.* Centers for Disease Control and Prevention, Accessed: 4/16/2003. http://www.cdc.gov/tobacco/research_data/environmental/factsheet_ets.htm
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Land Use and Community Design

Fast Facts

- Community design is being increasingly viewed as a factor influencing the environmental quality and safety of cities, and may be partially responsible for the decline in physical activity and the increase in overweight and obesity among city inhabitants.
- In a 1994 Multnomah County survey, 13.6% of trips were made by walking or bicycling compared with 79% made by auto.
- While the rate of motor vehicle crash fatalities is consistently lower in Multnomah County than in Oregon and the U.S., motor vehicle accidents were the leading cause of death of Multnomah County and Oregon children age 1 to 17 years for the period 1997-2000.
- There has been a steady increase in recent years in the number of adults in Multnomah County, Oregon and the U.S. who are at risk of overweight-related health problems.
- Only one quarter of adults in Multnomah County participated in recommended physical activity of at least 30 minutes 5 times a week in 2000.
- Only 34% of 8th graders and 29% of 11th graders participated in moderate physical activity 5 times or more a week in 2001.

Problem Statement

Community design and transportation systems can significantly impact the lifestyle and personal health of individuals.

Understanding the environmental consequences of how we build our cities is an important public health issue. Community design and transportation systems can significantly impact the lifestyle and personal health of individuals. Up to twice as many people may walk or cycle in neighborhoods that have good public transportation than in neighborhoods that are designed for automobile use.[3] In neighborhoods with square city blocks, people walk up to three times more than in neighborhoods with cul-de-sacs or other features that keep streets from connecting.[3] Directly related to this is **physical activity**, which is one of the key elements in maintaining personal health. A 1996 surgeon general report concluded that a **sedentary lifestyle** is a primary factor in more than 200,000 deaths each year.[1] Cardiovascular disease, diabetes, hypertension, obesity and osteoporosis are linked to a sedentary lifestyle. At least one-third of all cancers are attributable to poor diet, physical inactivity, and being overweight.[2] In Multnomah County planners in the areas of transportation, land use design and public health are only just beginning to understand, analyze and evaluate the environmental and health impacts of the built environment.

Transportation

North Americans are much more likely to use a car for transportation than are Europeans. In 1996, for example, the car was the mode of transportation for 84% of all U.S. trips in urban areas compared to 36% of all trips within urban

areas in Sweden.[3] In the U.S., 25% of all trips made are less than one mile, and 75% of these trips are made with a car.[1]

Although auto use for commuting to work is high within Multnomah County, it is lower than auto use for commuting to work in the State and nationally. Multnomah County has a well-developed transit system, along with pedestrian and bicycle advocacy groups that promote walking and biking. Data on commuting patterns can be found in the 2000 U.S. Census. The data are based on the long form questionnaire which was distributed to 1 in 6 American households during 1999. The census reports that walking, bicycling or other means (scooters, skateboards, roller blades etc.) comprise 7 percent of work commute trips in Multnomah County compared to 4.1 percent of work commute trips nationwide (Table 8).

Table 8 shows Multnomah County has a higher percentage of commute trips for work made by single drivers than San Francisco County (principal city – San Francisco) but lower than Pierce County, Washington (principal city – Tacoma). San Francisco County has two and a half times the percentage of work commute trips by public transit and twice the percentage of trips by walking than Multnomah County. Compared to the Nation, Multnomah County has twice the number of work commute trips made by public transit and four times the percent of trips by bicycle.

Table 8
Commuting Patterns, Multnomah County and Select Counties, 2000

Work Commute Trips	Auto Alone	Auto Carpool	Public Transit	Walk	Bicycle	Motorcycle /Other	Work at home
San Francisco County, CA	41.1%	9.3%	32.1%	8.8%	1.8%	2.1%	4.8%
Multnomah County	65.2%	12.2%	11.9%	3.9%	1.9%	0.9%	4.2%
Pierce County, WA	77.8%	12.2%	3.5%	1.3%	0.7%	0.8%	3.6%
Oregon	73.6%	12.6%	3.8%	3.2%	1.2%	0.8%	4.5%
United States	75.7%	12.2%	5.2%	2.7%	0.4%	1.0%	3.2%

Source: 2000 U.S. Census Supplementary Survey

San Francisco, California and Pierce County, Washington were identified as peer counties to Multnomah County by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. Peer counties are based on population composition and selected demographics and can be used to compare differences in a community's health.

People who live in areas with **mixed use development** and good access to transit (bus, streetcar, light rail) are more likely to use alternative transportation. Mixed use development is land use development in which there are multiple uses in the

Mixed use development is land use development in which there are multiple uses- residential, commercial, light industrial- in the same development.

same development; this includes a commingling of residential, retail, commercial, light industrial, entertainment, and institutional development. In 1994, the Metro Regional Government surveyed 6,000 households in Clackamas, Multnomah, Washington and Clark Counties on their travel behavior. Households kept a two-day diary of activities and tracked how they traveled to those activities. The survey showed that areas with good transit and mixed-use development had a higher percentage of trips by walking or biking than did areas with good transit access and single use development (Table 9). Increasing physical activity through walking and biking as alternative forms of transportation can be supported through land use development and transportation design. The Healthy People 2010 objective is to increase the proportion of trips made by walking for adults by 25% and for children (age 5 to 15 years) by 50%. The objective to increase the proportion of trips made by bicycling is 2% for adults and 5% for children.

Table 9
Travel Behavior Survey Results (for all trip purposes), Multnomah County, 1994

All Trips	Auto	Transit	Walk	Bicycle	Other
Good Transit/ Mixed use	58.1%	11.5%	27.0%	1.9%	1.5%
Good Transit Only	74.4%	7.9%	15. 2%	1.4%	1.1%
All Land Use Types	79.0%	4.9%	12.0%	1.6%	2.5%

Source: Metro Regional Framework Plan, 1997

Motor Vehicle Accidents

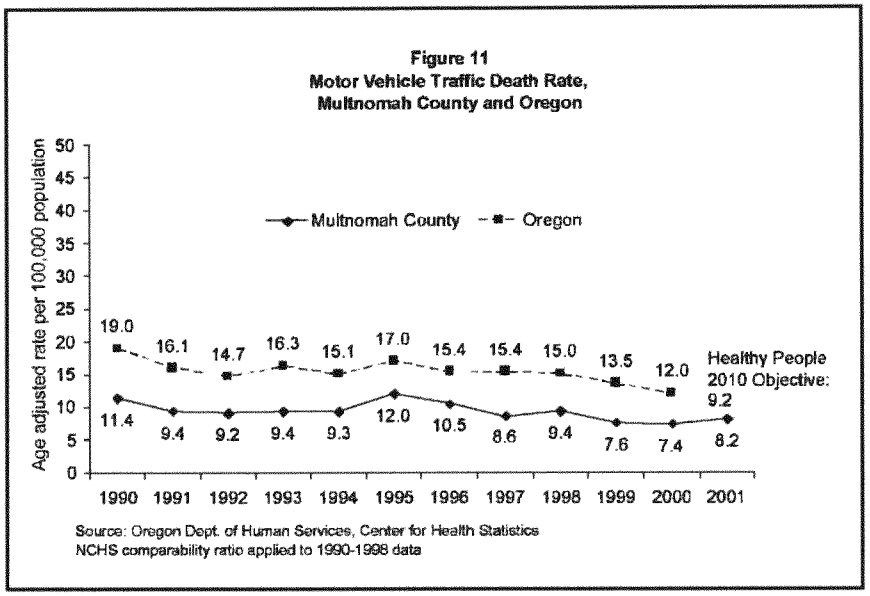
In Multnomah County and the nation, the leading cause of unintentional injuries is motor vehicle accidents.

In Multnomah County and the Nation, the leading cause of unintentional injuries is motor vehicle accidents. Public health efforts to prevent motor vehicle injuries have been highly successful. According to the National Center for Injury Prevention and Control, 240,000 lives were saved between 1966 and 1990 because of improved motor-vehicle and highway design, increased use of safety belts and motorcycle helmets, and enforcement of laws regarding driving under the influence of alcohol and speeding.[4]

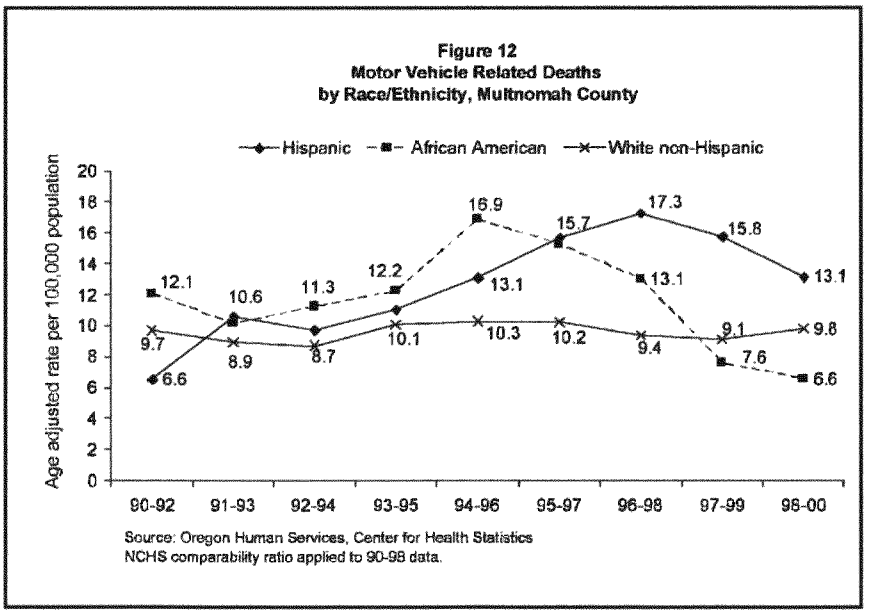
Most unintentional injury deaths are preventable. Compared to the United States, Oregon has a high motor vehicle safety restraint use, with 91% of adults and 69% of children aged 0-4 using safety restraints.[5] A new "booster seat" law became effective in Oregon on January 1, 2002 and requires drivers to use approved booster seats for children aged 4-6 years or 40-60 pounds.

Motor vehicle traffic deaths. Data on motor vehicle traffic deaths comes from Oregon Department of Human Services vital statistics records, which are maintained and reported by the Center for Health Statistics. The rate of motor vehicle traffic deaths in Oregon has declined since 1995. Multnomah County is

consistently lower in motor vehicle traffic deaths than Oregon and has met the Healthy People 2010 objective (Figure 11).

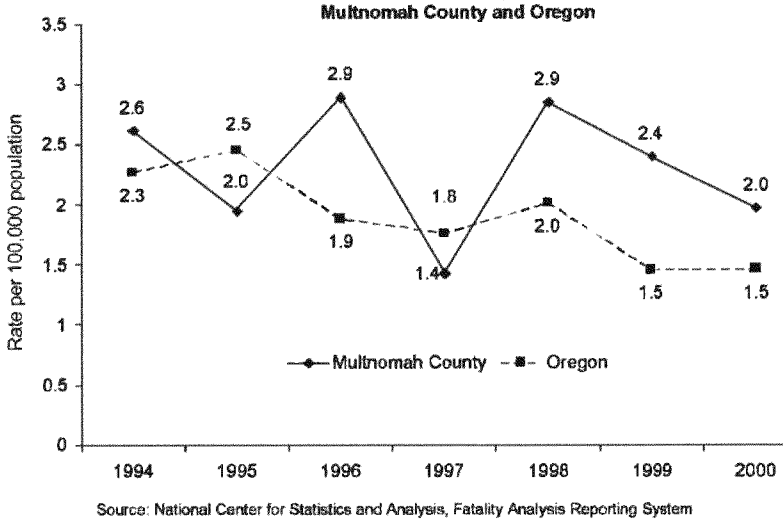


Motor vehicle-related deaths. Motor vehicle-related deaths include both traffic and non-traffic deaths. Traffic accidents are accidents occurring on a public trafficway, while non-traffic accidents are vehicle-related accidents occurring any place other than a public trafficway. Motor vehicle-related deaths among the Hispanic population increased in the early 1990's, but have decreased in recent years; such deaths among Hispanics are still higher than other racial and ethnic groups (Figure 12). The rates for African American and Asians have decreased, while the rates for White non-Hispanic have remained relatively steady. There were too few American Indian motor vehicle-related deaths to calculate rates.



Pedestrian deaths. Pedestrian fatalities resulting from a motor vehicle traffic accident are the second-leading cause of motor vehicle-related deaths, following occupant fatalities.[6] Pedestrian fatalities are monitored by the Fatality Analysis Reporting system of the National Center for Statistics and Analysis. The Fatality Analysis Reporting system defines a fatality as a police-reported crash involving a motor vehicle in transport on a trafficway in which at least one person dies within 30 days of the crash. A crash is defined as an event that produces injury and/or property damage, involves a motor vehicle in transport, and occurs on a trafficway or while the vehicle is still in motion after running off the trafficway.[7] Although pedestrian fatality rates have declined in Multnomah County since 1998, the rate is higher than the Healthy People 2010 objective of 1.0 pedestrian deaths per 100,000 population (Figure 13).

Figure 13
Pedestrian Fatality Rates
Multnomah County and Oregon



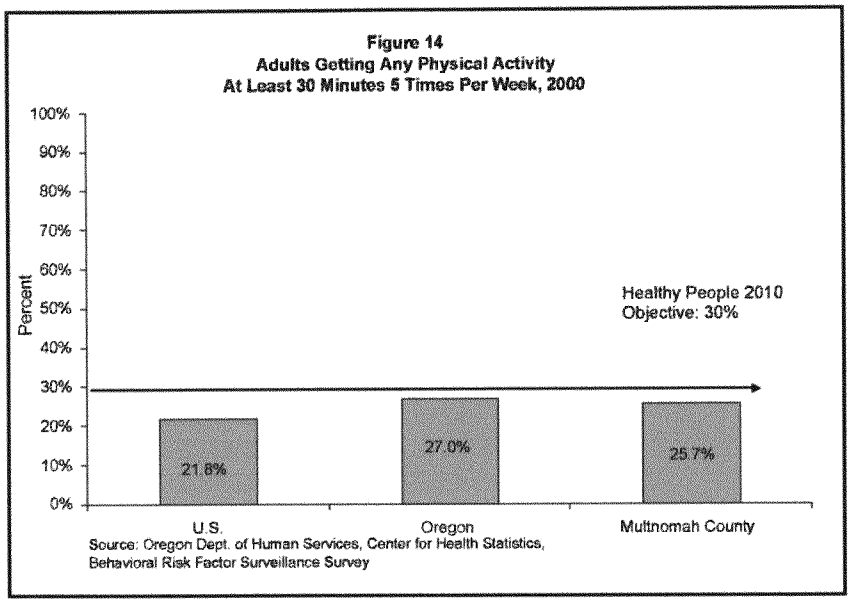
Source: National Center for Statistics and Analysis, Fatality Analysis Reporting System

In Multnomah County, only one quarter of adults participate in regular physical activity.

Physical Activity

The design of the built environment can determine the ease of walking and biking and can have an effect on the amount of physical activity people engage in.

Physical Activity in Adults. The Behavioral Risk Factor Surveillance Survey (BRFSS) is a telephone health survey of adults developed by the Centers for Disease Control and Prevention and conducted at the state level. The BRFSS collects information on nutrition, activity, health status and other topics. The 2000 BRFSS reports that, in Multnomah County, one quarter of adults participate in physical activity at least 30 minutes 5 times a week (Figure 14). Although higher than the nation wide percentage, Multnomah County, does not meet the Healthy People 2010 objective.

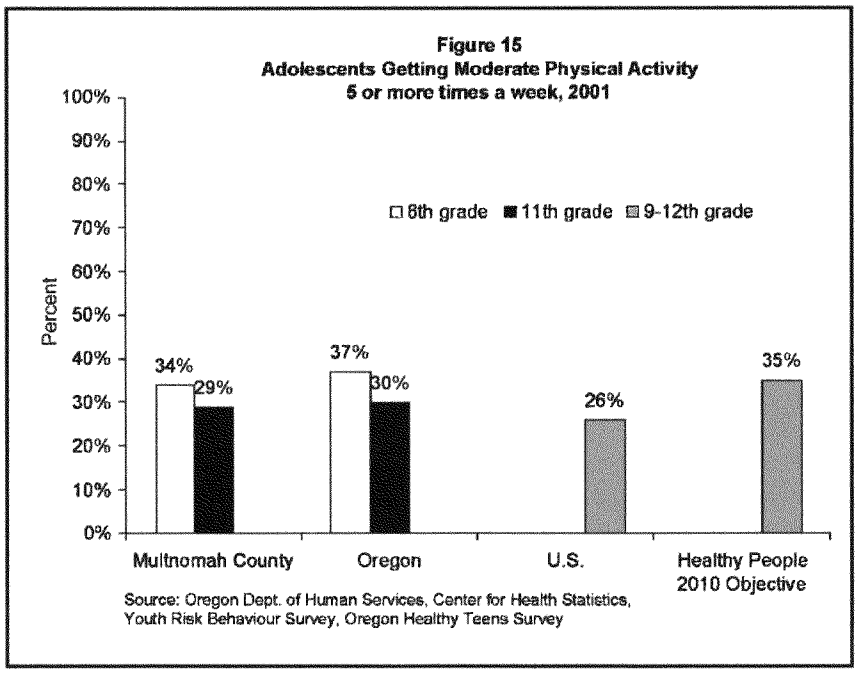


Physical Activity in Adolescents. The Youth Risk Behavior Survey (YRBS) is a voluntary health survey of 9th through 12th graders developed by the Centers for Disease Control and Prevention, and carried out every other year by the State of Oregon prior to 2001. In 2001, the Oregon Department of Human Services developed the Oregon Healthy Teens survey, a yearly survey combining the YRBS and the Student Use Survey conducted by the former Office of Alcohol and Drug Abuse Prevention. Oregon Healthy Teens reports data on 8th and 11th graders.

Moderate physical activity: Activities that use large muscle groups and are at least equivalent to brisk walking. Activities may include walking swimming, cycling, dancing, gardening and yard work.

Although the percentage of Multnomah County 8th and 11th graders participating in **moderate physical activity** for 30 minutes at least 5 days per week was somewhat higher than the national average in 2001, it did not meet the Healthy People 2010 objective and was lower than the state (Figure 15). Among the major barriers

With over half of the adult population at risk for health problems related to being overweight, Multnomah County is far from reaching the Healthy People 2010 objective of 60% of adults at a healthy weight.

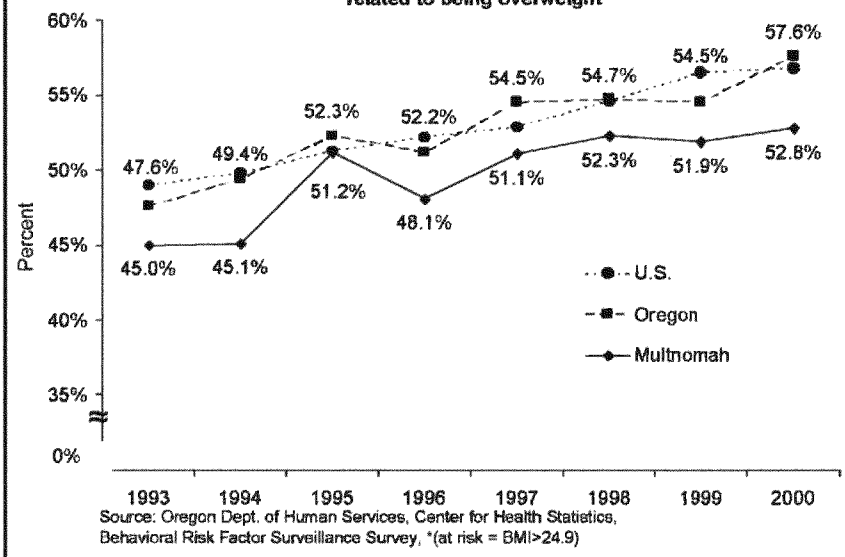


Healthy People 2010 identifies most adult and adolescent face when trying to increase phyical activity are lack of time, lack of access to convenient facilities, and lack of safe environments in which to be active.

Body Weight

Body Mass Index. **Body mass index (BMI)** is a method of estimating fitness based on a person's height and weight. There is consensus that a BMI of between 18.5 and 25 is a healthy weight range for adults (World Health Organization, National Institutes of Health, Department of Health and Human Services, U.S. Department of Agriculture). A BMI of 25 or greater can lead to health problems associated with being overweight or obese. Although the proportion of adults in Multnomah County who are at risk of health problems related to being overweight is consistently lower than Oregon and the Nation, there has been a steady increase in all population groups (Figure 16). With over half of the adult population at risk for health problems related to being overweight, Multnomah County is far from reaching the Healthy People 2010 objective of 60% of adults at a healthy weight. Among adolescents in 2001, 8.1% of 8th graders were overweight and 7% of 11th graders were overweight. The Healthy People 2010 objective is to reduce the proportion adolescents who are overweight or obese to 5%.

Figure 16
Adults at risk* for health problems related to being overweight



Source: Oregon Dept. of Human Services, Center for Health Statistics, Behavioral Risk Factor Surveillance Survey, *(at risk = BMI>24.9)

Conclusion

Public health has an important role to play in supporting land use development, transportation design and fostering opportunities for parks and recreation - all of which promote an increase in physical activity with support of alternative forms of transportation.

While motor vehicle traffic fatalities account for the largest percentage of unintentional injury deaths in Multnomah County, the rate of motor vehicle traffic fatalities is lower than both Oregon and the U.S. Motor vehicle-related death rates of Hispanics have decreased in recent years, however, they are still higher than for White non-Hispanics.

Physical activity is important in preventing and reducing injury and illness, including many chronic diseases. In Multnomah County, adolescents are doing better than adults at meeting physical activity objectives. Although the proportion of adults in Multnomah County who are at risk of health problems related to being overweight is consistently lower than Oregon and the U.S., there has been a steady increase in all population groups. Only one quarter of adults in Multnomah County participate in physical activity at least 30 minutes 5 times a week, while 34% of 8th graders and 29% of 11th graders are getting moderate physical activity 5 times a week or more.

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4. *National Center for Injury Prevention and Control.* Centers for Disease Control and Prevention. Accessed: 4/28/03. http://www.cdc.gov/ncipc/about/about.htm.
5. Boost 'Em Before You Buckle 'Em. *CD Summary.* Oregon Department of Human Services. October 23, 2001; Vol. 50: No. 23.
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Occupational Health

Fast Facts

- As of July 1, 2000, most businesses, including restaurants, are required to be smoke free throughout Multnomah County.
- There were a total of 6,115 accepted work related disabling claims in Multnomah County in 2001, down from a high of 8,366 claims in 1990.

Problem Statement

Workplace injuries and illness are significant issues in the United States. There were 3.8 deaths per 100,000 workers nationally, in 2000 and nearly 4 million American workers suffered disabling injuries on the job. Work injuries cost Americans $131.2 billion in 2000.[1] This amount included the sum of lost wages, lost productivity, administrative expenses, health care, and other costs. A **work related injury** is any personal injury incurred by a worker while on or off the work site but engaged in work-related activities. Injuries include cases such as a cut, fracture, sprain, or amputation. Illnesses include both acute and chronic illnesses, such as a skin disease, respiratory disorder, or systemic poisoning.[2]

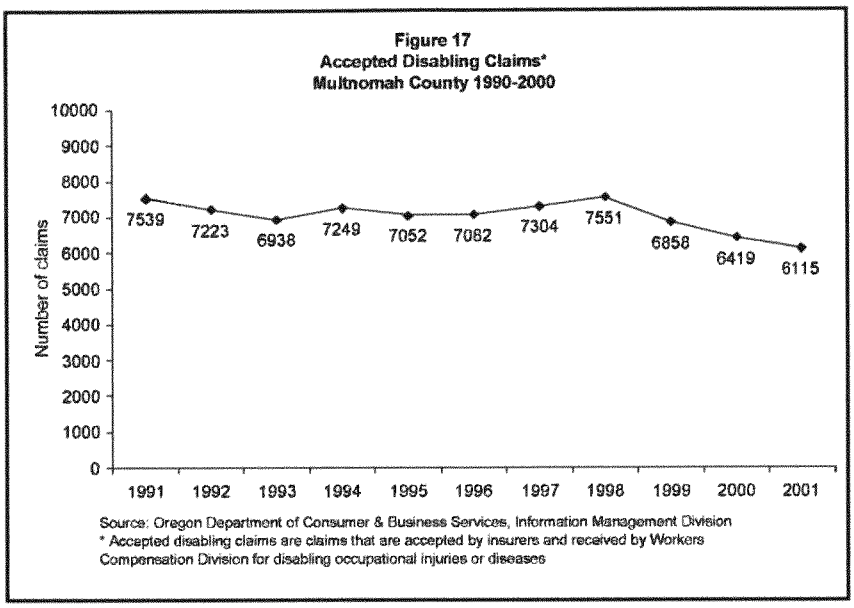
Occupational injury and illness rates drop: Nationally in 2000, occupational injury and illness rates dropped to their lowest level–6.1 injuries per 100 full time workers.

Researching and implementing effective prevention strategies to protect worker safety and health is an important public health function. In 2000, national occupational injury and illness rates dropped to their lowest level–6.1 injuries per 100 full time workers–since the data collection started. This drop continued an eight-year downward trend.[3] In Oregon the occupational injury and illness rate was 6.3 per 100 full time workers in 2000.

Work-related Injury and Fatality

Disabling claims. Disabling claims information is provided by Oregon Workers Compensation Division as reported by the Oregon Department of Consumer and Business Services, Information Management Division. There were 6,115 disabling claims accepted by workers compensation insurers in 2001 for injuries occurring in Multnomah County. There has been a decline in accepted disabling claims in both Oregon and Multnomah County in recent years (Figure 17). The decline could be due to a number of factors: declining numbers of accepted disabling claims from an expanding pool of workers; workers compensation reforms; and changes in claims handling procedures and claims management by insurers and employers. There has also been a shift in Oregon's economy, with fewer workers in the hazardous wood products industry and more workers in comparatively safer high-tech and service industries. Finally, an increased emphasis on safety and health among employers and workers may also be a factor in the decline.[4]

The majority, 81%, of all disabling claims were in one of five sectors: services, manufacturing, retail trade, transportation/public utilities and construction in



the county (Table 10). These five sectors accounted for the largest number of claims for the State in 2001.

Table 10
Disabling Claims by Sector

Sector	% Disabling Claims 2001	% Average Covered Employment* 2000
Services	22.6%	30.9%
Manufacturing	19.2%	11.4%
Retail Trade	16.3%	16.4%
Transportation/ public utilities	14.1%	7.4%
Construction	8.5%	4.8%
% of Total	**80.7%**	**70.9%**

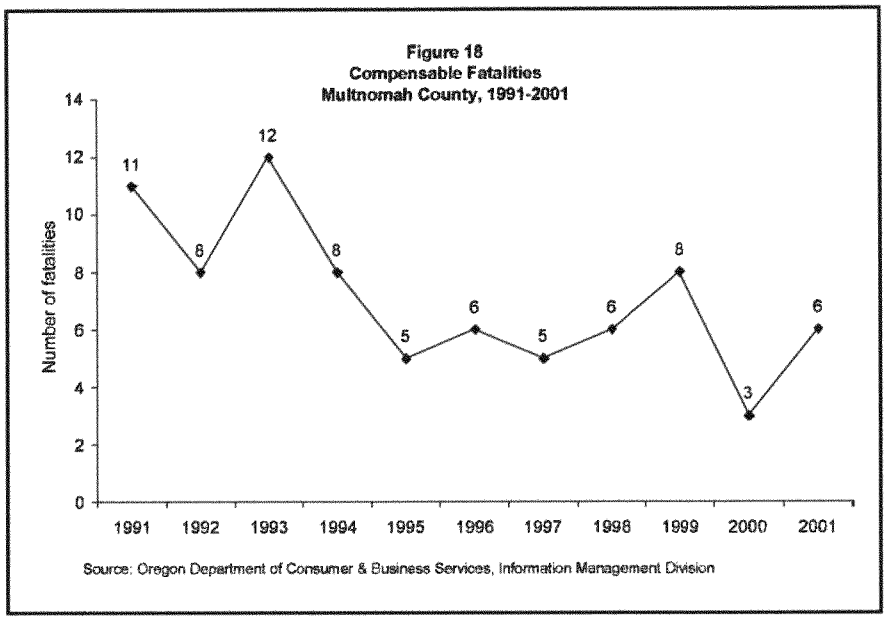
Source: Oregon Dept. of Consumer & Business Services, Information Management Division; Oregon Employment Dept. *Covered Employment refers to workers covered by unemployment insurance

The specific industries in each sector are as follows:

- Services: hotel, legal, health, educational, social, and auto.
- Manufacturing: logging, furniture, metal industries, fabrication, and industrial machinery.
- Retail trade: automotive dealers, apparel, furniture, and eating and drinking establishments.
- Transportation/public utilities: railroad, trucking, air, electric, gas and sanitary services.

While services, manufacturing, retail trade, transportation/public utility, and construction sectors make up 81% of injuries they also account for 71% of covered employment in the County in 2000. Covered employment refers to workers covered by unemployment insurance. There are twice as many claims as might be expected from the transportation/public utilities and construction sectors. Transportation/public utilities make up 7.4% of covered employment but their percent of disabling claims is 14% while construction makes up 4.8% of covered employment and 8.5% of disabling claims.

Workplace fatalities. There are very few deaths from work-related injuries in Multnomah County (Figure 18). Because the State does not calculate the total number of workers covered by workers compensation for each county, a county



fatality rate cannot be calculated. For Oregon in 2001, the rate of work related fatality was 3.1 per 100,000 workers. The U.S. rate in 2000 was 3.8 per 100,000 workers. The Healthy People 2010 objective for reducing deaths from work-related injuries is 3.2 per 100,000 workers aged 16 years and older.

Workplace Air Quality

Indoor air quality is associated with the environmental quality of a workplace. As of July 1, 2000, most businesses in Multnomah County, including restaurants, are required by county ordinance to be smoke free. The Countywide smoke free workplace ordinance exempts bars, bars in restaurants, bingo parlors, truck stops, racecourses, billiard halls, tobacco retail stores and rented hotel and motel sleeping rooms. The purpose of the ordinance is to protect workers from the known health dangers of secondhand smoke, which is classified by the EPA as a known human carcinogen. Compliance with the ordinance has been excellent. More than 47,000 businesses in Multnomah County are subject to the law. During the first year there were only 128 complaints. Most of these complaints were ameliorated by education resulting in only 19 citations. The following year, when fines were levied and implemented, there were 167 complaints resulting in only 5 citations. In 2002, a statewide smoke free workplace law went into effect on January 1. This statewide law further requires billiard halls, truck stops and racecourses in Multnomah County to be smoke free, thus enhancing smoke free workplace air quality. Efforts to promote voluntary smoke free workplace policies continue.

Conclusion

There has been a decline in accepted disabling claims in both Oregon and

Multnomah County in recent years. While the services and manufacturing sectors have the highest percentage of disabling worker claims and make up the largest percentage of covered employment in the county, transportation/public utilities and construction have twice the percentage of disabling claims as they do percentage of covered employment. As of July 1, 2000, most businesses, including restaurants, are required to be smoke free throughout the County.

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2. *Federal Register Occupational Injury and Illness Recording and Reporting Requirements - 66:5916-6135.* U.S. Department of Labor. Accessed: 1/7/03. http://www.osha.gov/pls/oshawebowadisp.showdocument?p_table=FEDERAL_REGISTER&p_id=16312&p_text_version=FALSE
3. *Injuries, Illness, Fatalities.* U.S. Department of Labor. Bureau of Labor and Statistics. Accessed: 6/30/02. http://www.bls.gov/iif/home.htm#tables. Rate calculated (number of injuries and illness/total hours worked by all employees during the calendar year) x 200,000 base for 100 equivalent FTE.
4. Ross-Mota J. First Glance at Accepted Disabling Claims. Oregon Department of Consumer and Business Services. Information Management Division. 2001.

Outdoor Air Quality

Fast Facts

- Multnomah County has been in compliance with standards for select pollutants since 1997. By comparison, eight counties in Oregon, and 318 counties throughout the United States are not in compliance for select pollutants as of July 2002.
- Fourteen toxic outdoor air pollutants in the County exceed health-based benchmarks, with 6 pollutants more than 10 times the benchmark.
- Most of the County exceeds the federal cancer risk benchmark for toxic air pollutants, with many areas in North and Northeast Portland reaching cancer risk rates higher than 100 per million.
- Motor vehicles, especially cars, account for the vast majority of air pollutants in Multnomah County. In 1996 and 1999, they accounted for 52% of toxic air pollutants, and 77% of criteria pollutants, respectively.

Children, the elderly, and those living next to heavy traffic are especially vulnerable to diseases associated with bad air, including asthma.

Problem Statement

Air pollution can make people sick. It is estimated that up to 100,000 deaths per year in the United States are associated with air pollution.[1] Bad air has been linked to asthma, bronchitis, high blood pressure, heart disease and lung cancer.[2-5] Children, the elderly, and those living next to heavy traffic are especially vulnerable to diseases associated with bad air. One scientific study found that ground-level ozone (created mostly by vehicle exhaust) may be a contributing factor in the development of childhood asthma.[6] Cars and trucks are an important cause of air pollution. A recent study found that those living close to highways and major roads were twice as likely to die from heart and lung diseases as those who did not.[7]

According to the U.S. Environmental Protection Agency (EPA), more than 170 million tons of air pollutants are released into the air each year in the U.S., and more than 130 million people in 2001 lived in counties where air was unhealthy at times because of high levels of at least one of six principal air pollutants. Still, our air is cleaner now than in the past. Due in part to federal and state regulations designed to reduce air pollution, total emissions of select air pollutants in the U.S. between 1970 and 2001 have declined by 25%.[8]

Criteria pollutants: Carbon monoxide, ozone, nitrogen dioxide, particulate matter, sulfur dioxide, and lead. All known to be unhealthy at high levels or with prolonged exposure.

Criteria Pollutants

The federal Clean Air Act of 1970 seeks to protect people from the harmful effects of poor air quality, and calls upon the EPA to regulate air pollutants. This act sets standards for six pollutants, called **criteria pollutants**, which are known to be unhealthy at high levels or with prolonged exposure (Table 11). These criteria pollutants have very well known health effects. Exposure to such pollutants can cause respiratory and cardiovascular problems such as asthma, aggravation of heart disease, and lung cancer. Two criteria pollutants that stand out are **ozone** and

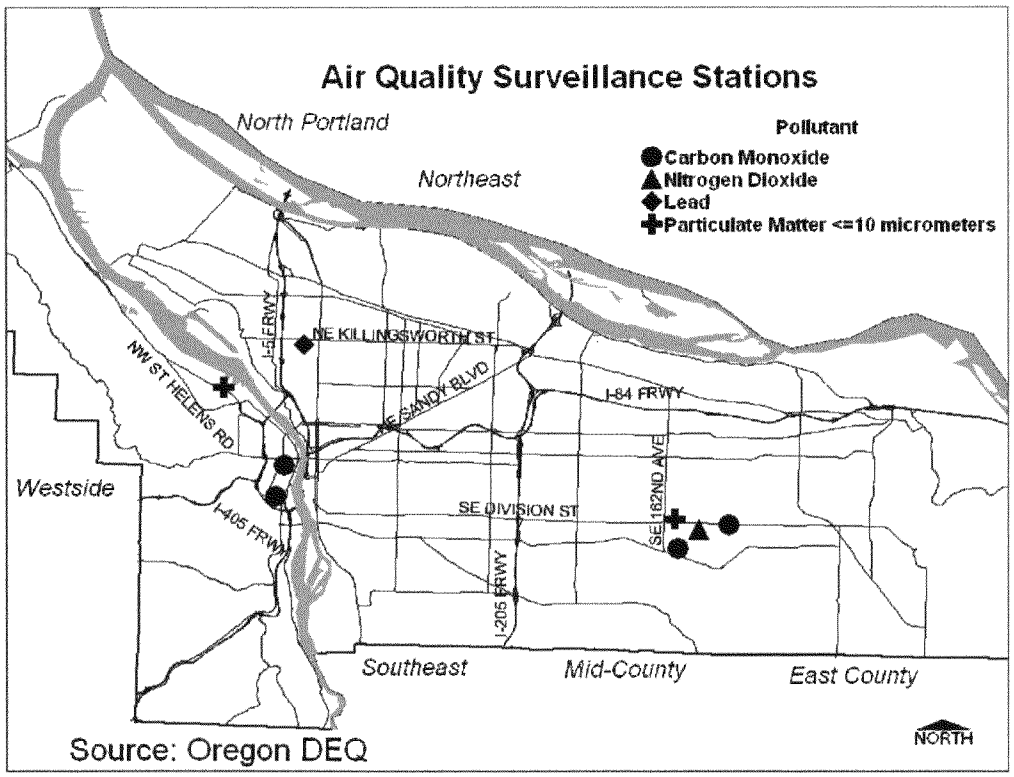
Table 11
The Six Criteria Pollutants

Pollutant	Major Sources	Health Effects
Carbon monoxide	Motor vehicles	Aggravation of cardiovascular diseases; visual impairment
Ozone	Motor vehicles, factories	Chest pain, cough, asthma
Nitrogen dioxide	Motor vehicles, power plants	Respiratory problems, and long-term respiratory infections; irreversible lung damage
Particulate matter	Motor vehicles, power plants, industrial facilities,	Heart and lung diseases; aggravation of asthma, bronchitis
Sulfur dioxide	Industrial facilities, coal-fired power plants	Respiratory problems, aggravation of cardiovascular diseases
Lead	Industrial facilities	Kidney, liver, nervous system damage; decreased IQ; high blood pressure

Source: Oregon Department of Environmental Quality

particulate matter. The vast majority of areas in the U.S. that had bad air days exceeded safe levels of one or both of these pollutants.[8]

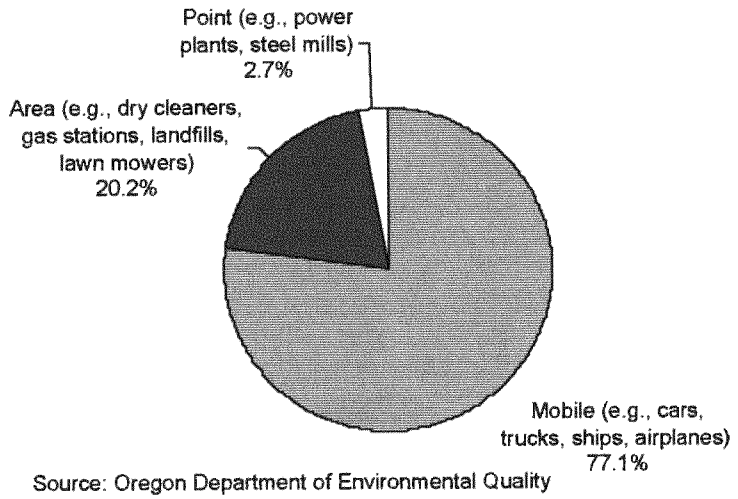
According to the Oregon State Department of Environmental Quality (DEQ), there are currently eight criteria air monitoring locations throughout Multnomah County, continually measuring levels of lead, particulate matter, carbon monoxide, and nitrogen dioxide (see map for locations).



Nonattainment areas: A locality where air pollution levels persistently exceed EPA's National Ambient Air Quality Standards.

Sources. Oregon DEQ data indicate that almost 290,000 tons of criteria air pollutants were released in Multnomah County in 1999, representing 8% of the Oregon total. Criteria air pollutants in Multnomah County are grouped into three sources, with the vast majority (77%) in 1999 – over 220,000 tons – coming from motor vehicles such as cars, trucks, ships, and airplanes. Area sources such as dry cleaners and gas stations contributed over 58,000 tons, about 20% of total criteria emissions. Point sources from industries contributed only 3% of criteria emissions, about 7,800 tons (Figure 19).

Figure 19
Sources of All Criteria Air Pollutants
Multnomah County, 1999



Source: Oregon Department of Environmental Quality

Multnomah County has acceptable levels of criteria air pollutants and has been in compliance with criteria pollutant standards since 1997.

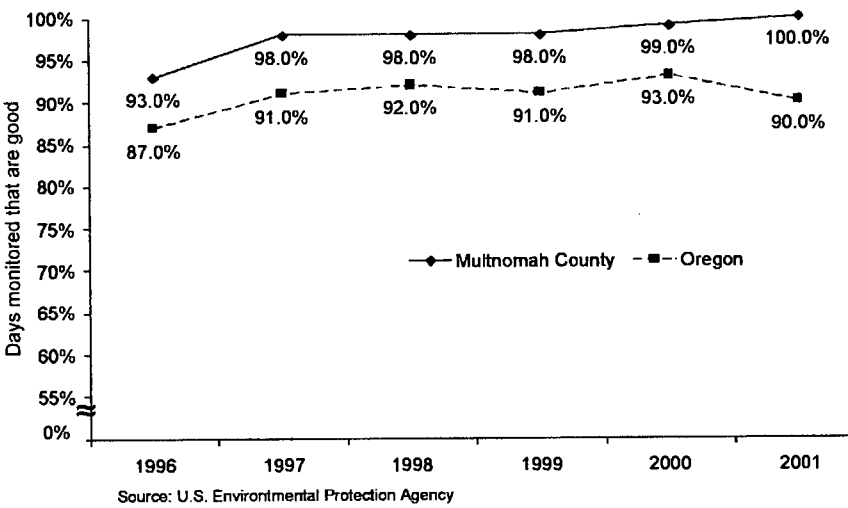
Nonattainment areas. The Oregon DEQ and the EPA closely monitor criteria pollutants, and place strict standards on their levels. As a result of violations of criteria pollutants, EPA designates counties (or parts of counties) as **nonattainment areas**. As of July 2002, Multnomah County had acceptable levels of criteria air pollutants and has been in compliance with criteria pollutant standards since 1997. The County, therefore, meets national Healthy People 2010 objective for criteria air pollutants (the objective is that no residents should breathe criteria air pollutants above the EPA standard). Eight counties in Oregon have a nonattainment designation in parts of their counties, mostly for violations of particulate matter levels. Six counties in Oregon are designated as nonattainment counties due to violations of particulate matter levels, and two counties are not in compliance with ozone and **carbon monoxide** standards. Nationwide, more than 300 counties were designated nonattainment areas as of July 2002.

Levels of carbon monoxide, ozone, and large particulate matter have declined or not changed between 1990 and 1999 in the Portland-Vancouver area, despite significant population growth.

Air data for the Portland-Vancouver area for 1990 – 1999 indicate that levels of three of the criteria pollutants – carbon monoxide, ozone, and large particulate matter – are declining or not changing, despite significant population growth in the region. Carbon monoxide levels, for example, have declined 40% between 1990 and 1999.[9]

Air Quality Index. The **Air Quality Index** combines the criteria pollutants into one value, ranging from 0 to 500, for each day of the year. Index values below 100 are considered satisfactory, while higher values are considered unhealthy. Index values less than 50 are considered good. In 2001, 100% of days in Multnomah County were good. The number of good air days in the County has been increasing since 1996, when 93% of days monitored were good (Figure 20). Oregon's overall percentage of good days in 2001 reached 90%.

Figure 20
Oregon Air Quality Index Scores
Multnomah County and Oregon



Source: U.S. Environmental Protection Agency

Air Toxics

Air pollutants other than criteria air pollutants are also tracked, and are called **air toxics** or **toxic air pollutants.** These pollutants are known or suspected to cause cancer, as well as respiratory, reproductive, and developmental problems. The EPA tracks 188 air toxics, with the goal of reducing or eliminating human exposure. Table 12 shows the health effects of four select air toxics.

Air toxics: 188 pollutants tracked by the EPA known or suspected to cause cancer, respiratory, reproductive and developmental problems.

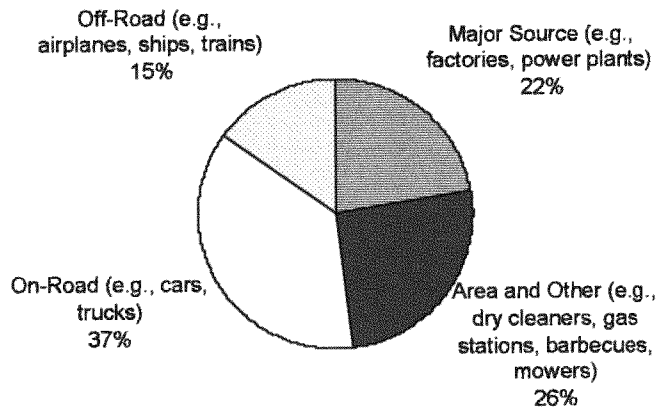
Table 12
Select Air Toxics

Pollutant	Major Sources	Health Effects
Benzene	Motor vehicle exhaust, gas fueling	Cancer, central nervous system depression
Formaldehyde	Motor vehicle exhaust, manufacturing, forest and wildfires	Cancer, respiratory damage
Acrolein	Motor vehicle exhaust, oil and coal burning, forest and wildfires	Kidney, liver, nervous system damage; decreased IQ; high blood pressure
Chloroform	Chrome plating, solid waste incineration, oil and coal burning	Cancer, central nervous system depression, liver damage

Source: Oregon Department of Environmental Quality

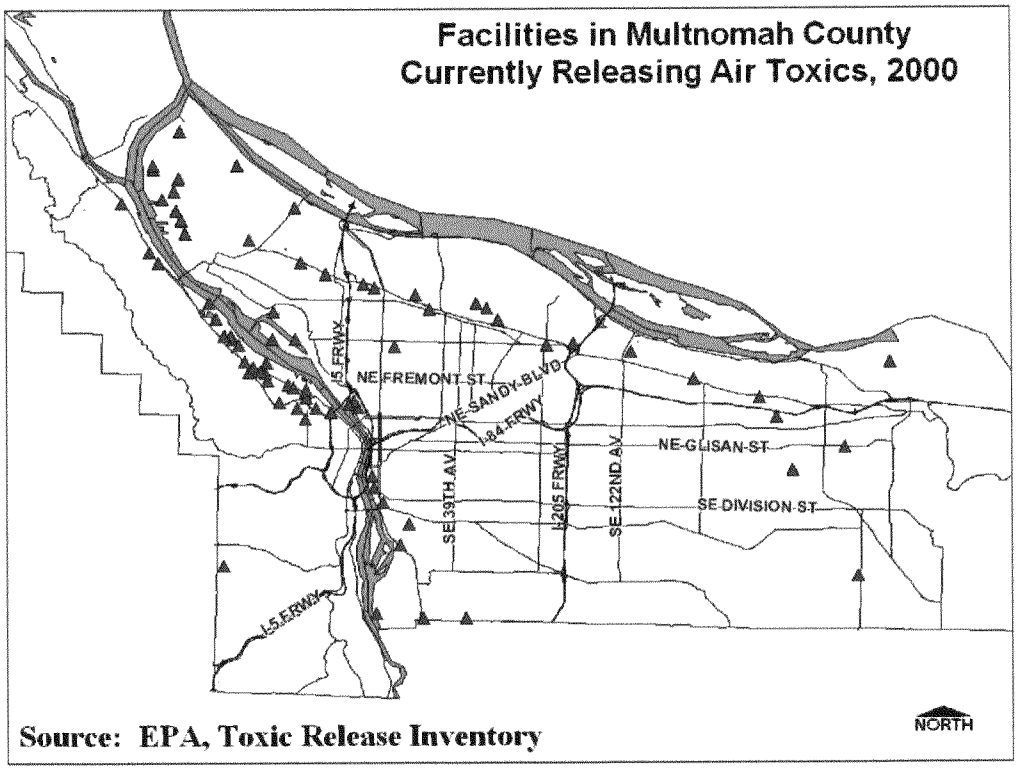
The highest percentage of air toxics in 1996 for Multnomah County comes from cars and trucks (Figure 21). Such vehicles are the cause of 37% of air toxics in Oregon.

Figure 21
Sources of Air Toxics
Multnomah County



Source: U.S. Environmental Protection Agency, National Toxics Inventory

The **National Air Toxics Assessment** (NATA) provides risk estimates of hazardous air emissions for 32 of the most dangerous air toxics, many of which are known or suspected to cause cancer. The purpose of the assessment is to measure the human health risk from exposure to these 32 air toxics. Analysis of the NATA data shows that Multnomah County released more than 2,400 tons of such air



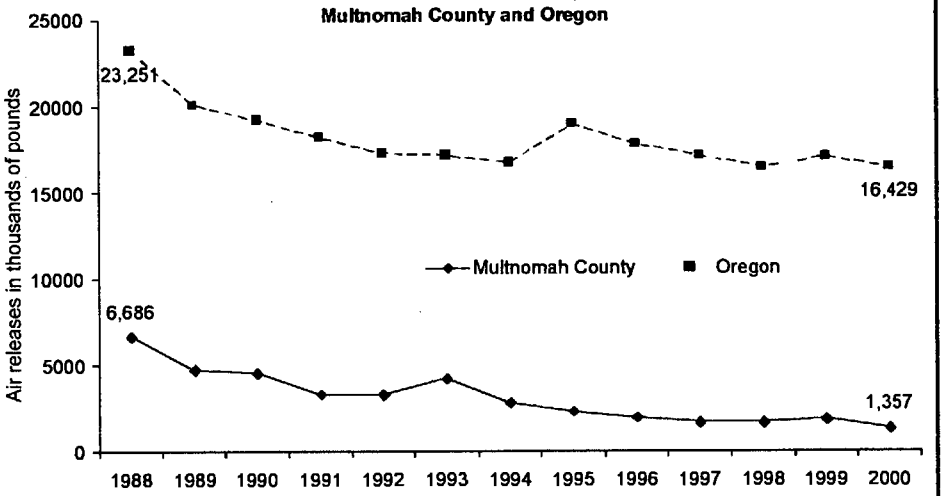
Source: EPA, Toxic Release Inventory

toxics in 1996, accounting for 11% of the Oregon total. Health risk calculations based on the NATA data are discussed in the "health effects" section below.

Industries – i.e., "major sources" – track their own air toxics on an annual basis, and report this information to the EPA. The EPA makes this information publicly available through the **Toxic Release Inventory**. The most recent available data show that 81 industrial facilities in the County released about 1.4 million pounds of air toxics in 2000.

Total air toxics from County industries have declined 80% since 1988 (Figure 22). There was a 30% decline in Oregon over the same time period (23.2 to 16.4 million pounds).

Figure 22
Industrial Air Emissions,
Multnomah County and Oregon



Source: U.S. Environmental Protection Agency, National Toxics Inventory

Other Air Quality Indicators

Cars and trucks are the largest source of air pollution in the County, and programs that regulate vehicle emissions may significantly reduce air pollution. The Oregon DEQ inspects vehicles for emissions in the Portland area, and requires newer cars to be inspected every two years. The **Vehicle Inspection Program** identifies those vehicles in need of maintenance to reduce air pollutants. In the years 1998-1999, more than 130,000 vehicles (13%) failed emissions control tests in the Portland area. In 2000-2001, 158,000 vehicles (15%) failed. DEQ estimates that repairs on failed vehicles for 2000-2001 reduced air pollutants by 76 tons per day.[10]

Health-based benchmark: Federal Clean Air Act guidelines based on a one in a million cancer risk for a specific air pollutant.

Another indicator of air quality is the number of outdoor air complaints by citizens of Multnomah County. The Oregon DEQ tracks such complaints. From 1997 to 2001, outdoor air complaints declined from 545 to 449. Such complaints peaked in 2000, at 784, a 100% increase from the previous year.[11]

Health Effects of Air Pollution

Researchers throughout the world have shown that air pollution has many negative health effects. Although limited, available health indicators for the County may highlight possible areas of concern. There is evidence to indicate that non-whites and the poor are disproportionately affected by air pollutants [12], and such disparities will be discussed where data are available for Multnomah County.

*14 air toxics in the Northwest region of Oregon have been estimated to exceed **health-based benchmarks.***

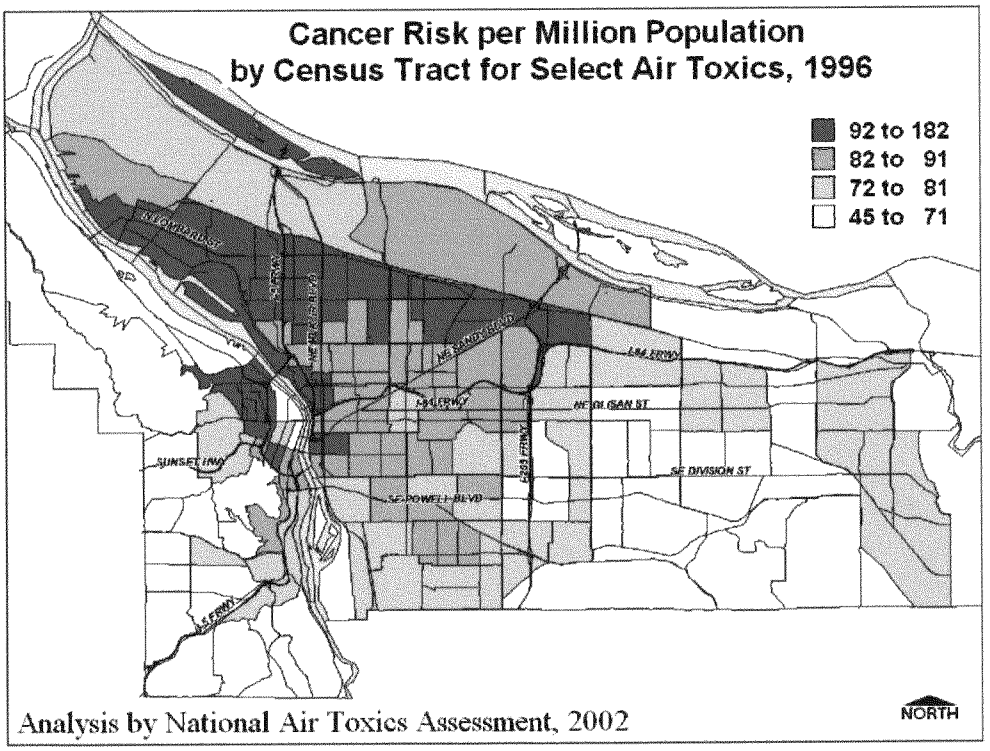
Air Toxics. Air quality data with the clearest link to human health for Multnomah County is found in the National Air Toxics Assessment (NATA). The assessment was conducted with 1996 data; it is unclear how current air toxics levels have changed since that time. Also, such risk estimates do not reflect exposures and risks from all compounds (for example, diesel) and may underestimate human risk from air toxics. Nonetheless, these data are the only know estimates available summarizing risks to air toxics.

Of the 14 air toxics exceeding health based benchmarks - six are more than 10 times the benchmark and four of these can be traced to motor vehicle emissions.

An examination of these data by the Oregon DEQ shows that 14 air toxics in the Northwest region of Oregon have been estimated to exceed **health-based benchmarks** (benchmarks are guidelines for safe levels). Multnomah is the only County in the region to exceed benchmarks for all 14 pollutants. In addition, emission levels in Multnomah County for six pollutants, including **benzene**, **chromium** and **chloroform**, are more than 10 times the benchmark. Four of these six pollutants can be traced mostly to motor vehicles such as cars, trucks, and airplanes.[13]

NATA also examines the cancer risk from air toxics. An analysis of 1996 emissions

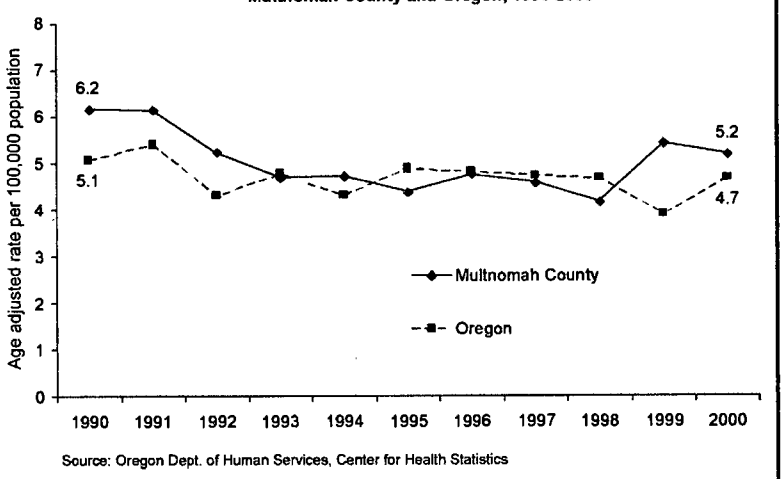
Many areas in North and Northeast Portland have a higher cancer risk due to air toxics.



data released in 2002, shows that for 33 of the most dangerous air toxics, the median cancer risk for Multnomah County residents – 82 in a million – is twice that for all Oregon residents (39 in a million). The national rate is 45 in a million. All areas of the County examined exceed the health-protective guideline for air toxics established under the Clean Air Act of a one in one million cancer risk. Furthermore, the cancer risk to Multnomah County residents varies based on where they live. Many areas in North and Northeast Portland have a higher cancer risk due to air toxics. Several census tracts in North and Northeast Portland have a cancer risk rate more than 100 per million. The highest cancer risk rate exists in an area in North Portland (180 per million), and is 4 times the rate for the lowest cancer risk rate in the County (46 in a million). As non-whites and those in poverty live in higher proportions in North and Northeast Portland, it is possible that racial minorities and the poor are more severely impacted by air toxics than other County residents. (see map)

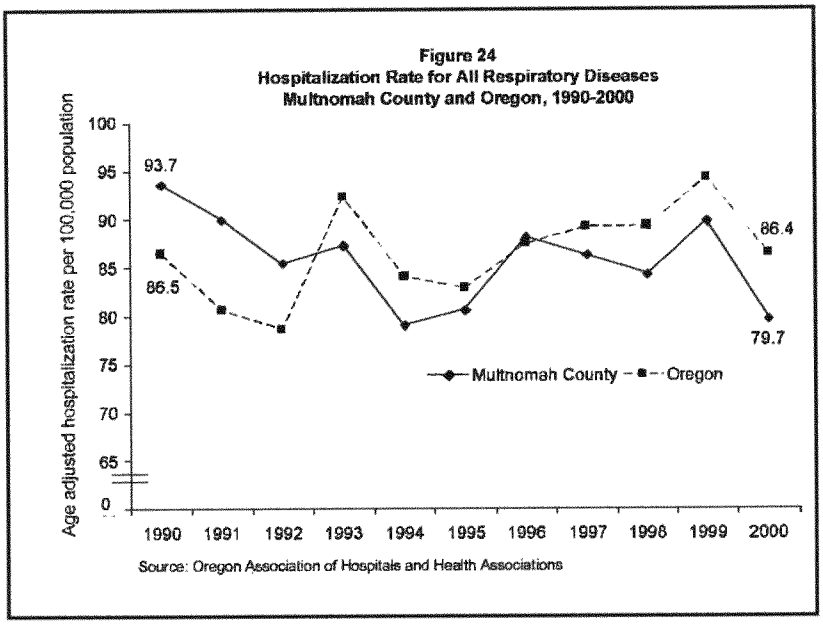
Hospitalizations and Mortality. Air pollutants have been shown to cause hospitalizations and deaths, especially for diseases of the respiratory and circulatory systems. Of particular concern are air pollutants — such as particulate matter and benzene — which are associated with lung cancer. Available data show no indication that air pollution in the County is increasing hospitalizations or death rates for lung cancer. There were more than 330 non-smoking lung cancer deaths in Multnomah County between 1990 and 2000, and the rate declined 16% from 1990 to 2000 (Figure 23). There was no indication in the data of health disparities by ethnicity and race. Nonetheless, the risk for cancer from air toxics is highest in the most diverse areas of the County.

Figure 23
Non-Smoking Lung Cancer Death Rates
Multnomah County and Oregon, 1990-2000



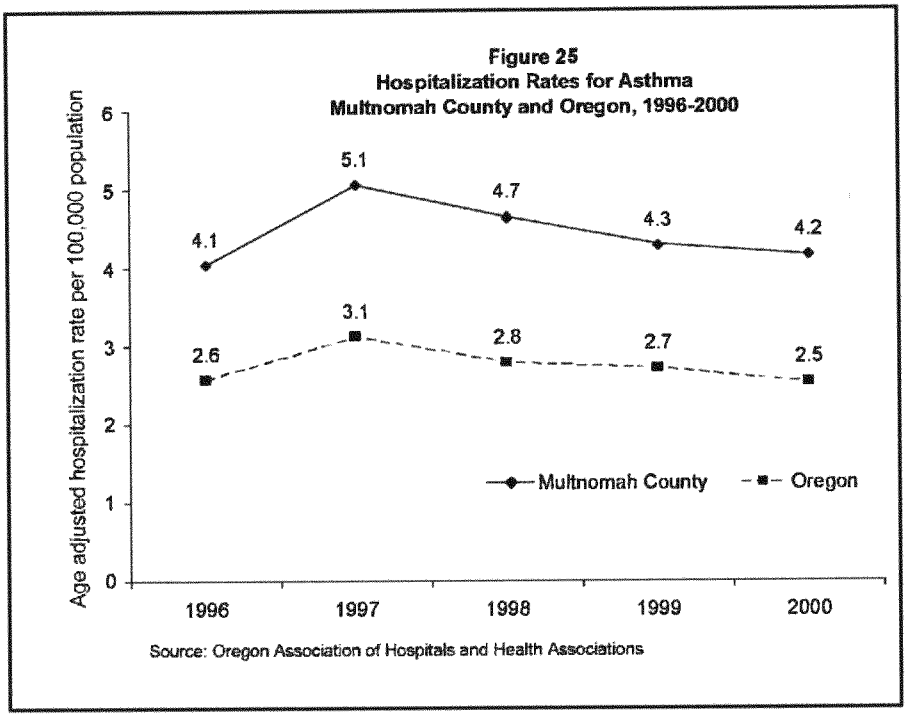
Source: Oregon Dept. of Human Services, Center for Health Statistics

The rate of hospitalization for respiratory diseases in the County remained unchanged between 1990 and 2000 (Figure 24), while hospitalization rates for circulatory diseases declined 21% in the same period. Hospitalization data are not available by ethnicity and race, so health disparities are not explored.



Asthma. Researchers have found evidence linking air pollution to asthma attacks, and some research indicates that air pollution can cause the development of asthma. Asthma affects more than 4.8 million U.S. children (7.5%), making it the most common serious and chronic disease among children. Asthma affects racial and ethnic minorities more than whites. It is estimated that asthma is 26% more prevalent in African American children than in White children.[14] In Multnomah County, an estimated 7% of children, and 9% of adults had asthma in 2000. There is some evidence to indicate that asthma rates are higher in areas of Multnomah County with poorer air quality. The Portland Neighborhood Survey - a recent survey of residents near the Northeast I-5 corridor in Portland (where NATA data shows that air toxics are emitted in higher concentrations) - has found that asthma rates are twice that of Multnomah County, Oregon (7.7%), and the Nation. Although these data should be viewed with caution due to small sample size, the survey found that 14.4% of residents had asthma. Nearly 50% of those reporting asthma in the survey were African American, possibly indicating that asthma rates for African Americans are higher in this area.[15]

According to data obtained from the Oregon Association of Hospitals, asthma hospitalization rates for asthma in Multnomah County are twice that for Oregon. Between 1996 and 2000, there were more than 1300 hospitalizations due to asthma (Figure 25).



Conclusion

Multnomah County has been in compliance for criteria pollutants since 1997, and has met Healthy People 2010 objective for criteria air pollutants. Air quality trends for the County indicate that air is better now than it was ten years ago. Similar to other large urban areas across the United States, air toxics remain a problem in Multnomah County. Finally, some evidence indicates that those living in North and Northeast Portland – areas where a higher proportion are poor or ethnic and racial minorities – may have poorer air quality, which may contribute to health disparities for these groups.

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15. Podobnik B. Portland Neighborhood Survey: Report on findings from Zone 1:The Northeast I-5 Corridor. Portland, OR: Lewis and Clark College. 2001

Recreational Water Quality

Fast Facts

- Six of seven waterways examined in Multnomah County are ranked by the Oregon Department of Environmental Quality as poor or very poor. Five water bodies are in violation of federal and State water standards that protect beneficial uses.
- Combined-sewer overflow causes 3 billion gallons of rainwater and raw sewage to flow into the Willamette River every year.
- A section of the Willamette River, known as the Portland Harbor, is listed as a Superfund site.
- Rates for recreational waterborne disease are low for Multnomah County and the State. There were two outbreaks of waterborne disease in the County in the 1990s, affecting 149 people.
- The unintentional drowning rate in Multnomah County was 2.4 deaths per 100,000 in 2000, which does not meet the Healthy People 2010 target rate of 0.9 drowning deaths per 100,000.

Problem Statement

According to the U.S. Environmental Protection Agency (EPA), 40% of assessed rivers in the U.S. are "not clean enough to support uses such as fishing and swimming."[1] Oregon is no different. Many miles of rivers and creeks – and some lakes – are in violation of federal clean water standards, and may pose a threat to human health. Chief among these threats is microbial contamination of water, which poses threats to swimmers; and contaminants in fish, which may pose health threats to those who eat fish from contaminated waters.

There are over 100,000 miles of rivers in Oregon, and more than 6,200 lakes. Oregon residents depend on these waters to be safe and free of contaminants. But, the Oregon Department of Environmental Quality has found that 26% of assessed rivers and 50% of surveyed lakes in Oregon are considered polluted. [2] And 44% of assessed rivers pose a health threat to swimmers. Lastly, Oregon has the 10th highest drowning rate in the country.

Recreational Water Quality

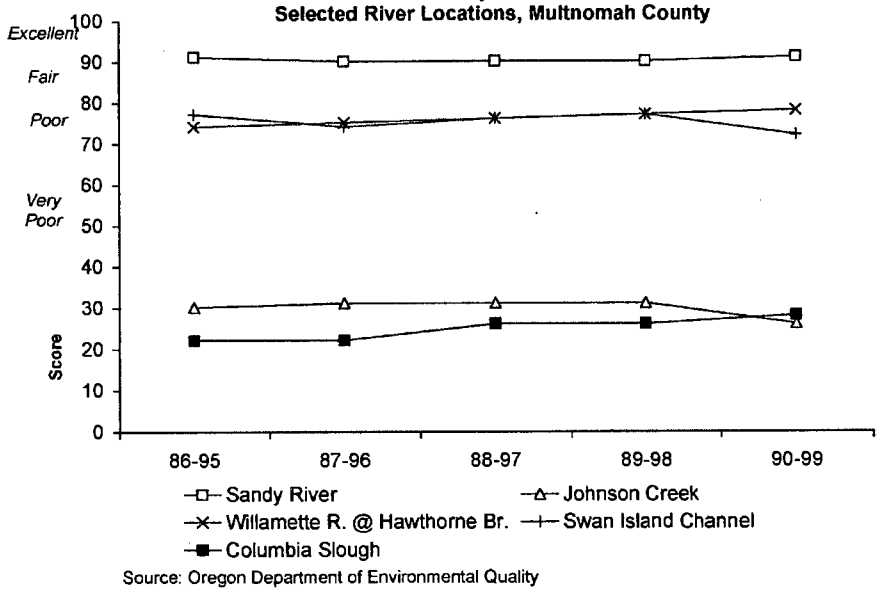
Recreational waters are regulated through the federal Clean Water Act, which sets standards for waters and waterways to ensure that they are, among other things, swimmable and fishable. The Oregon Department of Environmental Quality is responsible for setting and enforcing water quality standards for recreational waters, and develops lists of water bodies that do not meet federal and state standards. According to data from the Oregon DEQ, Multnomah County has lakes, creeks and rivers that do not meet water quality standards. Such water bodies in Multnomah County include Blue Lake, Smith and Bybee lakes, Columbia Slough, Fairview Creek, Johnson Creek, and the section of the Willamette River that runs through Portland.[3]

Water Quality Limited: Recreational water bodies that do not meet federal Clean Water Act standards.

Oregon's 2000 Water Quality Status Assessment Report identifies rivers, streams and lakes in Oregon that are impaired – or **water quality limited** - and may pose health threats from swimming and fishing. Unfortunately, the report does not list impaired waterways by county. Data for Oregon show that over 80% of river miles assessed, and 60% of lakes, have contaminated fish -mostly from mercury, dioxin and pesticides- that may pose a health threat. The Columbia Slough and part of the Lower Willamette River are included in this list. Over 40% of assessed rivers in Oregon are not safe for swimming, and those who do so have an increased risk of catching waterborne diseases. The Lower Willamette River, Fairview creek and the Columbia Slough are among those unsafe for swimming.[4] Unfortunately, only about half of river miles and lake acres have been assessed, so the actual extent of recreational water pollution in Oregon could not be calculated.

DEQ also tracks river systems using a water quality index, which combines many different measures of water quality into a general water quality score. The scores range from 10 (very poor water quality) to 100 (ideal water quality). Oregon DEQ data for the Willamette Basin indicate that seven waterways in Multnomah County are monitored and have been scored since 1986. Only one river is in excellent shape: the Sandy river at Troutdale bridge. Although the water quality index for the Columbia Slough has been increasing in quality between 1986 and 1999, water quality in the slough is the worst of all waterways measured for the County, and is ranked very poor. Johnson Creek is also ranked as very poor. Water quality in the Willamette River has changed very little in the time period examined, and the water quality in the Portland area is considered poor (Figure 26).

Figure 26
Water Quality Index Scores,
Selected River Locations, Multnomah County



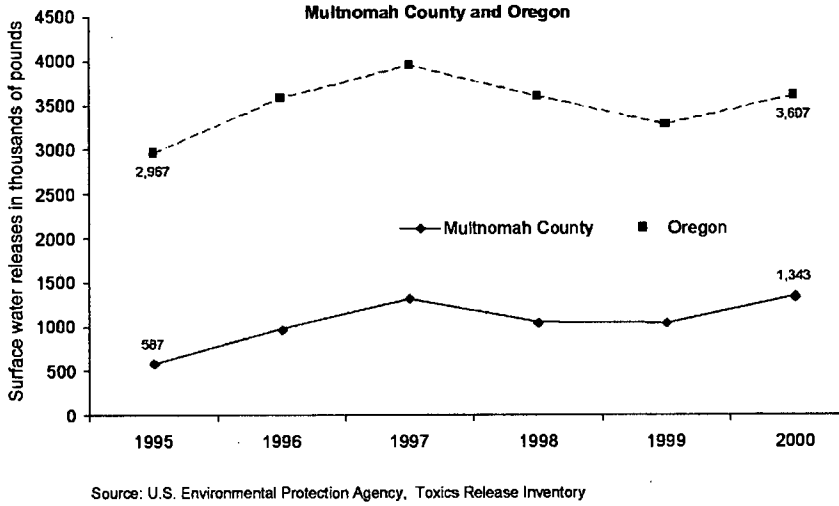
Source: Oregon Department of Environmental Quality

Water Pollution Sources

Pollution into Multnomah County water bodies is grouped into two categories. Non-point sources – from urban and agricultural runoff, primarily when it rains – are probably the most significant source of water pollution, but are difficult to quantify. It has been estimated that non-point sources account for 70-80% of recreational water pollution.[5] Point sources of pollution – usually wastewater entering rivers and streams via pipes – are the second source of water pollution. Wastewaters from industries are one point source of pollution. The EPA requires that industries report discharges of approximately 600 toxic chemicals into recreational waters such as streams and rivers. Analysis of such data for Multnomah County and Oregon reveals that industries – mostly manufacturing facilities – released over 1.3 million pounds of toxic chemicals into recreational waters in 2000, an increase of 128% from 1995, when such chemicals were first tracked (Figure 27).[6] Some have noted that industrial wastewater discharges are self-reported by industries, with minimal regulation to ensure accurate reporting, so wastewater amounts shown here may be an underestimate.

Combined sewer overflows (CSOs) are another point source of water pollution. Each year, about 2.8 billion gallons of CSOs - storm water mixed with raw sewage - flows into the Willamette River through 42 outfall pipes.[7] Such pollution increases waterborne disease risks to swimmers.

Figure 27
Water Releases of Toxic Chemicals by Industries, Multnomah County and Oregon



Source: U.S. Environmental Protection Agency, Toxics Release Inventory

Portland Harbor

The portion of the Willamette River - called the Lower Willamette - that runs through the center of Portland is a popular recreational area, especially for fishing. As mentioned above, the Lower Willamette is in violation of federal and state water quality standards, and has been given a poor quality ranking by the Oregon DEQ. In addition, six miles of the Willamette River - called the Portland Harbor

- are so heavily polluted that this stretch of river, roughly from the southern tip of Sauvie Island to Swan Island, is on the **National Priorities List** – commonly known as **Superfund**. It is a heavily industrialized section, and has high concentrations of metals, pesticides and industrial chemicals in its sediments. Such pollutants may make this section of the river unsafe for recreational use.

Public pools

The Multnomah County Health Department monitors water quality in public pools and spas to ensure that there are no contaminants (e.g., fecal contaminants) that would endanger public health. There were 543 inspections of public pools in Multnomah County in 2001, and 309 spa inspections. There were no closures of pools and spas in 2001 due to fecal contamination.

Waterborne disease outbreaks: Incidents of infectious agents or chemical poisoning in which two or more people experience a similar illness after consumption or use of water and evidence implicates water as the source of illness.

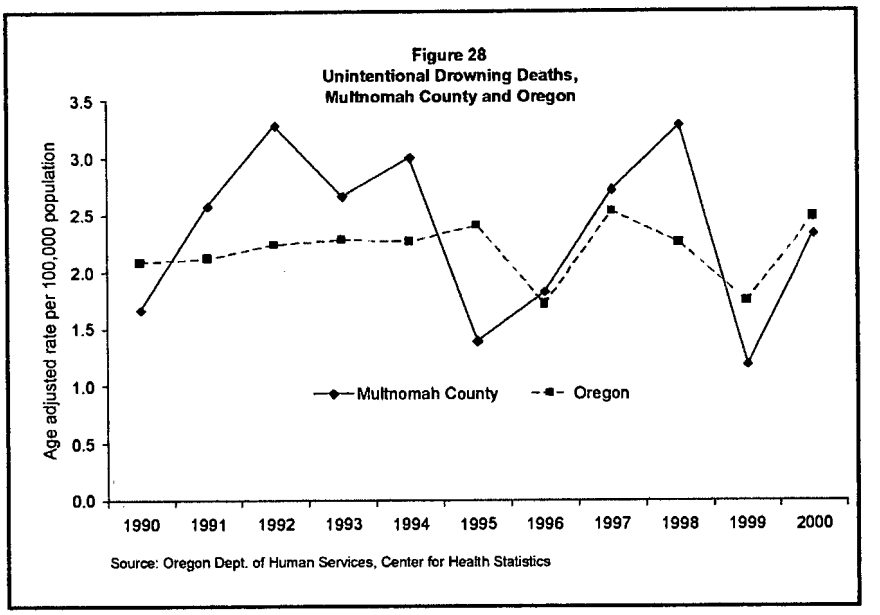
Health effects

Chronic disease. Recreational water pollution is difficult to link to specific chronic health problems such as cancer and liver diseases. The extent of chronic illness to Multnomah County residents from recreational water use – e.g., swimming and fishing – is unknown.

Waterborne disease. Waterborne disease outbreaks in recreational water usually cause gastrointestinal illnesses in humans, and are an acute health threat to those exposed. Such disease outbreaks are caused by bacterial contamination of water bodies. According to data from the U.S. Centers for Disease Control and Prevention, there were eight recreational waterborne disease outbreaks in Oregon between 1991 and 1998, affecting 800 people. Two of those outbreaks occurred in Multnomah County: one was an **E. coli** outbreak affecting about 80 people in Blue Lake in 1991, and the second was a **Cryptosporidiosis** outbreak at a community pool that affected 69 people in 1998. Rates of illness due to E. coli in Multnomah County declined 75% between 1991 and 2000, and were generally lower than Oregon for most years examined. In 2000, 11 cases of E. coli illness (1.7 cases per 100,000) were reported, compared to 41 cases in 1991 (6.8 per 100,000). Rates for Cryptosporidiosis have remained fairly stable since 1992, apart from the outbreak in 1998. There were 1.1 cases per 100,000 in Multnomah County in 2000, compared to 0.6 per 100,000 in Oregon in the same year.

Rates of illness due to E. coli in Multnomah County declined 75% between 1991 and 2000, and were lower than Oregon for most years examined.

Unintentional drowning. The Oregon State Center for Health Statistics tracks death data indicating there were 758 unintentional drownings in Oregon between 1990 and 2000, with 22%, or 165 cases, occurring in Multnomah County. The rate per 100,000 in Multnomah County for 2000 was 2.42, a 29% increase in unintentional drownings since 1990 (Figure 28). The drowning rate for Multnomah County and Oregon is higher than the national rate, and Oregon has one of the highest drowning rates in the Nation.[8] Multnomah County does not meet the Healthy People 2010 target rate of 0.9 drowning deaths per 100,000.



The drowning rate for Multnomah County and Oregon is higher than nationally, and Oregon has one of the highest drowning rates in the nation.

In Oregon, 68 drownings, or 47% of drownings, occurred in natural waters (lakes, ocean, river, stream) between 1999 and 2000. In Multnomah County for these years, 42% or 10 drowning deaths occurred in natural waters. Unintentional drowning in swimming pools were rare events in Oregon for 1999-2000. There were four deaths in Oregon in 1999-2000, with none occurring in Multnomah County.

Water-related injury. The number of hospitalizations- obtained from the Oregon Association of Hospitals- for near drowning are low in Multnomah County and Oregon. There were 26 hospitalizations for near-drowning in Oregon in 2001, seven of these occurred in Multnomah County. The 26 near-drownings in Oregon in 2001 account for less than 1% of injury-related hospitalizations. Between 1996 and 2001, there were 32 hospitalizations for near drowning in Multnomah County, with eight related to recreational waters.

Hospitalizations related to boating accidents were low in number in Oregon and Multnomah County. There were 40 hospitalizations in 2001 for Oregon, seven from Multnomah County. Between 1996 and 2001, there were a total of 50 boating-related hospitalizations in Multnomah County.

Conclusion

Some water bodies in Multnomah County have poor water quality (particularly the Willamette River and the Columbia Slough), with real health risks to those swimming, boating, and fishing in recreational waters. Unintentional drowning in Multnomah County and Oregon remains unacceptably high, and does not meet Healthy People 2010 objectives. Water-borne outbreaks in recreational waters were rare events in the years examined, but there were two outbreaks in Multnomah County- one in a lake, the other in a public pool.

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Solid Waste and Wastewater Quality

Fast Facts

- Multnomah County is home to the St. Johns landfill, in operation for 50 years, and closed since 1991. It has known leaks of hazardous substances.
- 3 billion gallons of combined sewer overflow are released into the Willamette River each year.
- Portland's recycling rate is 54%, the best in the country. This rate meets the Healthy People 2010 objective of 27%.

Problem Statement

The control of infectious diseases, partly though proper disposal of solid waste and sewage, is considered a significant public health achievement of the twentieth century.[1] Still, much can be done in Multnomah County and Oregon to reduce the impacts that solid waste disposal and wastewater have on the environment and human health. Some of the public concerns involve aesthetics (looking at and smelling waste), but improper solid waste and wastewater disposal can pollute groundwater, rivers, and streams, and can attract vectors such as rodents and insects.[3] Pollution of air and waterways through such waste can adversely affect human health.

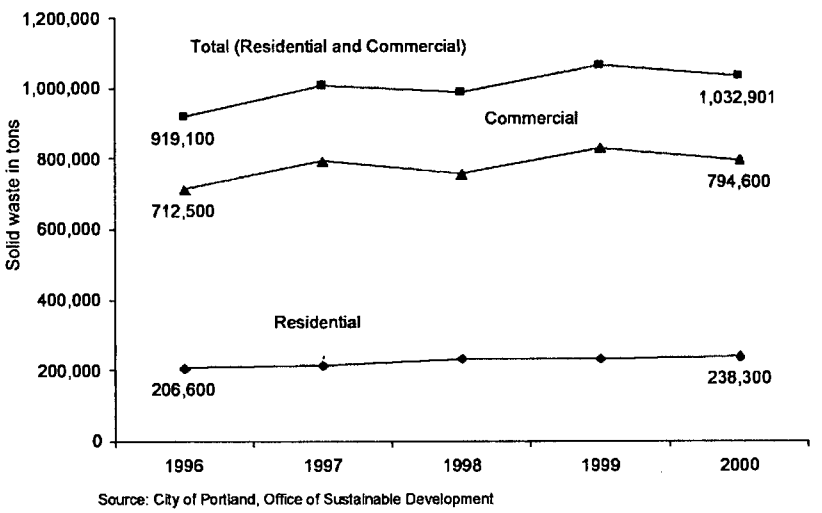
Solid waste: Common garbage or trash generated by industries, businesses, institutions and homes.

Solid Waste

Solid waste (or garbage) for Multnomah County is disposed of mostly in landfills. In 2000, the tri-county region generated about 1.4 million tons of solid waste that was disposed of in landfills. In 2000, Portland residents and commercial activities generated more than 1 million tons of solid waste (Figure 29), up 12% from 1996. Almost 77% of the waste generated in 2000 can be attributed to commercial activity. Close to 54% of the solid waste in 2000 was recovered

Close to 54% of the solid waste in 2000 was recovered (recycled), which appears to be the best recycling rate in the country among the 20 largest metropolitan regions.

Figure 29
Solid Waste Generated in Portland, Oregon

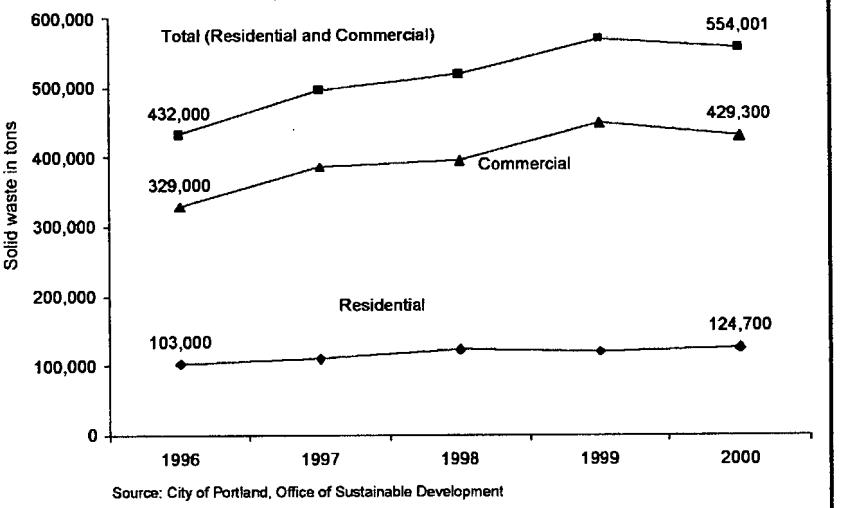


Source: City of Portland, Office of Sustainable Development

(recycled), which appears to be the best recycling rate in the country among the 20 largest metropolitan regions.[2] This rate meets the Healthy People 2010 solid waste recycling objective of 27%.

The amount of recycled material has risen steadily since 1996 (Figure 30), when only 47% of solid waste was recovered (and kept out of landfills).

Figure 30
Recycled Solid Waste in Portland, Oregon



Source: City of Portland, Office of Sustainable Development

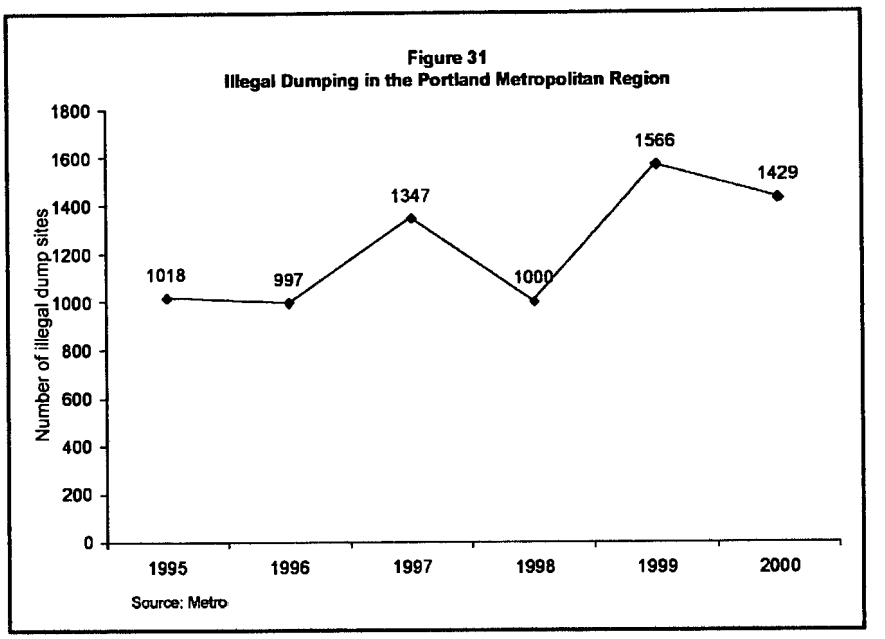
There are 12 solid waste facilities in Multnomah County, according to the Oregon Department of Environmental Quality. Of these 12, six are landfills, while the rest are transfer stations, treatment facilities, or material recovery facilities. Three are industrial waste landfills, two are construction landfills, and one is a municipal solid waste landfill - a landfill where residential garbage goes. All six Multnomah County landfills have groundwater monitoring that tests for leakages of hazardous substances from a landfill.

St. Johns landfill has confirmed leaks of hazardous substances, and some of these substances are making their way into the Columbia Slough.

The municipal solid waste landfill is located in St. Johns, near Smith and Bybee lakes and the Columbia Slough. It was the primary landfill for Portland's waste for 50 years until it closed in 1991. While in operation, this landfill accepted residential and industrial waste. Industrial waste included approximately 5,000 drums of pesticide manufacturing waste, disposed of in the early 1960's [3]. St. Johns landfill has confirmed leaks of hazardous substances, and some of these substances are making their way into nearby lakes (Smith and Bybee lakes), streams (e.g., the Columbia Slough), and groundwater. These hazardous substances are potentially harmful to human health.

Illegal dumping. Illegal dumping remains a problem in the County, as it does in counties throughout the U.S. Aside from the mess, illegal dumping can attract rodents and other animals, which can spread disease. In 1995, 1,018 illegal

dumpsites were identified in the tri-county area. In 2000, that number increased 40% to 1,429, representing more than 200 tons of waste (Figure 31).



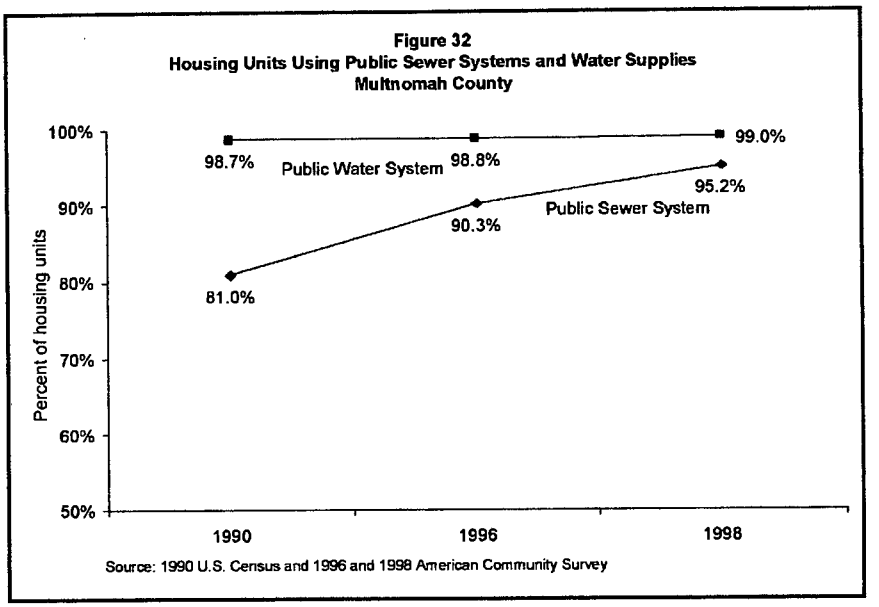
Wastewater

Wastewater, if not properly disposed of or treated, can contaminate drinking water and waterways, and can cause illness to those exposed. Therefore, it is essential that such waste be treated properly. One way to assure proper disposal of wastewater is to treat it at a public wastewater treatment facility. Private wastewater systems – commonly known as septic tanks - are considered more liable to cause illness, because they are more likely, for example, to leak into groundwater. Such contamination of groundwater can lead to waterborne illnesses such as Cryptosporidiosis. Many precautions must be taken to ensure that private septic systems are built correctly and maintained regularly to prevent illness. In 1990 an estimated 81% of Multnomah County housing units were connected to public sewer systems compared to 70% of the entire state. In 1998 this number increased to 95% in Multnomah County.

A higher number of housing units in Multnomah County are connected to public water systems. In 1998, 99% of housing units in the County were connected to public water systems, with an estimated 2400 housing units with individual wells (Figure 32). Therefore, the risk of contamination of groundwater by septic systems in Multnomah County is small.

According to data provided by the U.S. Geological survey, Multnomah County had 5 wastewater treatment facilities in 1999, which returned 92 million gallons per day of treated wastewater to the Willamette River and other waterways. Untreated wastewater is also being released into waterways in Multnomah County.

Combined sewer overflow: Discharge of a mixture of storm water and domestic waste when the flow capacity of a sewer system is exceeded during rainstorms.



Sewer water and storm water flow into the same sewer pipes creating a combined sewer system. When it rains, storm water combines with sewer water and can overflow directly to rivers and sloughs – this is called combined sewer overflow. There are 55 outfall pipes, or "relief valves," which release this combined sewer overflow directly to the Willamette River and the Columbia Slough. The untreated waste carries many microbes that may cause illness, and is a threat to public health. According to the Oregon DEQ, "those people most likely affected by this sewage include water skiers, swimmers, people who fish, and other people involved in water contact sports.[4]" In 1991, six billion gallons of combined sewer overflow went into Portland waterways. The city of Portland is currently working to eliminate combined sewer overflow, and is working to finish by 2011. Much work has already been done to reduce the amount of combined sewer overflow. By 2000, the amount of combined sewer overflow was reduced to 3.4 billion gallons, a decline of 43% from 1991.

The amount of combined sewer overflow in Portland was reduced from 6 to 3.4 billion gallons from 1991 to 2000.

Conclusion

The infrastructure in place in Multnomah County for treating and disposing of solid waste and wastewater has been working effectively to minimize public health threats for many years. However, problems still remain. Billions of gallons of combined sewer overflow (which includes untreated sewage) are released into the Willamette each year. Multnomah County is known to have at least one landfill - the St. Johns landfill - that is leaking hazardous substances, and is probably contributing to the contamination of the Columbia Slough and other waterways.

1. Achievements in Public Health, 1990-1999: Control of Infectious Diseases. Morbidity and Mortality Weekly Report (MMWR). Centers for Disease Control and Prevention. 1999;48: (29): 621-629.

2. Solid Waste and Recycling Division: Management Report for 2000 Activities. City of Portland, Office of Sustainable Development: Portland, Oregon. 2001
3. St. Johns Landfill: Cleanup Project Status Report. Oregon Department of Environmental Quality: Portland, Oregon. 2003.
4. Combined Sewer Overflows. Fact Sheet. Oregon Department of Environmental Quality: Portland, Oregon. 2001.

Vector-Borne Diseases

Fast Facts

- Multnomah County experiences only one or two cases of vector borne illness a year.
- As of the beginning of 2003, mosquitoes tested in Multnomah County had not been found to carry the West Nile virus, St. Louis encephalitis, or Western Equine encephalitis.
- In the nine years between 1991 and 2000, only four animals tested positive for rabies in the County.

Problem Statement

A vector (or carrier) is any organism capable of transmitting disease. Some examples of vectors are mosquitoes, rodents, fleas and ticks. Vectors are able to spread disease to humans by biting, burrowing or contaminating living spaces.

Some examples of vectors are mosquitoes, rats, fleas, and ticks.

West Nile virus is a disease new to the United States. It was first identified in the eastern U.S. in 1999, and it is moving across the U.S.[1] The virus has been found in mosquitoes as far south as Texas and as far north as North Dakota in early 2002. Multnomah County has surveyed for West Nile virus since 2001 and recently received funding to increase staff and materials for prevention, with additional surveillance and suppression activities of this virus.

Vector Control Activity

Mosquito Control. Diseases caused by mosquitoes can be prevented in one of two ways. The first is through personal protective measures, and the second is by public health measures to reduce the population of infected mosquitoes. Personal measures include: reducing time outdoors, particularly in early evening hours; wearing long pants and long sleeved shirts; applying mosquito repellent to exposed skin areas; and eliminating areas of standing water. Public health measures often require spraying of insecticides to kill juvenile (larvae) and adult mosquitoes.

Vector and Nuisance Control in the Environmental Health Section of the Multnomah County Health Department monitors and investigates complaints and conducts mosquito surveillance in the County. The **Vector Control** unit conducts adult mosquito surveillance between April and October. Mosquitoes are captured in traps baited with dry ice, which releases carbon dioxide and mimics the breathing of humans and other animals. The mosquitoes are collected, counted and identified to monitor the fluctuation in mosquito populations and species diversity. Some species of mosquitoes collected are then tested for St. Louis encephalitis, Western Equine encephalitis, and West Nile virus. St. Louis encephalitis, Western Equine encephalitis and West Nile virus are types of mosquito-borne viruses that most often cause no symptoms or a mild illness in an individual who has been bitten by an infected mosquito. In very rare instances,

a Western Equine encephalitis or West Nile virus infection can cause fatal illness or coma.

There are approximately 20 species of mosquitoes in Multnomah County. Each species differs in appearance and habitat preference. Multnomah County Vector Control currently treats approximately 3,000 acres for mosquitoes yearly. A large part of the treatment program centers on the floodplains along the Willamette and Columbia Rivers that seasonally fill with water when river levels rise due to snowmelt runoff, heavy rain, and controlled water release for salmon migration, typically April through June.

Known mosquito breeding sites are checked throughout the summer. Other typical sources checked and treated include roadside ditches, sloughs, marshes and all complaint calls from the public concerning mosquitoes. An active treatment program runs year round.

Rodent Abatement. Annually, Multnomah County Vector Control baits approximately 1,000 manholes for rodents and carries out other efforts in rodent control as well as responding to citizen rodent complaints. The number of rodent complaints fluctuates yearly. Rodent complaints by year from 1997 to 2001 are shown in Table 13. Rodent complaints peak April through October. Complaints are frequently property or sewer-related. Food sources such as pet food, wild animal food, or compost contributes to rodent infestation. In addition, broken or open sewer pipes or other building openings can provide rats access to property. Furthermore, debris or refuse accumulation as well as firewood or stored lumber can harbor rats.

Table 13
Rodent Complaints by Citizens, Multnomah County

	1997	1998	1999	2000	2001
Number of complaints	1320	1939	1331	1257	1348
Rate per 1,000 population	2.1	3.0	2.1	1.9	2.0

Source: Multnomah County Health Department, Vector Control
Population: PSU Population Research Center

Vector Borne Disease Incidence. Multnomah County Communicable Disease Control Program monitors and reports vector borne disease incidence. There are only one or two cases of vector borne disease acquired in Multnomah County each year (Table 14). Vector borne disease is primarily acquired outside of Multnomah County and the predominate disease acquired is malaria.

Vector borne disease: Illnesses that are transmitted to people by organisms, such as insects and rodents.

The Multnomah County Health Department and Multnomah County Animal Services respond to animal bites or exposures to humans from animals. The number and types of animal bites or exposures is shown in Table 15. Bites from dogs are consistently half of all bites reported. The health concern of animal bites is due to

Table 14
Vector Borne Disease Incidence, Multnomah County

	1993	1994	1995	1996	1997	1998	1999	2000	2001
Cases acquired in Multnomah County	0	0	1	1	0	2	2	2	1
Cases imported from elsewhere	**4**	**4**	**12**	**12**	**7**	**6**	**11**	**25**	**6**
Total	**4**	**4**	**13**	**13**	**7**	**8**	**13**	**27**	**7**

Source: Multnomah County Health Department, Communicable Disease Control

Table 15
Animal Bites or Exposure to Humans*, Multnomah County

	1998	1999	2000	2001
Bat	4	7	4	3
Cat	8	17	15	8
Dog	28	36	36	41
Ferret	2	1	0	0
Raccoon	3	6	0	2
Other	9	10	5	7
Total Cases	**54**	**77**	**60**	**61**

* Responded to by MCHD or Animal Control
Source: Multnomah County Health Department, Communicable Disease Control

the wide variety of bacteria found in animal saliva. The bacteria can be transmitted into a wound through the bite. The consequences of infection can range from mild discomfort to life-threatening complications. Nationally, as well as in the County, rabies cases are rare. In the nine years between 1991 and 2000, only 4 animals tested positive for rabies in the County.

Conclusion

Vector borne disease incidence is very low in the County. As of the end of 2002, mosquitoes tested in Multnomah County have not been found to carry the West Nile virus. However, Oregon and Multnomah County anticipate the presence of West Nile virus in 2003. In preparation significant effort is being performed to increase public awareness of mosquito-borne disease risk and what people can do to limit their risk, and to prepare for the county government's role in West Nile virus surveillance and control.

The Health Department responds to all citizen complaints about rats and performs rodent control efforts through the county. The number of rodent complaints by citizens has remained relatively steady between 1999 and 2001. The number of animal bites or exposures to humans from animals is low and dog bites consistently make up half of all bites reported.

1. *West Nile Virus.* Centers for Disease Control and Prevention. Accessed: 7/1/02. http://www.cdc.gov/ncidod/dvbid/westnile/index.htm

Glossary

Air toxics: Also know as toxic air pollutants, are 188 pollutants tracked by the EPA known or suspected to cause cancer, respiratory, reproductive and developmental problems.

Air Quality Index: An assessment that combines criteria pollutants into one value of air quality for each day of the year.

Benzene: A colorless volatile flammable toxic liquid used in organic synthesis, as a solvent, and as a motor fuel.

Blood lead level: The concentration of lead in a sample of blood. The concentration is expressed in micrograms per deciliter (ug/dL).

Body Mass Index (BMI): A method of estimating fitness based on a person's height and weight. BMI = weight in kilograms/height in meters^2.

Brownfields: Abandoned, idle, or underused industrial or commercial sites that raise concern in nearby community that any expansion or redevelopment could contaminate the environment.

Campylobacteriosis: An illness caused by bacteria that lives in the intestines of health birds that can make people ill if ingested.

Carbon monoxide: A colorless, odorless, poisonous gas produced by incomplete fossil fuel combustion.

Chloroform: A colorless volatile heavy toxic liquid with an ether odor used especially as a solvent or as a veterinary anesthetic.

Chromium: A heavy metal that can damage living things at low concentrations and tends to accumulate in the food chain.

Combined sewer overflow: Discharge of a mixture of storm water and domestic waste when the flow capacity of a sewer system is exceeded during rainstorms.

Community water system: A public water system that provides water to at least 15 service connections used by year-round.

Conditionally Exempt Generator: Any business that produces less than 2,200 pounds of hazardous waste, less than 2.2 pounds of acute hazardous waste, or less than 220 pounds of spilled hazardous waste per month. Conditionally exempt generators are not required by law to report their hazardous waste production.

Criteria pollutants: A set of six air pollutants which are known to be unhealthy at high levels or with prolonged exposure. Carbon monoxide, ozone, nitrogen dioxide, particulate matter, sulfur dioxide, and lead. Major sources of criteria pollutants are vehicles - cars, trucks, ships and airplanes.

Cryptosporidium: A protozoan microbe associated with the disease cryptosporidiosis. The disease can be transmitted through ingestion of drinking water, person-to-person contact, or other pathways.

Cryptosporidiosis: A gastrointestinal illness caused by the cryptosporidium parasite.

E. coli: A bacteria commonly found in cattle. E. coli is also infrequently found in drinking water.

Environmental tobacco smoke: Smoke given off by cigarettes, pipes, or cigars to which nonsmokers can be exposed.

Foodborne illness: Infection caused by microbial or chemical contaminants in foods. Some foodborne illness can be caused by a single helping or less of a food that contains a contaminant. Other foodborne illnesses result from eating compounds in foods over a long periods of time.

Foodborne disease outbreak: The occurrence of two or more cases of the same illness among people from different households resulting from the ingestion of the same food.

Giardia lamblia: Protozoan in the feces of humans and animals that can cause severe gastrointestinal ailments. It is a common contaminant of surface waters.

Giardiasis: A gastrointestinal illness caused by the giardia parasite.

Hazardous substances: any substance that possesses properties that can cause harm to human health and ecologic systems.

Hazardous waste: Potentially harmful substances that have been released or discarded into the environment.

Health-based benchmark: Federal Clean Air Act guidelines based on a one in a million cancer risk for a specific air pollutant.

Healthy People 2010: A report from the U.S. Department of Health and Human Services which provides 467 objectives in 28 focus areas to target national health improvement activities.

Household lead dust: Very fine particles containing lead that are usually caused by the deterioration of lead paint.

Indoor air quality: The overall state of the air inside a building as reflected by the presence of pollutants, such as dust, fungi, animal dander, volatile organic compounds, carbon monoxide, and lead.

Large Quantity Generators: Any business that produces more than 2,200 pounds of hazardous waste, more than 2.2 pounds of acute hazardous waste, or more than 220 pounds of spilled hazardous waste per month.

Mixed use development: Land use development in which there are multiple uses: residential, retail, commercial, light industrial, entertainment, institutional.

Moderate physical activity: Activities that use large muscle groups and are at least equivalent to brisk walking. Activities may include walking swimming, cycling, dancing, gardening and yard work.

National Air Toxics Assessment: Provides risk estimates of hazardous air emissions for 32 of the most dangerous air toxics.

National Priorities List: EPA's list of the most serious uncontrolled or abandoned hazardous waste sites identified for possible long-term cleanup under Superfund.

Nonattainment area: A locality where air pollution levels persistently exceed EPA's National Ambient Air Quality Standards.

Ozone: In the stratosphere ozone is a natural form of oxygen that provides a protective layer shielding the earth from ultraviolet radiation. In the troposphere (the layer extending up 7 to 10 miles from the earth's surface), ozone is a chemical oxidant and major component of smog.

Particulate matter: Fine liquid or solid particles such as dust, smoke, mist, fumes, or smog, found in air or emissions.

Pathogens: Microorganisms (e.g., bacteria, viruses, or parasites) that can cause disease in humans, animals and plants.

Physical activity: Bodily movement that is produced by the contraction of skeletal muscle and that substantially increases energy expenditure.

Radon: A colorless, naturally occurring radioactive gas found in some soils and rocks.

Recreational waters: Recreational water bodies include lakes, rivers, streams, and public swimming pools.

Salmonella: A bacteria that is frequently found in birds as well as other animals.

Secondhand smoke: A mixture of the smoke exhaled by smokers and the smoke that comes from the burning end of the tobacco product.

Sedentary lifestyle: A person who is relatively inactive and has a lifestyle characterized by a lot of sitting.

Small Quantity Generator: Any business that produces between 100 and 2,200 pounds of hazardous waste per month.

Solid waste: Common garbage or trash generated by industries, businesses, institutions, and homes.

Superfund: A program operated under the legislative authority of Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) and Superfund Amendments and Reauthorization Act (SARA) that funds and carries out EPA solid waste emergency and long-term removal or remedial activities. Superfund sites are uncontrolled or abandoned places where hazardous waste is located.

Toxic air pollutants (air toxics): EPA's list of 188 pollutants known or suspected to cause cancer, respiratory, reproductive and developmental problems.

Toxic Release Inventory: EPA's list of more than 600 designated chemicals that threaten health and the environment. Authorized under the Emergency Planning and Community Right-To-Know Act (EPCRA) of 1986, this system requires manufacturers to report releases of these chemicals to EPA and State governments.

Vector borne diseases: Illnesses that are transmitted to people by organisms, such as insects.

Vector control: Control of any object, organism or thing that transmits disease from one host to another.

Vehicle Inspection Program: A vehicle emissions inspection program operated by the Oregon Department of Environmental Quality in the Portland and Rogue Valley areas. The program is intended to reduce vehicle emissions.

Wastewater: The spent or used water from a home, community, farm, or industry that contains dissolved or suspended matter.

Waterborne disease outbreak: Incidents of infectious agents or chemical poisoning in which two or more people experience a similar illness after consumption or use of water and evidence implicates water as the source of illness.

Water quality limited: Recreational water bodies which do not meet federal Clean Water Act standards.

West Nile virus: A mosquito-borne disease new to the U.S. that was first identified in the eastern U.S. in 1999. Most people who become infected with West Nile virus will have either no symptoms or only mild ones. However, on rare occasions, West Nile virus infection can result in severe and sometimes fatal illnesses.

Work related injury (fatal or nonfatal): Any personal injury incurred by a worker while on or off the worksite but engaged in work-related activities. Work-related injuries may be unintentional or intentional (i.e. homicide or assault).

Data Sources

Drinking Water Quality

Drinking Water Program. Oregon Department of Human Services.
www.ohd.hr.state.or.us/dwp/swp.cfm
U.S. Environmental Protection Agency *Envirofacts Data Warehouse.* U.S. Environmental Protection Agency.
www.oaspub.epa.gov/enviro/ef_home2.water
Acute and Communicable Disease Program. Oregon Department of Human Services.
www.dhs.state.or.us/publichealth/acd/about.cfm
National Water Use Information Program. U.S. Geological Survey.
www.water.usgs.gov/watuse/
City of Portland Water Bureau.
www.water.ci.portland.or.us/

Food Safety

Acute and Communicable Disease Program. Oregon Department of Human Services.
www.dhs.state.or.us/publichealth/acd/about.cfm
FoodNet. Foodborne and Diarrheal Diseases Branch. Centers for Disease Control and Prevention.
www.cdc.gov/foodnet/

Hazardous Waste

DEQ Environmental Profiler. Oregon Department of Environmental Quality.
deq12.deq.state.or.us/fp20/
Environmental Cleanup Site Information (ECSI). Oregon Department of Environmental Quality.
www.deq.state.or.us/wmc/ecsi/ecsiquery.htm
Agency for Toxic Substances and Diseases Registry. Centers for Disease Control.
www.atsdr.cdc.gov/
Superfund Program. U.S. Environmental Protection Agency.
www.epa.gov/superfund/

Housing and Indoor Air Quality

Summary File 3. 2000 U.S. Census. U.S. Census Bureau.
www.factfinder.census.gov/servlet/BasicFactsServlet
Lead-Based Paint Program. Oregon Department of Human Services.
www.ohd.hr.state.or.us/leadpaint/index.cfm
Regional Land Information System (RLIS). Metro Regional Government.
www.metro-region.org/article.cfm?articleid=593
U.S. Environmental Protection Agency.
www.epa.gov/iaq/radon/zonemap/oregon.htm
Radiation Protection Services, Oregon Public Health Services, Oregon Department of Human Services.
www.dhs.state.or.us/publichealth/rps/radon/county.cfm

Tobacco Prevention and Education Program. Oregon Public Health Services.
www.ohd.hr.state.or.us/tobacco/fctsheet/mult.htm.

Land Use and Community Design

Supplementary Survey. 2000 U.S. Census. U.S. Census Bureau.
Metro Regional Framework Plan. Metro Regional Government.
www.metro-region.org/
Vital Statistics. Center for Health Statistics. Oregon Department of Human Services.
www.ohd.hr.state.or.us/chs/vstats.cfm
Fatality Analysis Reporting System. National Center for Statistics and Analysis.
www-fars.nhtsa.dot.gov/
Behavioral Risk Factor Surveillance Survey. Center for Health Statistics, Oregon Department of Human Services.
www.ohd.hr.state.or.us/chs/brfsdata.cfm
Youth Risk Behavior Survey, Oregon Healthy Teens. Center for Health Statistics, Oregon Department of Human Services.
www.ohd.hr.state.or.us/chs/yrbsdata.cfm#yrbs

Occupational Health

Information Management Division. Oregon Department of Consumer and Business Services.
www.cbs.state.or.us/external/imd/
Covered Employment and Payroll. Oregon Employment Department.
www.qualityinfo.org/olmisj/CEP

Outdoor Air Quality

National Emissions Inventory. U.S. Environmental Protection Agency.
www.epa.gov/ttn/chief/trends/index.html
AirData. U.S. Environmental Protection Agency.
www.epa.gov/air/data/index.html
Air Quality Index (or *Pollutant Standards Index*). U.S. Environmental Protection Agency.
www.epa.gov/airdatamonpsi.html
Green Book. U.S. Environmental Protection Agency.
http://www.epa.gov/oar/oaqps/greenbk/index.html
DEQ Environmental Profiler. Oregon Department of Environmental Quality.
www.deq12.deq.state.or.us/fp20/
National Air Toxics Assessment. U.S. Environmental Protection Agency.
www.epa.gov/ttn/atw/nata/nsata1.html
Oregon DEQ Air Program. Oregon Department of Environmental Quality.
www.deq.state.or.us/aq/
Toxic Release Inventory. U.S. Environmental Protection Agency.
www.epa.gov/triexplorer/introduction.htm

Vehicle Inspection Program. Oregon Department of Environmental Quality.
www.deq.state.or.us/aq/vip/

Recreational Water

Water Quality Program. Oregon Department of Environmental Quality.
www.deq.state.or.us/wq/
Oregon Water Quality Index. Oregon Department of Environmental Quality.
www.deq.state.or.us/lab/wqm/wqimain.htm
Combined Sewer Overflow Program. Environmental Services, City of Portland.
www.cleanrivers-pdx.org/what_we_do/cso_program.htm
Water Quality Division. U.S. Environmental Protection Agency.
www.epa.gov/OWOW/monitoring/
Center for Health Statistics. Oregon Department of Human Services.
www.ohd.hr.state.or.us/chs/

Solid Waste and Wastewater Quality

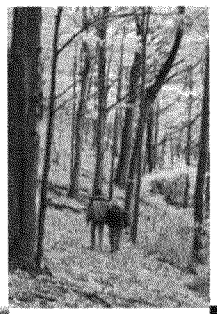
Office of Sustainable Development. City of Portland.
www.sustainableportland.org/
Environmental Management Department. Metro Regional Government.
www.metro-region.org/pssp.cfm?ProgServID=1
Environmental Services. City of Portland.
www.cleanrivers-pdx.org/
Solid Waste Program. Oregon Department of Environmental Quality.
www.deq.state.or.us/wmc/solwaste/rsw.htm

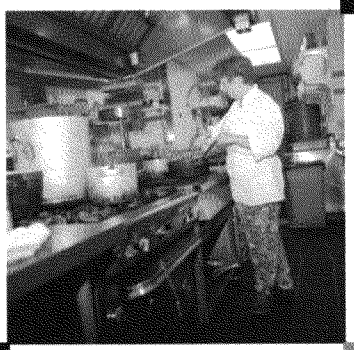
Vector-Borne Diseases

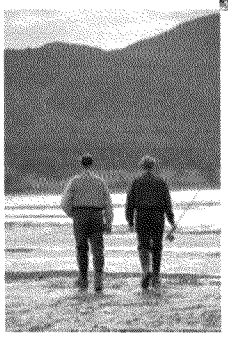
Environmental Health Section - Vector and Nuisance Control. Multnomah County Health Department.
www.mchealthinspect.org/vector/
Communicable Disease Control. Multnomah County Health Department.

Website Resources

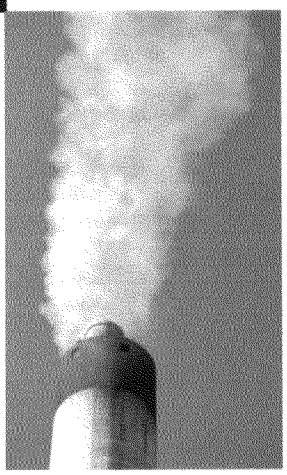
Oregon Dept. of Human Services, Acute and Communicable Disease Program	www.ohd.hr.state.or.us/acd
Centers for Disease Control and Prevention	www.cdc.gov
City of Portland Office of Sustainable Development	www.sustainableportland.org
Oregon Department of Environmental Quality	www.deq.state.or.us
Institute of Medicine	www.iom.edu
Metro	www.metro-region.org
Multnomah County Animal Control	www.co.multnomah.or.us/dscd/pets
Multnomah County Health Department	www.co.multnomah.or.us/health
Multnomah County Vector and Nuisance Control	www.mchealthinspect.org/vector
National Center for Statistics and Analysis, Fatality Analysis System	www-fars.nhtsa.dot.gov/
National Institutes of Health	www.nih.gov
National Center for Health Statistics	www.cdc.gov/nchs/
Oregon Association of Hospitals & Health Associates	www.oahhs.org
Oregon Department of Human Services	www.ohd.hr.state.or.us
Oregon Dept. of Consumer and Business Services	www.cbs.state.or.us/external/dfcs
Oregon Dept. of Human Services, Center for Health Statistics	www.ohd.hr.state.or.us/chs
Oregon Dept. of Human Services, Lead Paint Program	www.ohd.hr.state.or.us/esc/lead
Oregon Employment Department	www.emp.state.or.us
Oregon Workers Compensation Division	www.cbs.state.or.us/external/wcd
Pew Charitable Trusts	www.pewtrusts.com
Population Research Center, Portland State University	www.upa.pdx.edu/cprc
Portland Water Bureau	www.water.ci.portland.or.us
U. S. Census Bureau	www.census.gov
U. S. Department of Agriculture	www.usda.gov
U. S. Department of Health and Human Services	www.hhs.gov
U. S. Environmental Protection Agency	www.epa.gov
U. S. Food and Drug Administration	www.fda.gov
U.S. Geological Survey	www.usgs.gov/
World Health Organization	www.who.int







MULTNOMAH COUNTY
Health Department



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Multnomah County
Portland, Oregon

The Environmental Health of Multnomah County, 2003

MULTNOMAH COUNTY

Purpose

- To provide an assessment of our local environment and highlight potential hazards that may impact human health.
- To fulfill a core public health service: monitoring health status to identify community health challenges.
- To guide development of environmental health priorities.

Environmental Health

- A branch of public health focusing on the relationships between people and their environment.
- Identifies and controls hazards that may harm human health.
- Surveys show that the public is very concerned about environmental hazards.
- Scientific evidence identifies environment as an important health determinant.

Environmental Health Topics

- Drinking Water Quality
- Food Safety
- Hazardous Waste
- Housing and Indoor Air Quality
- Land Use and Community Design
- Occupational Health
- Outdoor Air Quality
- Recreational Water Quality
- Solid Waste and Wastewater
- Vector-Borne Disease

Layout of Report

Each section provides:

- Fast Facts. Highlight key findings.
- Problem statement. Specifies extent of problem: When, where and how big? Seeks to link environmental factor to health.
- Analysis of data, which includes:

Data Sources

Violations of standards

Comparisons

Health effects

Environmental Hazard Sources

Trends

Hazard Amounts

Environmental Health of Multnomah County

Environmental Factor	Overall Quality	Strengths	Areas for Improvement
Drinking Water	**Excellent**	**In compliance with federal and state drinking water quality standards since 1993; Waterborne disease outbreaks rare.**	**No fluoride in water supply; Five public water systems violated health-based federal standards in 2001.**
Food Safety	Very Good	Rates of foodborne illness declined in 1990s; MCHD conducted inspections of 3,000 food service facilities with less than 1% non-compliance.	Have not met national objectives for reducing foodborne illness.
Hazardous Waste	Needs Improvement	Since 1989, 143 hazardous waste sites, and 6,800 leaking underground storage tanks cleaned up.	Three superfund sites require clean-up; 155 sites with confirmed hazardous waste contamination.

MULTNOMAH COUNTY

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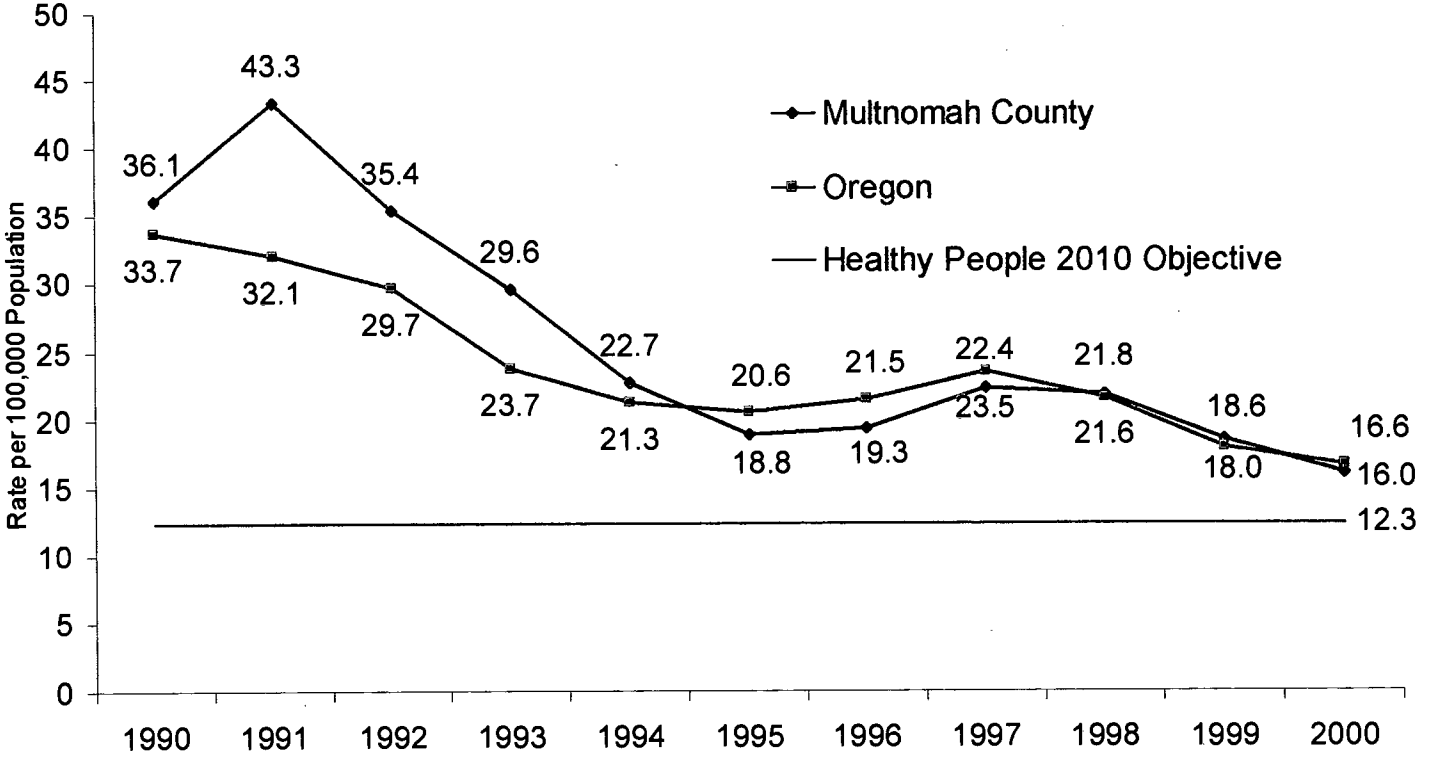
MULTNOMAH COUNTY

Food Safety

Campylobacteriosis Rates
Multnomah County and Oregon, 1990-2000



Source: Oregon Department of Human Services, Acute and Communicable Disease Program

MULTNOMAH COUNTY

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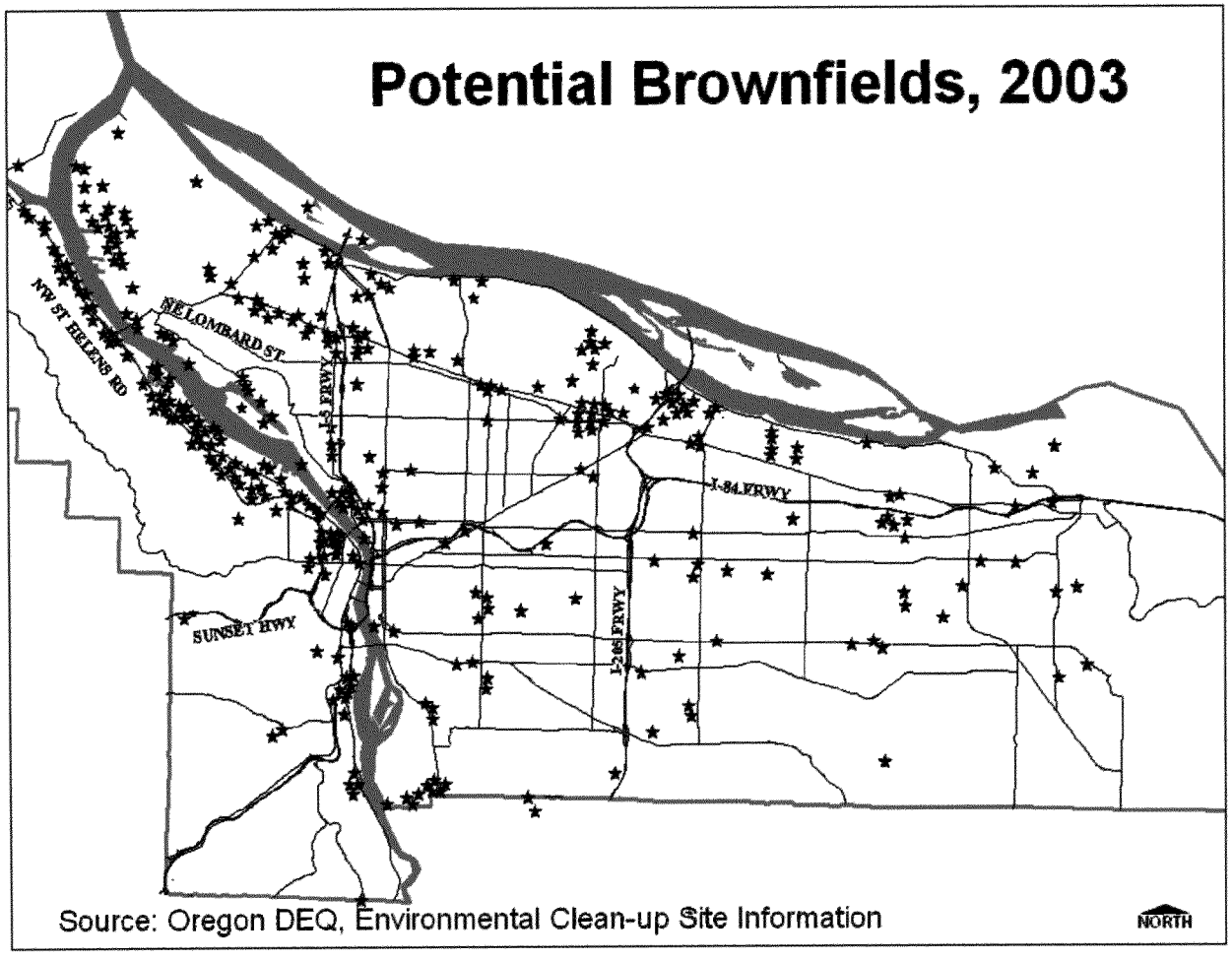
Hazardous Waste Superfund Sites, Multnomah County

Name	Location	Date Listed
McCormick & Baxter Creosote Company	North Portland	5/31/1994
Portland Harbor	North Portland	12/01/2000
Reynolds Metals Company	Troutdale	12/16/1994

Brownfields in Multnomah County, 2003



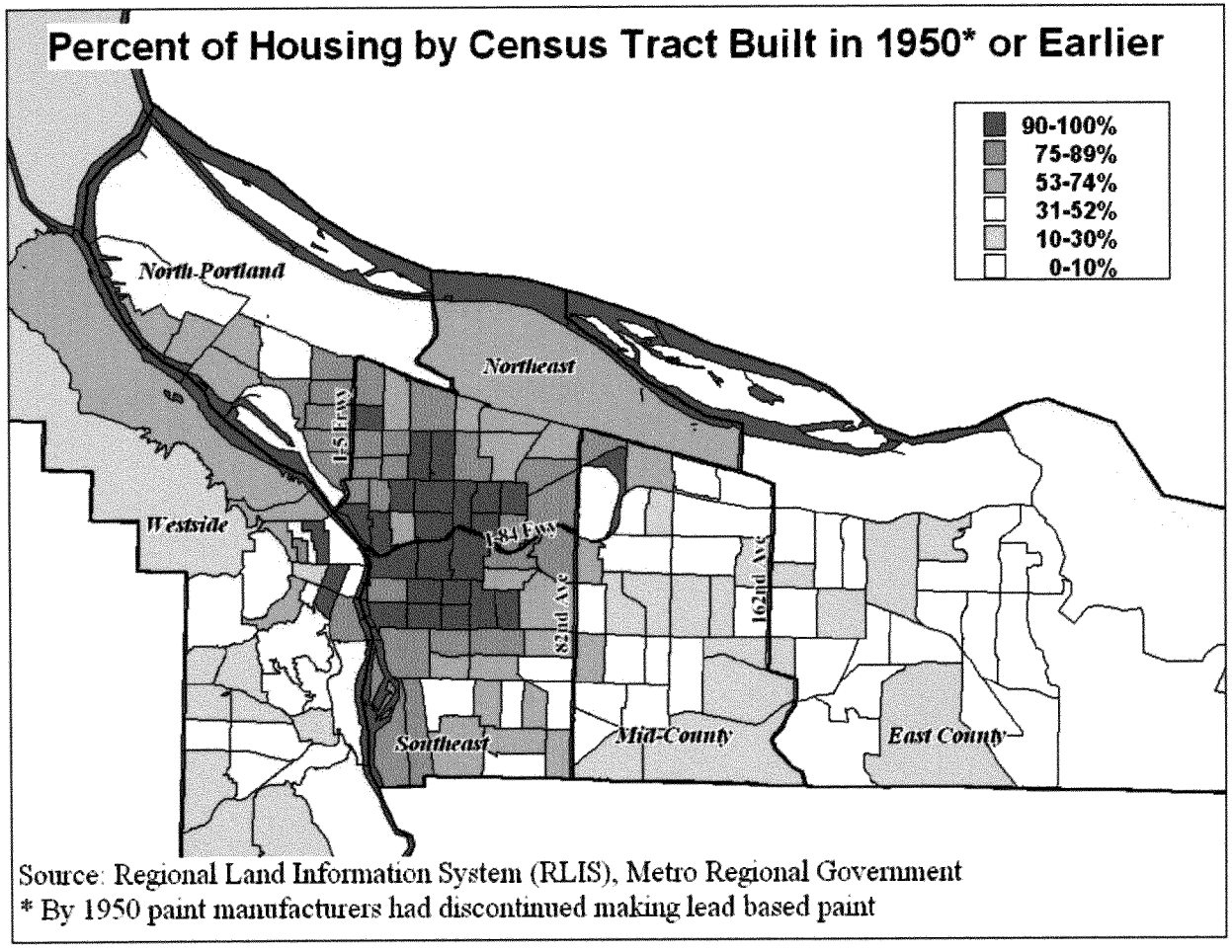
The Environmental Health of Multnomah County 2003

MULTNOMAH COUNTY

Environmental Health of Multnomah County

Environmental Factor	Overall Quality	Strengths	Areas for Improvement
Housing and Indoor Air	**Good**	**Radon levels below levels of concern.**	**Lead-based paint in older housing still poses health threat to children.**
Land Use and Community Design	Very Good	Excellent public transit system; 35% use alternatives to single occupancy cars for commuting.	Need more promotion of alternative modes of transportation (other than cars).
Occupational Health	Not rated	Most businesses smoke-free.	
Outdoor Air	Needs Improvement	In compliance with federal standards for criteria pollutants since 1997.	Air toxics remain a problem – 14 air pollutants exceed benchmarks; Motor vehicles major contributors.

Housing and Indoor Air



Source: Regional Land Information System (RLIS), Metro Regional Government
* By 1950 paint manufacturers had discontinued making lead based paint

MULTNOMAH COUNTY

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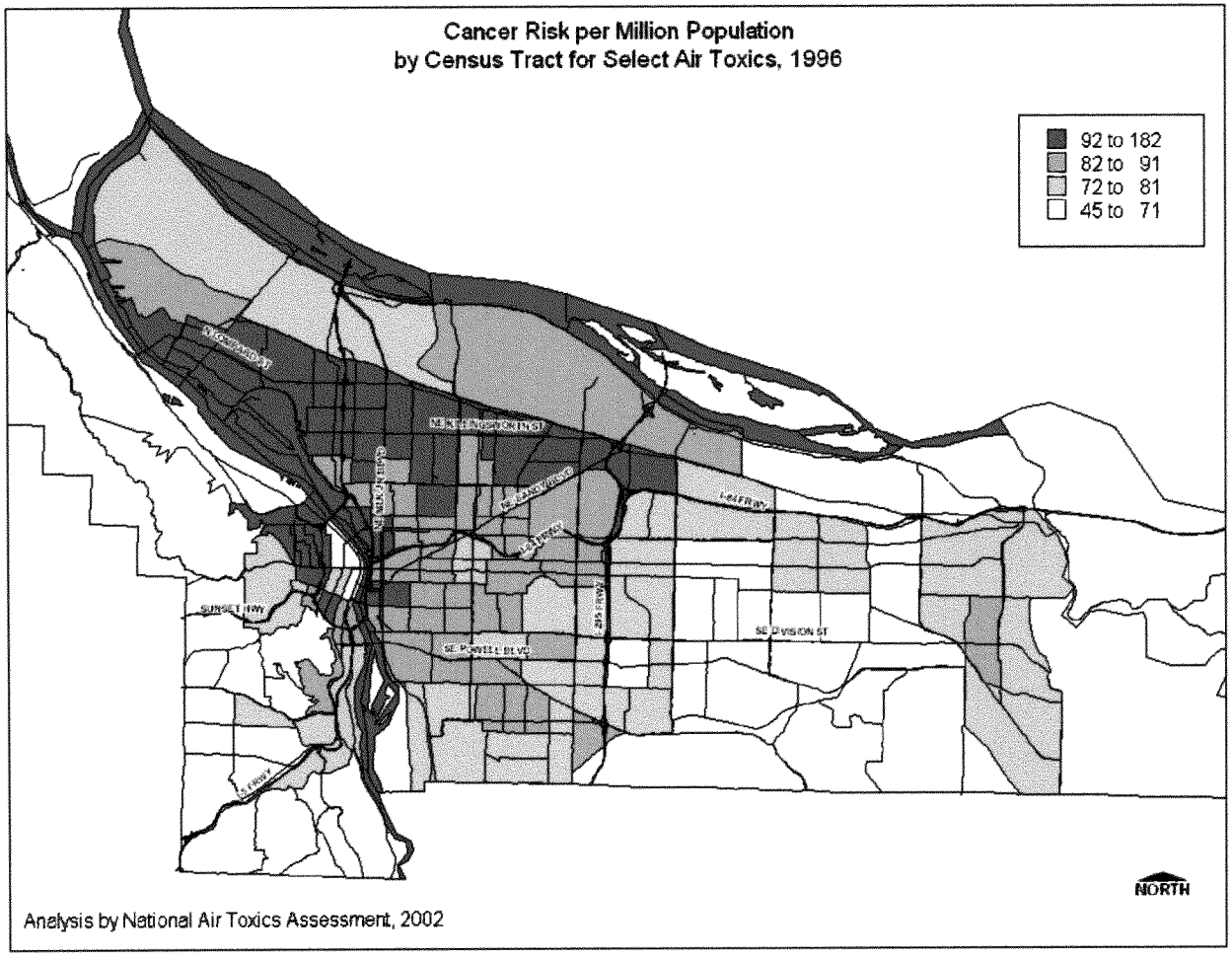
Outdoor Air Quality

Six Criteria Pollutants

Pollutant	Major Sources	Health Effects
Carbon monoxide	Motor vehicles	Aggravation of cardiovascular diseases; visual impairment
Ozone	Motor vehicles, factories	Chest pain, cough, asthma
Nitrogen dioxide	Motor vehicles, power plants	Respiratory problems and long-term respiratory infections; lung damage
Particulate matter	Motor vehicles, power plants, industrial facilities	Heart and lung diseases; aggravation of asthma; bronchitis
Sulfur dioxide	Industrial facilities, coal-fired power plants	Respiratory problems, aggravation of cardiovascular diseases.
Lead	Industrial facilities	Kidney, liver, nervous system damage; decreased IQ; High blood pressure

Air Quality



The Environmental Health of Multnomah County 2003

MULTNOMAH COUNTY

Environmental Health of Multnomah County

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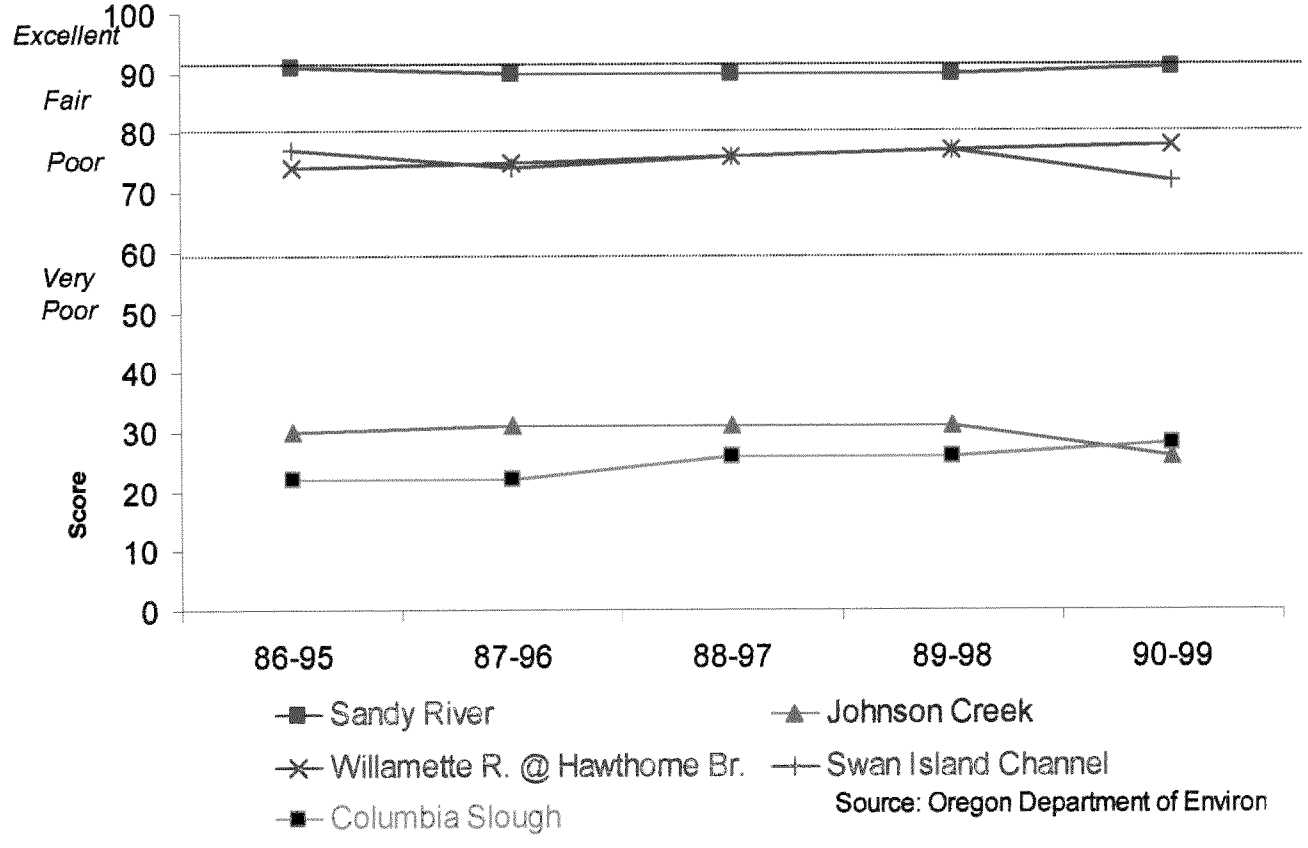
Solid Waste and Wastewater	Needs Improvement	Portland has best recycling rate in the Nation.	St. Johns landfill has known leaks of hazardous substances; Combined sewer overflow continues to pollute the Willamette River.
Vector-Borne Disease	Excellent	Vector-borne illness rare; Only four animals have tested positive for rabies, 1991-2000.	West Nile Virus expected to arrive soon.

Recreational Water

Water Quality Index Scores,
Selected River Locations, Multnomah County



Source: Oregon Department of Environ

The Environmental Health of Multnomah County 2003

MULTNOMAH COUNTY

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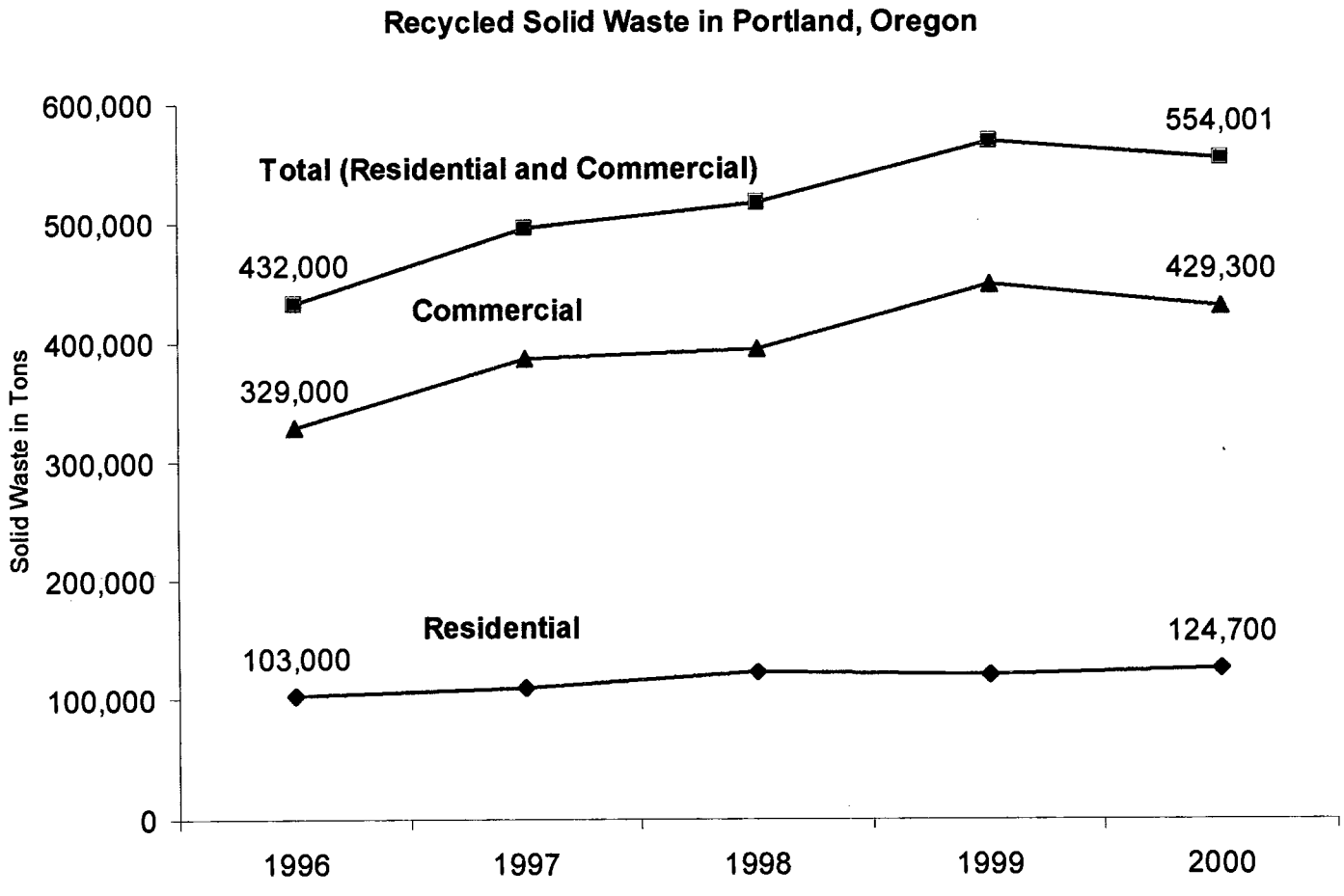
Solid Waste



Source: City of Portland, Office of Sustainable Development

MULTNOMAH COUNTY

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MULTNOMAH COUNTY

Conclusions – Strengths:

- Excellent drinking water quality
- Food safety is very good
- Vector-borne illness is rare

Conclusions – Areas Needing Improvement

- No fluoride in water supply
- Three Superfund sites and 155 hazardous waste sites need clean up
- Air toxics exceed health benchmarks
- Five water bodies are in violation of federal water standards
- St. Johns landfill has known leaks of hazardous substances

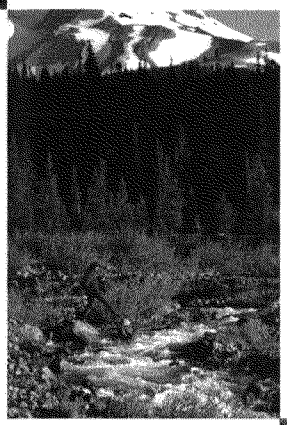
For a copy of this report:

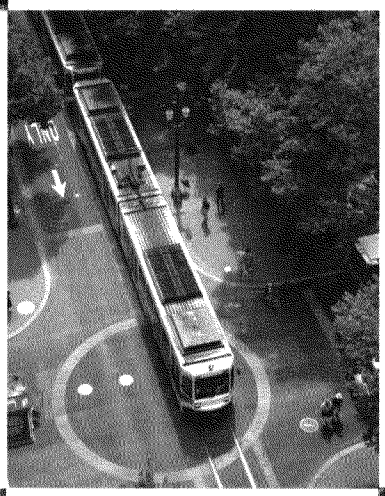
- On the Web
  www.co.multnomah.or.us/health
- Email
  jon.p.duckart@co.multnomah.or.us
- Phone
  (503) 988-3663 ext. 29055

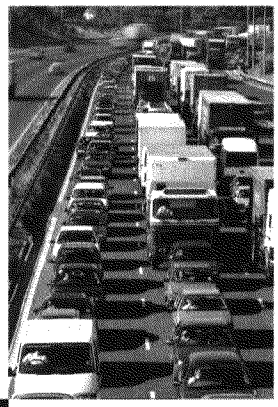
MULTNOMAH COUNTY

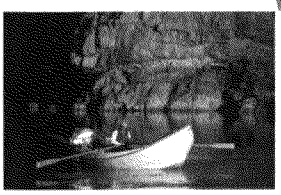
The Environmental Health of Multnomah County

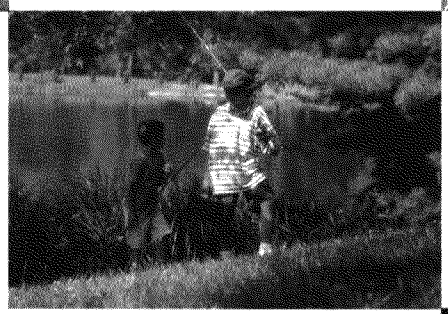
2003











MULTNOMAH COUNTY
Health Department

Multnomah County Health Department

Lillian Shirley, RN, MPH, MPA
Director

Board of County Commissioners

Diane Linn	Chair of the Board
Maria Rojo de Steffey	District 1 Commissioner
Serena Cruz	District 2 Commissioner
Lisa Naito	District 3 Commissioner
Lonnie Roberts	District 4 Commissioner

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Health Research and Assessment
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Portland, Oregon 97204

Phone 503-988-3663 x29055
Or access this document at the following website:
www.co.multnomah.or.us/health/

June, 2003

Dear Multnomah County Residents,

Our health is tied to our environment's health. Public health professionals have long understood this connection and have studied the relationships between human health and the quality of the air we breathe, the water we drink, the food we eat, the places we work, the houses we live in, the items we purchase, and many other aspects of our physical world.

Over the past century, an increasing number of people have become interested in and advocates for the health of our environment. The early 1900's brought public health movements resulting in laws protecting people from hazardous products and unsafe working conditions. The 1960's saw consumer-driven movements resulting in the protection of air and water quality. And today, as our Country continues to benefit from these and many other accomplishments, we face new occurrences of old challenges along with new threats to the environment's health.

An example of these challenges occurred in 1993, when more than 400,000 residents of Milwaukee, Wisconsin became ill from a pathogen in their drinking water supply. Tragedies like this underscore the need for continual monitoring of the environment as a part of preventing disease and protecting the public's health.

I am pleased to announce the *Environmental Health of Multnomah County*, a report developed to help us monitor the health of our local environment by identifying and discussing environmental factors that can affect human health. This report is a wealth of information that provides:

- An in-depth local assessment of many of the most important environmental health issues;
- Identification of local, state and federal agencies responsible for monitoring and protecting the environment; and
- Comparisons of our community's health to that of the State, the Nation, other counties', and important national health targets.

I would like to acknowledge the Health Department researchers and numerous individuals from local community groups, neighborhood associations, universities and governmental agencies who contributed to this effort. Working together, we continue our history of improving the health of our environment and move closer to our vision of healthy people in healthy communities.

Sincerely,

Lillian Shirley

Lillian Shirley, RN, MPH, MPA

Director Multnomah County
Health Department

Diane M. Linn

Diane M. Linn, Chair

Multnomah County
Board of Commissioners

Acknowledgments

Special thanks to the residents and individuals from organizations and professions around the county who provided valuable feedback to the report:

Madeleine Eno, Jeff Smith, and Martha Richards, *Southeast Neighborhood Association*
Martha Gannett, Sharon Genasci, and Bob Osmunde, *Northwest District Association Air Quality Committee*
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Larry Tuttle, *Center for Environmental Equity*
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Tricia Tillman, *Multnomah County Health Department*
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Table of Contents

Executive Summary

The Environmental Health of Multnomah County presents information on the state of Multnomah County's natural and built environment as it relates to public health. It was prepared by the Multnomah County Health Department to address a core public health function, that of assessing and monitoring the health of the community. We have examined the quality of our County's air and water, its waste system, occupational health, food-borne illnesses, unintentional injuries, and other environmental factors. When possible, we have linked these to available public health data. We have also presented trends so that improvements and problems in the environment over time can be highlighted. We anticipate that this report will address a need among community residents and decision-makers for information on this important topic, and hope that it supports the efforts of interested groups to address public health issues stemming from the environment.

This report relies almost exclusively on secondary data, i.e. data collected by other organizations. The availability and quality of the data vary. The data are as current as possible, but many variations exist on the most current year available for both environmental and health measures.

Key Findings

+Strengths - Challenges ± Neutral

Drinking Water

+ Multnomah County has been in compliance with all federal and state drinking water quality standards since 1993. The County meets the Healthy People 2010 drinking water objective calling for 95% of residents to receive water from water systems meeting federal safety standards.

+ Waterborne disease outbreaks were rare in Multnomah County between 1991 and 2000, and waterborne disease rates have remained stable or declined since 1992.

- Five public water systems in Multnomah County, serving 2% of residents, were in violation of health-based standards for drinking water in 2000-2001.

- Multnomah County does not meet the Healthy People 2010 objective calling for at least 75% of community residents to receive optimal levels of fluoridated water. Less than 10% of the population in Multnomah County has access to optimal levels of fluoride in drinking water.

Food Safety

+ Rates of illness caused by unsafe food handling have declined in both Multnomah County and Oregon since the early 1990's.

+ Rates for one important source of food-borne illness – the bacteria E. coli – were consistently lower for Multnomah County than for Oregon between 1995 and 2000.

- However, Multnomah County has not met national objectives in reducing foodborne illness.

Hazardous Waste

+ Since 1989, 143 hazardous waste sites have been cleaned up, and no longer pose an environmental or health threat. In addition, over 6,800 leaking underground storage tanks have been cleaned up over the past 20 years.

± While two Superfund sites in Multnomah County have been cleaned up and have been removed from the National Priorities List, there are currently three listed Superfund sites in Multnomah County. Two additional sites are candidates for the Superfund program.

-There are 155 sites throughout Multnomah County with confirmed hazardous waste contamination.

Housing and Indoor Air Quality

+ Radon levels in Oregon have been designated of moderate or low concern by the EPA.

- In 2000, 1.1% (3,117 units) of housing stock in Multnomah County lacked complete kitchen facilities and 0.8% (2,252 units) lacked complete plumbing facilities.

-The percentage of overcrowding in renter occupied units (8.7%) is higher than in owner occupied units (2.9%).

- Lead-based paint is most prevalent in houses built before 1950. There is a higher percentage of housing built in 1950 or earlier in the inner Northeast and Southeast neighborhoods.

Land Use and Community Design

±While the rate of motor vehicle crash fatalities is consistently lower in Multnomah County than in Oregon and the U.S., motor vehicle accidents were the leading cause of death of Multnomah County and Oregon children age 1 to 17 years for the period 1997-2000.

± While there has been a steady increase in recent years in the proportion of adults in Multnomah County who are at risk of overweight-related health

problems, the proportion in the county is consistently lower than Oregon and the Nation.

- Only one quarter of adults in Multnomah County participate in regular physical activity.

Occupational Health

+ There were a total of 6,115 accepted work-related disabling claims in Multnomah County in 2001, down from a high of 8,366 claims in 1990.
+ As of July 1, 2000, most businesses, including restaurants, are required to be smoke free throughout Multnomah County.

Outdoor Air Quality

+ Multnomah County has been in compliance with federal air quality standards since 1997, and meets Healthy People 2010 objective for criteria air pollutants established by the Clean Air Act. By comparison, eight counties in Oregon are not in compliance, as of July 2002.
- Fourteen air toxics (among 188 air toxics tracked by the EPA) in the County exceed health-based benchmarks, with six pollutants more than 10 times the benchmark.
- Most of the County exceeds the federal cancer risk benchmark for toxic outdoor air pollutants. The highest risk areas are in North and Northeast Portland.

Recreational Water

+ Rates for recreational waterborne disease are low for Multnomah County, and outbreaks are rare. There were two waterborne disease outbreaks in the County in the 1990's.
-Six of seven waterways in Multnomah County examined by the Oregon Department of Environmental Quality are ranked as poor or very poor. Five water bodies are in violation of federal Clean Water standards that protect beneficial uses.
- Current sewer designs in Multnomah County cause three billion gallons of rainwater and raw sewage to flow into the Willamette River every year.

Solid Waste and Wastewater

+ Portland's recycling rate is at 54%, the best in the country.
- St. Johns landfill, located in Portland and closed since 1991, has known leaks of hazardous substances that are polluting nearby waterways.

Vector-Borne Disease

+ Multnomah County experiences less than two cases of vector borne illness a year.
+ In the nine years between 1991 and 2000, only 4 animals tested positive for rabies in the County.
- Although mosquitoes tested in Multnomah County have not been found to carry the West Nile virus, the virus is expected to arrive in 2003.

Introduction

Purpose

The Environmental Health of Multnomah County provides an assessment of our environment, and highlights hazards in the community that may impact human health. It fulfills a core public health service, that of monitoring health status to identify community health problems. This resource document is the second in a series of health assessment reports conducted by the Multnomah County Health Department, and is part of our continuing commitment to provide the community with important health information. We hope that it will bring new depth to a continuing dialogue between the community and health professionals on factors that influence public health, so that together we can establish health priorities and continue to realize our vision of healthy people in healthy communities.

Environmental health "focuses on the relationships between people and their environment, promotes human health and well-being, and fosters a safe and healthy environment."

What is environmental health and why is it important?

Environmental health is a branch of public health that "focuses on the relationships between people and their environment, promotes human health and well-being, and fosters a safe and healthy environment."[1] According to a recent national survey, Americans are very much aware of the link between environment and human health. Ninety percent of Americans believe that environmental pollutants are important causes of disease. Further, 75% feel that they or a close family member live in a community where environmental pollutants such as air and water contaminants, hazardous wastes, and pesticides are a problem.[2] Scientific evidence linking environment to human health supports this belief.* The Centers for Disease Control and Prevention has estimated that 16% of all preventable deaths in the United States can be attributed to environmental factors. Researchers at the World Health Organization estimate that environmental factors may cause up to 33% of diseases worldwide. And one study of pediatric illnesses indicates that environmental pollutants may account for 5% of cancers, 30% of asthma cases, and 10% of neurobehavioral disorders, with costs exceeding $55 billion annually.[3-5]

...75% [of Americans] feel that they or a close family member live in a community where environmental pollutants such as air and water contaminants, hazardous wastes, and pesticides are a problem.

Although many public health departments take seriously the possible health threats coming from the environment, others have noted public health's shortcomings. More than a decade ago, the Institute of Medicine (IOM) presented a report arguing, in part, that environmental health had become disconnected from public health: "The removal of environmental health authority from public health agencies has led to fragmented responsibility, lack of coordination, and inadequate attention to the health dimensions of environmental problems." Among IOM's many recommendations was a call to public health departments to identify, understand and control environmental problems as health hazards.[6]

* *Social environment, biology, behavior, and health care access also play important roles in human health.*

Who is this report for?

This report is for anyone interested in an examination of Multnomah County's environment and its possible impacts on human health. Anyone living within the Portland metropolitan region may find this report of special interest. We anticipate that this report will also appeal as a resource document to community organizations, public agencies, policy makers, public health professionals, and students.

What does this report cover?

This report is a community resource on Multnomah County's environmental health. It provides an in-depth examination of selected environmental factors that influence human health. Each chapter focuses on nationally recognized environmental factors and provides data for several environmental health indicators, along with baseline data from previous years in order to highlight trends. We have examined the quality of our County's air and water, its waste, occupational health, food-borne illnesses, unintentional injuries, and other environmental factors, and we have linked these to human health data- where it exists.

What is not covered?

While this report contains a wealth of information on the County's environmental health, it is not a report of solutions. It does not prioritize issues or direct steps to be taken to address environmental health problems. In most cases, we do not advocate for or against any environmental health policies. We have sought simply to identify and understand factors in the physical and built environment in Multnomah County that may be health hazards. A more focused environmental health assessment is under way to address environmental problems in specific communities within the County (see PACE EH below).

This report addresses many environmental health issues; however, the list of topics is not exhaustive. There are other environmental health issues that do not appear in this report. Examples of topics not covered are radiation, mold and mildew, institutional health, environmental noise, and odors. In some cases, data for these environmental factors were difficult to obtain, inconsistently collected, or nonexistent. In other cases, time and staff resource constraints limited the number of environmental factors we could cover.

Finally, we were not able to show direct links between environmental exposures and human health problems. Measuring the actual health problems stemming from the environment is difficult, especially for chronic diseases such as cancer, birth defects and asthma.[7] Cancer is especially difficult to tie to environmental causes, primarily because the time between exposure and the detection of the cancer can take many years. Therefore, many chapters in this report rely upon environmental health indicators.

What are environmental health indicators?

Environmental health indicators are measures that assess health status or risk as

it relates to the environment. The best indicators, according the Centers for Disease Control and Prevention, are those that "reliably predict the relationship between human health and the environment, are routinely collected, and have well-accepted definitions and data collection standards."[8]

We relied greatly upon environmental health indicators developed by the Washington State Department of Health. Health researchers from this state recognized the need for an environmental health addendum to the Assessment Protocol for Excellence in Public Health (APEX/PH), developed by the National Association of City and County Health Officials (NACCHO) in 1991. These indicators are organized into major environmental topics – air, water, food, etc. – and each topic presents several environmental indicators. Indicators are of two types. Health status indicators measure health outcomes that can reliably be assumed to result from environmental exposure. An example of this is the foodborne illness indicator stemming from contaminated food. Environmental exposure indicators measure conditions or activities with the potential to expose humans to a contaminant or hazardous condition. Examples of these include air contaminant releases and hazardous waste sites.

Sources and Objectives

All data used in this report are secondary data – that is, data collected by other organizations. No primary data – i.e., new data, for the purpose of this project – were collected. The data were obtained from local, state, and federal agencies charged with monitoring a specific environmental factor. We have provided the most currently available data, and present data over several years in order to analyze trends. In many cases, data go back five years or more. We cannot guarantee the quality of the data, and in most cases we are not able to provide an in-depth analysis of data limitations. The availability and quality of the data vary by public agency.

Data by themselves are not very meaningful without something to compare them to. In many cases we compare ourselves to Oregon. In some cases we compare the County to the Nation and to other counties. The most useful comparisons come from national objectives found in **Healthy People 2010**, a resource developed by the U.S. Department of Health and Human Services, with input from more than 350 national organizations and 250 State public health and environmental agencies. It provides 467 10-year health objectives in 28 focus areas to target national health improvement activities for the Nation. Healthy People 2010 includes many health objectives that are relevant to the indicators in this report, including 30 environmental health targets. Environmental health indicators for Multnomah County are compared against Healthy People 2010 objectives whenever possible*.

* *For more information on the development of Healthy People 2010, visit their website at http://www.healthypeople.gov.*

Other Environmental Health Efforts – PACE EH

While environmental health monitoring is an important first step, it is not enough, especially without vital community input. Health professionals and community residents need to work together to identify environmental health issues and address the problems found. That is why Multnomah County Health Department has joined forces with community residents to assess the environmental health of our County. Through a process called the Protocol for Assessing Community Excellence in Environmental Health (PACE EH), a coalition of community residents and health and environmental professionals has emerged to set priorities for local action to address environmental hazards most clearly impacting human health.[6] As this report went to press, the coalition was in the final stages of determining the geographic area upon which to focus its efforts.

We hope that this report, and the efforts of PACE EH, will address a need among community residents to understand the important links between environment and health so that, together, we can set priorities for action.

1. Adapted from: National Association of County and City Health Officials (NACCHO) *Protocol for Assessing Community Excellence in Environmental Health: A Guidebook for Local Health Officials.* Washington, DC. 2000.
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8. *Environmental Public Health Indicators Project.* National Center for Environmental Health, Centers for Disease Control and Prevention. Accessed: 04/30/2003. http://www.cdc.gov/nceh/indicators/

Demographics of Multnomah County

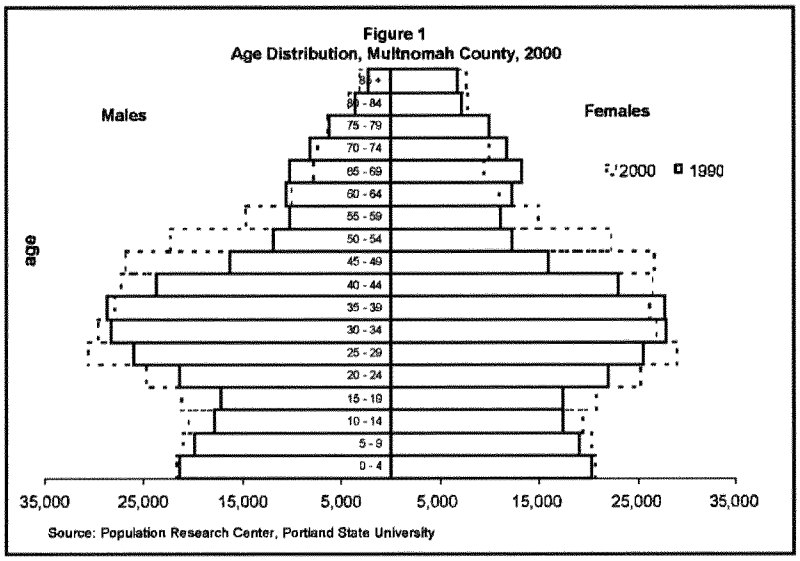
Population

Multnomah County is largely urban, and home to 19.3% of the State's population. The city of Portland comprises 80% of the County's population and is the County seat. The next largest city is Gresham with 14% of the population. The cities of Troutdale, Fairview, and Wood Village comprise the remainder of the population.

Age Distribution

From 1990 to 2000, the population of Multnomah County grew 13%, from 583,887 to 660,486. During the same period, the population of Oregon grew 20%. In 2000, the median age of Multnomah County residents was 35 years. Population growth was not evenly distributed among age groups. Figure 1 shows absolute population growth in the County between 1990 and 2000. The population of adults 74 years and older has remained relatively constant as has the population of very young children (0 to 4). The population of children 5 to 9, adolescents 10 to 19 and young adults 20 to 29 has increased. The largest increase in the adult population from 1990 to 2000 was among 45 to 54 year olds. The County has seen a decrease in the population of 60 to 74 year olds and 35 to 39 year olds.

Figure 1
Age Distribution, Multnomah County, 2000

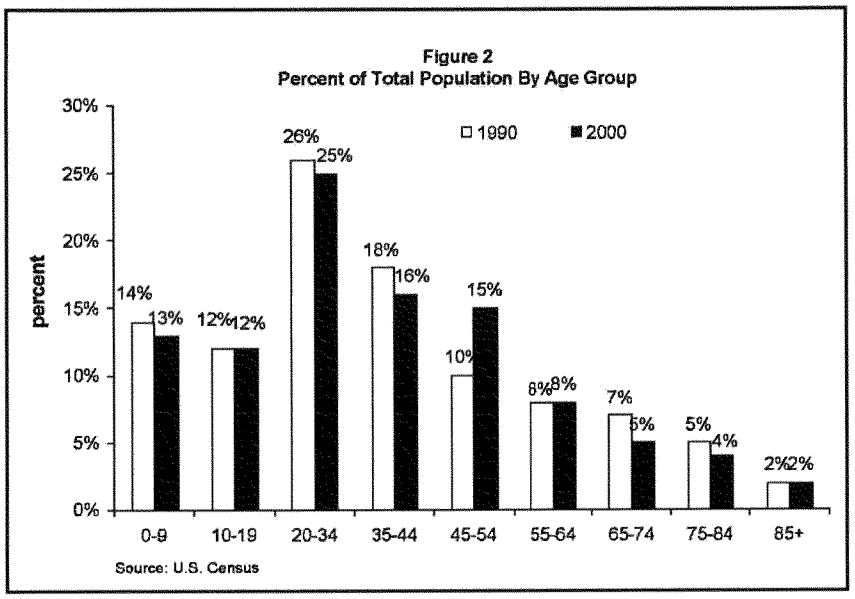


Source: Population Research Center, Portland State University

Figure 2 shows the percent of the population by ten year age groups in 1990 and 2000. The largest change in distribution was in the 45 to 54 year age group, which went from 10% of the population in 1990 to 15% in 2000.

Vulnerable Populations

A safe and healthy environment is important to maintain a physically and emotionally fit life. It is well recognized that vulnerable populations such as children and the elderly suffer greater health effects of poor environmental quality due to



Studies have shown that low-income, racial and ethnic minority individuals are much more likely to be exposed to toxic and hazardous wastes than affluent and white individuals.[1]

higher susceptibilities or higher levels of exposure. For example, **environmental tobacco smoke** is one of the primary causes of poor indoor air quality associated with respiratory health problems in children. The hazards of exposure to lead-based paint poisoning are greatest among children under seven. Very young children, the elderly, and individuals with compromised immune systems are more likely to experience serious effects of food borne illness. Many factors exist in the built environment that contribute to unhealthy communities for vulnerable populations. Among these are lack of safe play areas, unsafe streets and homes, noise, and substantial traffic.

The relationship between prosperity and better health is well established and studies over the last 20 years suggest that there is also a relationship between income and environmental risk factors. Socioeconomically disadvantaged groups such as African Americans, Hispanics, American Indians and Pacific Islanders experience higher rates of cancer, births defects, infant mortality, asthma, diabetes, and cardiovascular disease. Studies have shown that low-income, racial and ethnic minority individuals are much more likely to be exposed to toxic and hazardous wastes than affluent and white individuals. A higher percentage of low-income urban black children have blood lead levels that exceed safe limits compared to urban children with higher family incomes. According to a review of study data, "There is consistent evidence that people who are poorer in the United States are more likely to be exposed to multiple, environmental risks that portend adverse health consequences.[1]"

While Multnomah County is predominately White non-Hispanic, there are proportionately more young people among populations of color than in the White non-Hispanic population. American Indian, African American, and Hispanic populations have the highest percentage of people living at or below the poverty level.

Race and Ethnicity

The 2000 U.S. Census asked individuals to respond to the question of race differently than it had in the past. In 2000, individuals had the opportunity to choose more than one racial category to describe themselves. In addition, the category Asian/Pacific Islander was divided into two categories: Asian and Native Hawaiian or other Pacific Islander. This resulted in racial categories of White, African American, Asian, Native Hawaiian or other Pacific Islander, American Indian, two or more races, and some other race. The question of ethnicity Hispanic or non-Hispanic remained unchanged in 2000. These changes make comparisons to earlier census data on race difficult.

According to the 2000 U.S. Census, White non-Hispanics make up the largest percentage of the population of Multnomah County (Table 1). Among populations of color, Hispanics make up the largest percentage of the population followed by African American and Asian.

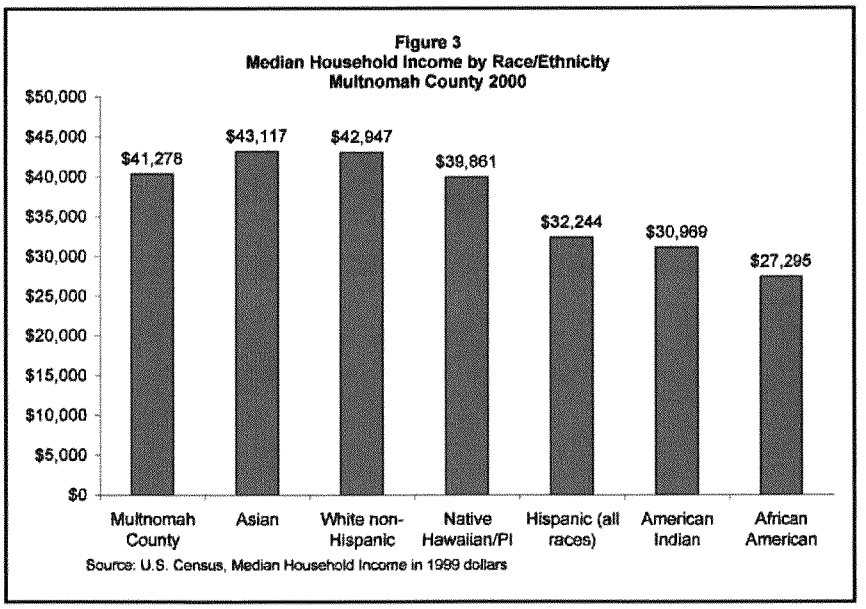
Table 1

Race/Ethnicity	Percent
White non-Hispanic	76.5%
Hispanic (of any race)	7.5%
African American	5.7%
Asian	5.7%
American Indian	1.0%
Native Hawaiian or Pacific Islander	0.4%
Two or more races	4.1%
Some other race	4.0%

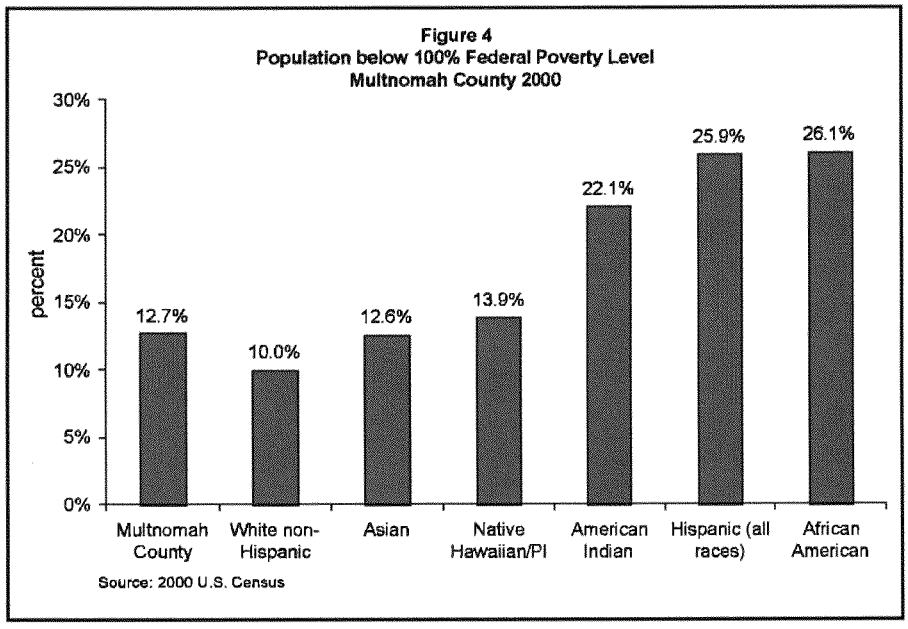
Source: 2000 U.S. Census

Income and Poverty

The 2000 U.S. Census reports that, at $41,278, the median income in Multnomah County was 0.9% higher than median income for Oregon ($40,916) and 1.7% lower than median income for the United States ($41,994). In Multnomah County Hispanic, American Indian and African American populations



have a lower median household income than other racial/ethnic groups (Figure 3). The median household income for African Americans is the lowest of any racial/ethnic group and is 33% lower than the County median household income.



African Americans and Hispanics have higher percentages of individuals at or below 100% of federal poverty level, followed closely by American Indians (Figure 4). The percentage of African Americans in poverty is more than twice as high as for the county as a whole.

Income Inequality

A recent study concludes that Oregon was one of two states in the nation in which the gap between the wealthy and the poor grew the fastest.

A recent study shows that Oregon's wealthiest 1% saw an increase in its average annual income from $374,000 to $741,000, an increase of 98% between 1989 and 2000.[2] In the same period, the State's median income rose from $24,600 to $26,700, an increase of 9%. According to the report, in 1989, the wealthiest 1% comprised 11% of the States' total income, while in 2000 they comprised 17%. The report concludes that Oregon was one of two states with the fastest growing gap between the wealthy and the poor.

1. Evans G, Kantrowitz E. Socioeconomic Status and Health: The Potential role of Environmental Risk Exposure. *Annual Review of Public Health.* 2002; 23:303-331.
2. Leachman M, Thompson J. *Boom, Bust & Beyond: The State of Working Oregon 2002.* Oregon Center for Public Policy. Silverton, OR; 2002.

Drinking Water Quality

Fast Facts

- The Portland Water Bureau - the supplier of almost 90% of the water to County residents - has been in compliance with all federal and State water quality standards since 1993.
- Multnomah County meets the Healthy People 2010 Drinking Water objective calling for 95% of residents to receive water from water systems meeting federal safety standards.
- Five of the 23 public water systems in Multnomah County, serving 1.5% of residents, were in violation of health-based standards for drinking water in 2000-2001.
- Multnomah County does not meet the Healthy People 2010 objective that calls for 75% of residents to receive fluoridated water. Less than 10% of the population has access to optimal levels of fluoride in drinking water.
- 11% of Multnomah County residents have private water systems, which are not required to undergo monitoring, and are therefore more susceptible to contamination.
- Waterborne disease outbreaks were rare in Multnomah County (and Oregon) between 1991 and 1998, and disease rates associated with waterborne disease have remained stable or declined since 1992.

Problem Statement

The link between drinking water quality and human health has been understood for many years. Public concern over safe drinking water has led to strict federal and state standards, and as a result, drinking water in the U.S. is among the safest in the world. In turn, Americans have come to trust the quality of their drinking water. For example, according to the 2000 Oregon Population Survey, 85% of residents believe Oregon is doing a good or very good job of maintaining clean water. Still, drinking water can cause many acute and chronic illnesses from contaminants such as chemicals and **pathogens** (i.e., bacteria, viruses, protozoa). A dramatic example of this occurred in 1993 in Milwaukee, Wisconsin, when over 400,000 became ill from a pathogen in the drinking water supply. There are, on average, 7,600 reported cases of waterborne illness in the U.S. each year, with actual cases estimated as high as 900,000 per year.

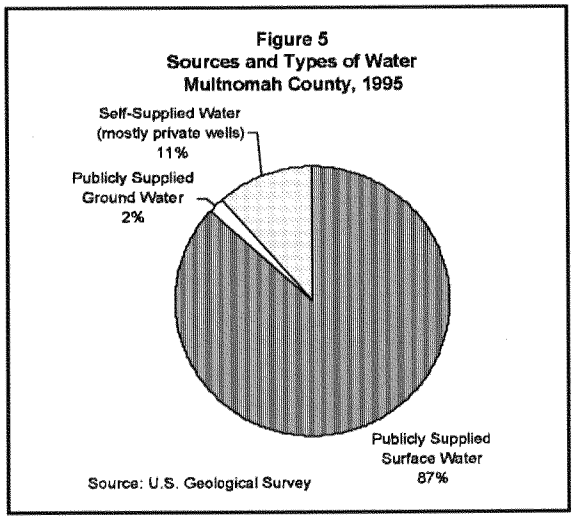
Drinking Water Regulations

Drinking water is regulated through the federal Safe Drinking Water Act and the Oregon Drinking Water Quality Act. The purpose of these acts is to assure safe drinking water free of contaminants to Oregonians using public water supplies. Primary (i.e., legally enforceable) standards for drinking water call for regulation and treatment of water supplies to eliminate pathogens, chemicals, and disinfectants (and their by products) in drinking water. To accomplish this objective, these Acts require that drinking water be tested regularly for 94 contaminants. Seven of these contaminants are pathogens such as Cryptosporidium, Giardia lamblia,

and E. coli, all of which can cause gastrointestinal illness if ingested. Regulations require the disinfection of water to remove or inactivate such organisms so that they do not pose a health threat. Organic and inorganic chemicals are also regulated, especially those that have been linked to chronic illnesses like liver and kidney disease, nervous system problems, and cancer. Nitrate, a chemical mostly linked to fertilizer runoff, is especially dangerous to infants, and can interfere with breathing.

Drinking Water Sources

According to data from the U.S. Geological Survey, 11,540 residents (1.9% of Multnomah County's population) relied upon publicly supplied ground (well) water as their primary source in 1995, whereas 533,000 (87%) relied upon publicly supplied surface water sources (primarily though the Bull Run Watershed and the Portland Water Bureau) (Figure 5). More than 69,500 residents (11%) in the County supplied their own drinking water in 1995, primarily through private wells. By comparison, 32% of residents in Oregon, and 16% nationally, supply their own drinking water. Since private water wells are not regulated under the federal and state drinking water acts, they can be a potential source of contaminants, and pose a greater risk of causing waterborne illnesses.[1]



There are 23 active **community water systems** (CWS) in Multnomah County. Each of these community water systems is publicly operated, and serves a minimum of 15 year-round resident households. The City of Portland Bureau of Water Works, the primary public water supplier of surface water to the County, supplies almost 90% of Multnomah County's CWS drinking water. The Bull Run Watershed, east of the County near Mount Hood, is the largest source of surface water. It has been Portland's primary water source for more than 100 years, and is of such high quality that it is one of the few surface water sources not required by the Environmental Protection Agency to be filtered.[2]

The Portland Water Bureau collects 10,000 water samples each year from throughout the water system, and conducts about 50,000 water analyses on the samples collected. They test for more than 150 contaminants. Of the regulated contaminants for which samples were collected, nearly all were below the maximum level before treatment. Treatment of the water (with chlorine, for example) eliminates risk of pathogen contamination, and all such contaminants were treated

effectively in 2000.[3] Furthermore, no health-based or reporting violations have been reported for the Portland Water bureau since 1993 (the earliest year data is available).[4]

Drinking Water Violations

An analysis of County water systems through the Safe Drinking Water Information System (provided by the EPA) shows that five of the 23 active community water systems in the County in 2000 and 2001 violated health-based standards (i.e., having contaminants exceeding the EPA safety standard, or having water that was not treated properly). These five systems – Corbett Water District, Casselman's Water System, City Bible College, Interlachen Water District, and Rocky Pointe Marina – served approximately 1.5% of Multnomah County residents in 2001. By comparison, statewide there were 177 community water systems violating health-based standards in 2000, serving 6% of Oregon's population.[4] Two water systems in Multnomah County, representing 6,500 residents, violated a maximum contaminant level for pathogens. The rest failed to comply with water treatment reporting. Multnomah County meets the Healthy People 2010 Water Quality objective that 95% of community residents receive drinking water that meets EPA safety standards. Over 98% of County residents using community water systems had safe drinking water in 2001.

Over 98% of Multnomah County residents using community water systems had safe drinking water in 2001.

Water Fluoridation

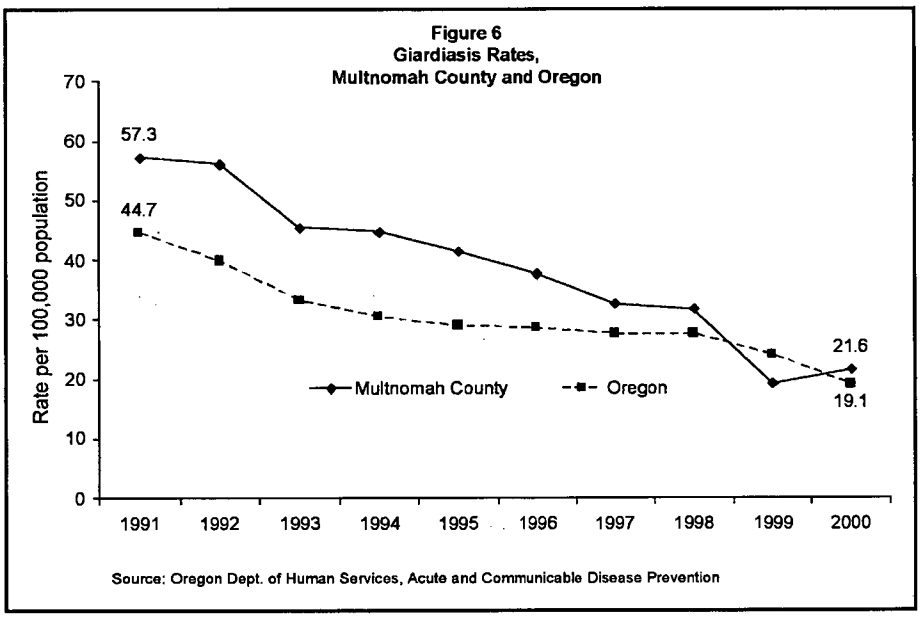
The U.S. Public Health Service recommends that drinking water be treated with optimal levels of fluoride - around one part per million. Optimal levels of fluoride in drinking water can help prevent tooth decay.[5] According to the U.S. Surgeon General, "community water fluoridation continues to be the most cost-effective, practical and safe means for reducing and controlling the occurrence of tooth decay in a community."[6] In 2000, 66% of the U.S. population served by public water systems had drinking water with optimal fluoride levels.

No fluoride was detected in the Portland Bureau's water supply. Portland is one of the few communities in the U.S. that does not fluoridate its water. Though specific statistics regarding fluoridation of public water are not available for Multnomah County, we estimate that less than 10% of County residents live in areas with optimal fluoride levels. Therefore, Multnomah County does not meet the Healthy People 2010 objective calling for at least 75% of community residents to receive optimal levels of fluoridated water. According to the CDC, only 23% of Oregon's population is supplied drinking water with optimal levels of fluoride, the fifth lowest in the nation.[7]

Health Effects of Drinking Water

Drinking water is a potential source of many pathogens and chemicals, and can lead to a variety of acute and chronic illnesses. The most common acute illnesses are gastrointestinal illness, whereas chronic illnesses may include kidney and liver diseases, and many types of cancer, perhaps from chemicals and pathogens in a

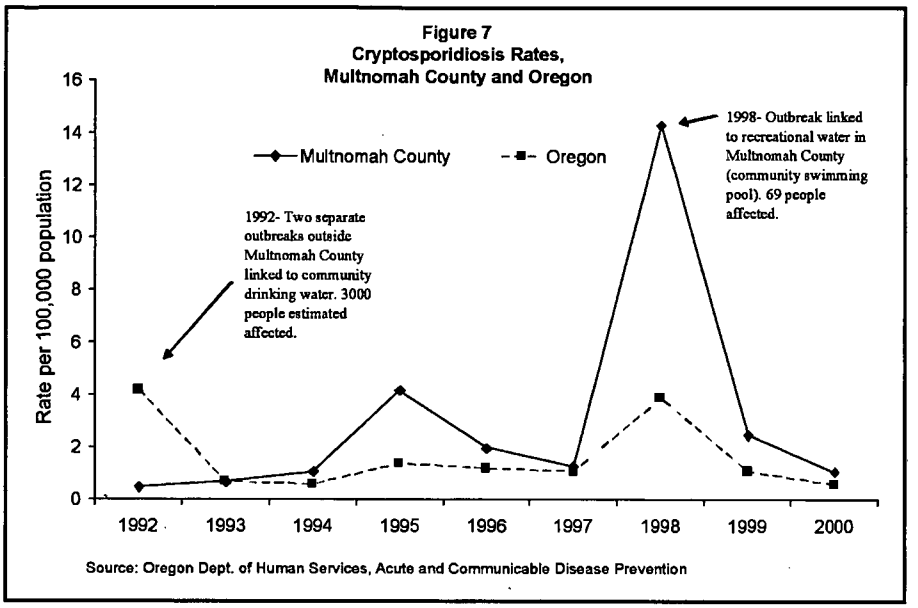
water supply over many years. Data for chronic diseases are difficult to link to water quality and are unavailable for Multnomah County. Data on acute waterborne diseases are available through the Oregon Department of Health Services Acute and Communicable Disease program. It is likely that waterborne disease data are underreported –e.g., not all who become ill from drinking water seek medical treatment. Such data probably underestimate actual water-related illnesses and outbreaks.



Giardiasis, caused by the **giardia** parasite, is considered one of the most common causes of waterborne disease in the U.S.[8] The 1991-2000 average rate for Multnomah County is 34.7 per 100,000, compared to 27.2 for Oregon. Giardia rates from 1992 to 2000 in Multnomah County have declined continually and substantially. Rates declined 65% from 1992 to 2000 (Figure 6). It is not clear to what extent drinking water supplies are responsible for either the incidence of the disease, or in its decline.

Cryptosporidium is another parasite that may be found in a community water supply. Rates for this disease have remained fairly stable since 1992 (Figure 7), and there is no indication that drinking water is contributing to a rise in this disease. There was a fairly large outbreak of about 70 people in 1998, but this has been attributed to a contaminated community swimming pool.

According to the U.S. Centers for Disease Control and Prevention, there were three **waterborne disease outbreaks** of drinking water in Oregon from 1992 to 1998 (the latest for which data is available). Two outbreaks in 1992 were linked to a community water system, and 3,000 people were estimated affected by Cryptosporidium. The third outbreak in 1997 was associated with a campground



water source, and 100 people were affected with Giardia. It is unclear whether any of the outbreaks affected Multnomah County residents.

Conclusion

Stringent requirements for drinking water due to the federal Safe Drinking Water Act, combined with a high-quality surface water source, have provided a safe water supply for Multnomah County residents, with very few contaminants found, and only rare instances of waterborne disease outbreaks associated with drinking water.

Two issues relating to drinking water and health effects have been found. First, fluoride is not in drinking water at an optimal level in Multnomah County. Less than 10% of drinking water in the County has optimal fluoride levels. Second, 11% of Multnomah County residents supply their own water, primarily through private wells. As no testing is required for contaminants in the drinking water of private systems, these residents have an increased risk of drinking unsafe water.

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2. *Water Quality in the Willamette Basin, Oregon, 1991-1995.* U.S. Geological Survey. U.S. Department of the Interior. 1998.
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4. *Envirofacts Data Warehouse.* U.S. Environmental Protection Agency. Accessed 9/1/2002. http://oaspub.epa.gov/enviro/ef_home2.water
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6. *Community Water Fluoridation: Surgeon General's Statement, 2001.* Centers for Disease Control and Prevention. Accessed 3/26/2003. http://www.cdc.gov/OralHealth/factsheets/fl-surgeon2001.htm

7. Populations Receiving Optimally Fluoridated Public Drinking Water – United States. *Morbidity and Mortality Weekly Report (MMWR).* Centers for Disease Control and Prevention. 2002; 51:07:144-7.
8. *Giardiasis.* Acute and Communicable Disease. Oregon Department of Human Services. Accessed 05/01/2002. http://www.ohd.hr.state.or.us/acd/giardiasis/index.cfm

Food Safety

Fast Facts

- Rates of illness caused by unsafe food handling have declined in both Multnomah County and Oregon since the early 1990's. However, Multnomah County has not met national objectives in reducing foodborne illness.
- Rates of Campylobacteriosis in Multnomah County have declined steadily since 1991. The rate in 2000 was 16.0 cases per 100,000 population.
- Incidence of Salmonella fluctuates and does not show a steady trend. The rate in 2000 was 11.7 cases per 100,000.
- Illness rates from E. coli are consistently lower in Multnomah County as compared to the State of Oregon. The rate in Multnomah County in 2000 was 1.7 cases per 100,000.

Problem Statement

Although the food supply in the United States is one of the safest in the world, preventing **foodborne illness** and death continues to be a major public health challenge. The CDC estimates that 76 million people get sick, more than 300,000 are hospitalized, and 5,000 Americans die each year from foodborne illness. [1]

Multnomah County Health Department performs approximately 8,000 inspections of restaurants, special events, street vendors, hotels and motels, child care centers, schools, and adult foster care settings each year. Health inspectors make sure that hot foods are hot, cold foods are cold, hand washing facilities are available and used, and raw meats are not mixed with vegetables. These practices, if improperly performed, can lead to foodborne illness.

Although foodborne illnesses are reported to the local health department, surveillance of exposure and illness is complicated. Foodborne illnesses can be severe or even fatal, yet milder cases are often not detected because individuals do not seek medical care. Further, many diseases that are transmitted through food are also spread through water or from person to person. Thus, the cause of the disease may be difficult to trace.

Foodborne Disease Outbreak: The occurrence of two or more cases of the same illness among people from different households resulting from the ingestion of the same food.

Foodborne Outbreaks

Although most foodborne illness occurs in a private or home setting, occasionally **foodborne disease outbreaks** affect large groups of people. A foodborne disease outbreak is defined as the occurrence of two or more cases of the same clinical illness among people from different households resulting from the ingestion of the same food. A food borne outbreak is an indication that there was a breakdown in the food safety system. Laboratories and clinicians are required to report incidence of foodborne illness to the Multnomah County Health Department. The Health Department then investigates the foodborne illness incident and reports the case(s) to the State Acute and Communicable Disease Office. Public

health epidemiologists investigate outbreaks to control them, and also to learn how similar outbreaks can be prevented in the future.

Outbreaks are identified through citizen complaints or surveillance data from individual counties of identifiable foodborne illnesses. Outbreak data are, however, difficult to quantify. Frequently an individual case of foodborne illness may be identified, and while the case may be part of an outbreak, the cases are not linked. While outbreaks do not represent nearly as many cases of foodborne illness as isolated cases, there is much to learn about foodborne illness from outbreaks. Incubation periods, exposure time, and specific food practices that led to the outbreak can be tracked more definitively in an outbreak than in an isolated case. Table 2 presents the number of outbreaks and the number of cases associated with an outbreak in Multnomah County as reported by the Oregon Department of Human Services. Because outbreaks are difficult to quantify, this is not a complete account of outbreaks occurring in the County.

Table 2
Multnomah County
Foodborne Illness Outbreaks

	1996	1997	1998	1999	2000	2001
Number of outbreaks	2	3	1	5	9	2
Cases associated with an outbreak	N/A	81	24	119	136	26
Rate per 100,000 population	N/A	12.7	3.7	18.4	20.6	3.9

Source: Oregon Department of Human Services, Acute and Communicable Disease Program

Campylobacteriosis: An illness caused by bacteria that lives in the intestines of healthy birds that can make people ill if ingested.

National foodborne illness surveillance data come from FoodNet, a collaboration between the CDC, the U.S. Department of Agriculture, the U.S. Food and Drug Administration, and selected state health departments that began in 1996. FoodNet collects data on laboratory-confirmed cases of foodborne illness in eight states, including Oregon. Data from 1996-2000 show Oregon third behind California and Minnesota for the highest incidence of **Campylobacteriosis** infections and second behind Minnesota for **E. coli** infections.[2] Table 3 shows that in 2000 Oregon and Multnomah County were higher than the eight state sample from 1996-2000 for Campylobacteriosis. Oregon was higher than the eight state sample for E. coli, while Multnomah County was lower; both Oregon and Multnomah County are lower for Salmonella.

Table 3
Food Borne Illness,
Rate per 100,000 population

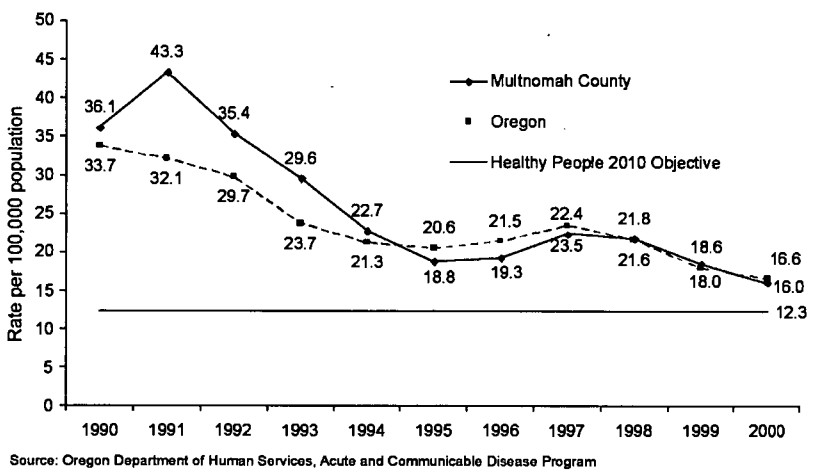
	8 State Sample 1996-2000	Oregon 2000	Multnomah County 2000
Campylobacteriosis	15.7	16.6	16.0
Salmonella	12.0	8.7	11.7
E. coli	2.9	3.9	1.7

Source: FoodNet, Centers for Disease Control and Prevention and Oregon Department of Human Services, Acute and Communicable Disease Program

Campylobacteriosis. Campylobacteriosis is one of the most frequently reported foodborne illnesses in the United States and causes fever and diarrhea. Campylobacter is the bacteria that causes Campylobacteriosis, and it lives in the intestines of healthy birds. Most raw poultry is contaminated with Campylobacter. Eating undercooked poultry, red meats or other food that has been contaminated with juices from raw poultry or red meats is the most frequent source of this infection.

Rates of Campylobacteriosis have declined in both Multnomah County and Oregon since 1991 (Figure 8). In 1991 there was a spike in the rate of Campylobacteriosis in Multnomah County due to increased screening of children with diarrheal illnesses. This screening occurred in association with a Shigella (a bacteria spread by not washing hands) outbreak in children's day care centers.

Figure 8
Campylobacteriosis Rates
Multnomah County and Oregon, 1990-2000



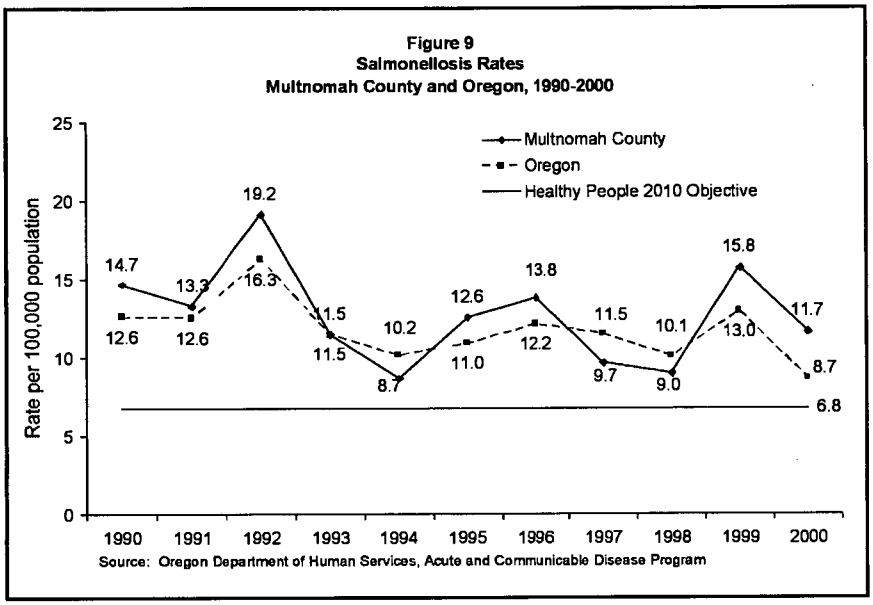
Source: Oregon Department of Human Services, Acute and Communicable Disease Program

Salmonella: Bacteria that are frequently found in birds as well as other animals.

Salmonella. **Salmonella** are bacteria that are widespread in the intestines of birds, reptiles and mammals. The bacteria can spread to humans through a variety of different foods made from animals. Salmonella can get into the blood stream and cause life-threatening infections in persons with poor health or weakened immune systems, especially the very young or elderly. Incidence of Salmonella has fluctuated throughout the 1990's. and do not show a steady trend. The rate in the County in 2000 was 11.7 cases per 100,000 (Figure 9).

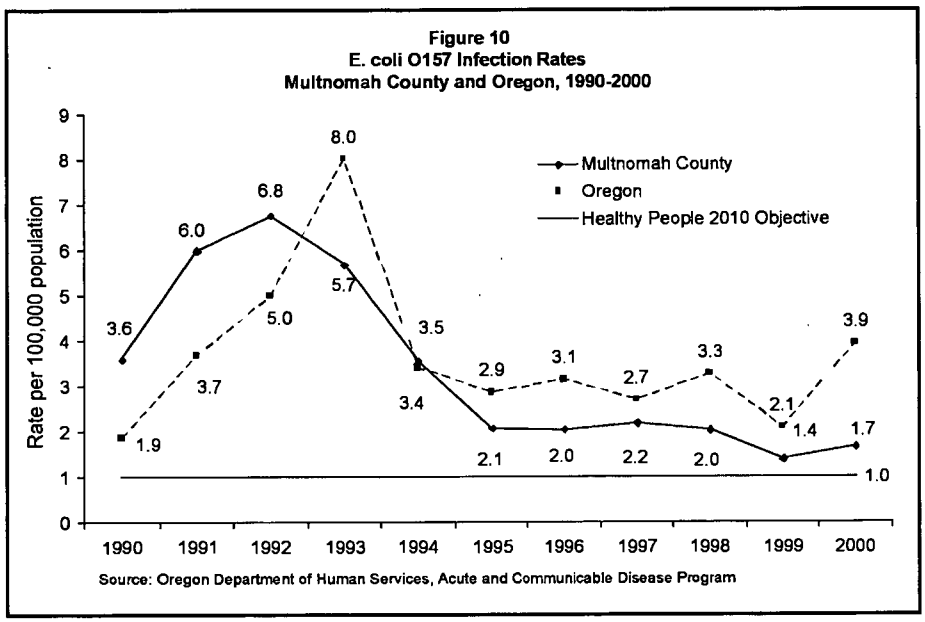
At special risk: Very young children, the elderly, and individuals with compromised immune systems are most likely to experience serious effects of foodborne illness.

E. coli. E. coli is a bacterial pathogen commonly found in cattle. Human illness typically follows consumption of food or water that has been contaminated with microscopic amounts of cow feces and can cause severe and bloody diarrhea and painful abdominal cramps, without fever. E. coli has the potential for causing kidney failure, especially in children.



E. coli:
A bacterial pathogen commonly found in cattle.

Rates of E. coli infection have steadily declined in Multnomah County since 1992 (Figure 10). The increased incidence of E. coli in the State in 1993 was due to an outbreak in three restaurants. The slight increase in the State rate of E. coli in 2000 was due to an outbreak in a restaurant in Marion County.



Health Department inspections

In order to prevent foodborne illness outbreaks, local health departments inspect food service facilities to insure they comply with food safety regulations. In Multnomah County in 2001, there were 2,922 year-round food service facilities requiring two inspections a year. Of the total number of inspections in 2001, six different facilities (0.24%) failed to comply with Oregon Food Sanitation Rules.

In 2001, there were 436 food borne related complaints to the health department, a rate of 0.654 complaints per 100,000 population.

Food handlers' certification training is required for all food service workers. In training sessions food service workers learn how to properly prepare and store food items. As of 2001, 82% of food handlers in Multnomah County had a food handlers card. There were 33,106 food handlers with a food handlers card out of 40,571 food handlers identified from inspection reports.

Fish Advisories

The State Office of Environmental Health and Systems and the Oregon Department of Environmental Quality have issued a number of fish advisories identifying elevated levels of mercury in fish caught in the Willamette River. In Oregon, including the Willamette River, most of the mercury in fish is from volcanic and geothermal mercury minerals rather than from man-made sources, unlike much of the remainder of the U.S.[4] However, human activities that release mercury include burning petroleum and coal, mining, smelting processes, pesticide applications and industrial discharges. Mercury is absorbed by plants and small animal life and when eaten by larger animals the mercury accumulates so that older and larger fish have the highest concentrations of mercury.

Although rates of illness caused by unsafe food handling have declined since the early 1990s, the County has not met national objectives in reducing rates of foodborne illness.

Mercury is poisonous to the human body when it reaches certain concentrations in specific organs. The nervous system (brain, spinal cord and nerves) appears to be the most sensitive to mercury effects. Excessive exposure can result in tremors, loss of sensation in extremities, vision and hearing loss, and developmental and behavioral abnormalities.[4]

Mercury is especially harmful to fetuses and to small children. Women of childbearing age are at special risk because of the effect the level of mercury in their body would have if they were to become pregnant. Babies and small children are at special risk because their organ systems are developing rapidly and are more vulnerable to damage. Limiting consumption of fish is the only way to protect against mercury exposure. Cleaning or cooking techniques do nothing to reduce mercury exposure. The Oregon Department of Human Services recommends the following guidelines for the consumption of fish from the Willamette River:

- Children six years of age and younger should not eat more than one 4-ounce fish meal every seven weeks;
- All women of childbearing age, including pregnant females and breastfeeding mothers, should not eat more than one 8-ounce fish meal per month; and
- Women past the age of childbearing, children older than six years and all other healthy adults may safely consume as much as one 8-ounce fish meal per week.[4]

Conclusion

Although rates of illness caused by unsafe food handling have declined in both Multnomah County and Oregon since the early 1990s, Multnomah County has not met national objectives in reducing rates of foodborne illness. To meet national objectives involves risk reduction activities by individuals, education of food processors, preparers and servers, and adherence to national food manufacturing regulations.

1. *Food Safety Office.* Centers for Disease Control and Prevention. Accessed: 6/28/2002. http://www.cdc.gov/foodsafety/
2. Preliminary FoodNet Data on the Incidence of Foodborne Illnesses: Selected Sites, United States, 2000. *Morbidity and Mortality Weekly Report (MMWR)* Centers for Disease Control and Prevention. April 6, 2001;50:13:241-6.
3. *Population estimates 2001.* Population Research Center. Portland State University. *February 3, 1997 Oregon Health Services Fact Sheet Methylmercury In Sport-caught Fish: How Does Methylmercury Affect Health?* Oregon Department of Human Services. Accessed: 3/36/03. http://www.ohd.hr.state.or.us/esc/docs/fishfact.cfm

Hazardous Waste

Fast Facts

- There are currently three Superfund sites in Multnomah County. Two additional sites are candidates for the Superfund program.
- There are currently 155 sites throughout Multnomah County with confirmed hazardous waste contamination.
- There are close to 3,000 reported or confirmed leaking underground storage tanks in Multnomah County. The vast majority are residential heating oil tanks.
- Since 1989, 143 hazardous waste sites have been cleaned up, and no longer pose an environmental or health threat. In addition, over 6,800 leaking underground storage tanks have been cleaned up over the past 20 years.
- Two Superfund sites in Multnomah County have been cleaned up and have been removed from the National Priorities List.

Hazardous Waste: Potentially harmful substances that have been released or discarded into the environment.

Problem Statement

Hazardous wastes - including acids, solvents, resins, sludge, and heavy metals - are toxic chemicals, primarily generated through commercial and industrial activity. According to the Environmental Protection Agency (EPA), over 40 million tons of hazardous waste is produced in the U.S. each year. Examples of hazardous waste producers include: large industrial facilities such as chemical manufacturers, electroplating companies, and steel mills; and more common businesses such as dry cleaners, auto repair shops, hospitals, exterminators, and photo processing centers. [1]

Long-term exposure to hazardous waste is linked to cancer as well as damage to the brain, kidneys, nervous system and fetal development.

According to a recent national survey, six in ten Americans feel that hazardous wastes pose a very serious health threat.[2] Hazardous wastes that are mishandled or spilled can contaminate the environment and can harm human health. Long-term exposure to hazardous wastes such as benzene are known to cause cancer in humans, and heavy metals such as mercury and lead can damage the brain, kidneys, the nervous system and fetal development.[3]

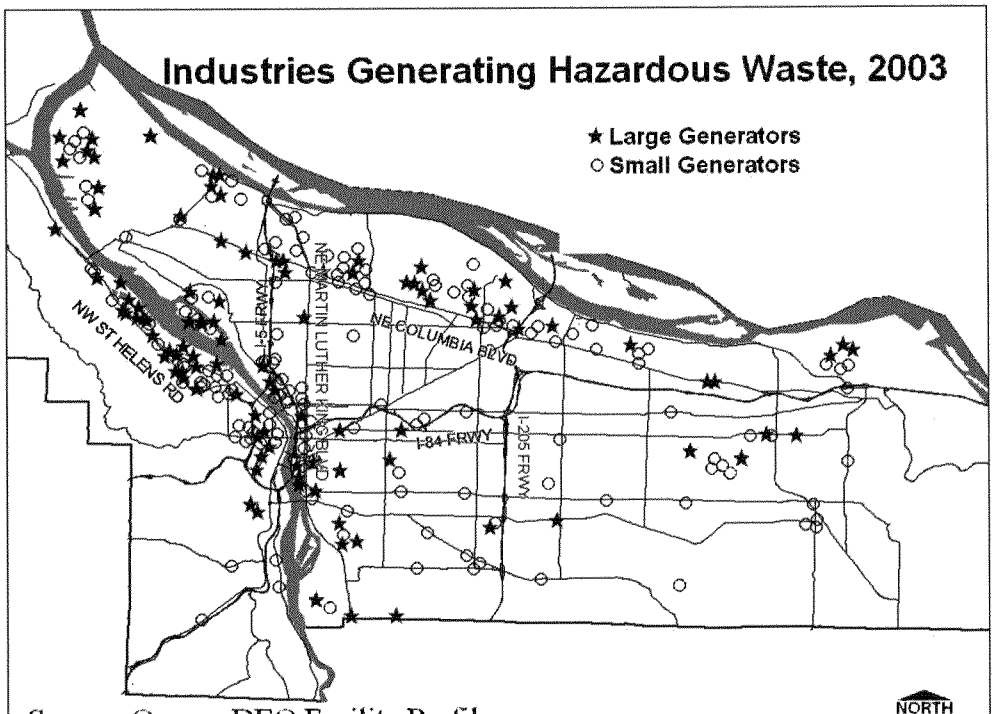
Hazardous Waste Sources and Amounts

Hazardous waste is usually thought to originate at a commercial or industrial facility, such as a dry cleaner or a factory. When industries or commercial properties do not properly contain or dispose of waste, or if a hazardous substance spill occurs, contamination of soil and water can occur. Contamination of the environment can also occur from residential properties, mostly through leaking underground storage tanks. Cleanup is essential in such cases to prevent harm to human health and the environment. Household hazardous wastes probably contribute significant amounts to the overall hazardous waste stream, but no data are currently available for Multnomah County. Such hazardous waste is not examined in this report.

Most Large and Small Quantity Generators are located in the Northwest Industrial, North, and Northeast areas of Portland.

Generators. Industries that generate hazardous waste are grouped into three separate categories, depending upon the amount they generate. **Large Quantity Generators** produce more than 2,200 pounds per month, **Small Quantity Generators** produce less than 2,200 pounds, and **Conditionally Exempt Generators** (CEGs) produce less than 100 pounds of hazardous waste. CEGs are not required to submit information on their hazardous waste. The Oregon DEQ issues permits to industries that generate hazardous waste. In 2003, there were 119 Large Quantity Generators, 160 Small Quantity Generators, and 1,162 (81% of the total) conditionally exempt generators. Most Large and Small Quantity Generators are located in the Northwest Industrial, North, and Northeast areas of Portland (see map).

Twenty of the largest 50 waste generators in Oregon are located in Multnomah County.



Source: Oregon DEQ Facility Profiler

Multnomah County has been home to five Superfund sites over the past twenty years, with cleanup completed on two sites. Superfund sites are uncontrolled or abandoned places where hazardous waste is located.

The total amount of hazardous waste generated in Multnomah County is not available. However, data are available for Large Quantity Generators. According to a 1999 report by the EPA, Oregon generated over 81,000 tons of the total 40 million tons of hazardous waste in the United States that year. Twenty of the largest 50 waste generators in Oregon are located in Multnomah County, and these twenty generated over half - 46,000 tons- of the total Oregon hazardous waste in 1999. The top five hazardous waste generators in Multnomah County generated 43,000 tons, or 53% of the Oregon total (Table 4).[4]

Table 4
Top Five Large Quantity Generators, Multnomah County

Site Name	City	Tons Generated
McCormick & Baxter Superfund Site	Portland	33,792
Oregon Steel Mills, Inc.	Portland	6,112
Reynolds Metal Co.	Troutdale	2,321
Standard Battery	Portland	425
PCC Structurals Inc.	Portland	406
Total		**43,056**

Source: EPA, 1999 National Biennial RCRA Hazardous Waste Report

A **brownfield** is any "abandoned, idled, or under-used industrial and commercial facility where expansion or redevelopment is complicated by real or perceived environmental contamination."[5]

Superfund Sites

The EPA has the authority to cleanup the most hazardous sites in the U.S., and keeps track of over 1,200 sites through the **National Priorities List** (NPL). The **Superfund** program is the cleanup funding source for the NPL. There have been 16 hazardous waste sites in Oregon that have been proposed or listed on the National Priorities List. Multnomah County has seven such sites, five of which were listed on the final NPL. Two sites have been cleaned up and have been removed from the NPL list (Table 5). Three Superfund sites in Multnomah County are currently undergoing cleanup.

Table 5
National Priorities List (Superfund) Sites, Multnomah County

Name	Location	Proposed Listing	Final Listing	Cleanup Completion	Removed from List
Allied Plating, Inc.	North Portland	1/22/87	2/21/90	6/29/93	11/14/93
East Multnomah Co. Ground Water Contam.	Gresham	5/10/93			
Gould Inc.	Northwest Portland	12/30/82	9/08/83	9/28/00	9/30/02
Harbor Oil	North Portland	9/05/02			
McCormick & Baxter Creos. Co.	North Portland	6/23/93	5/31/94		
Portland Harbor	North Portland	7/27/00	12/01/00		
Reynolds Metals Co.	Troutdale	8/23/94	12/16/94		

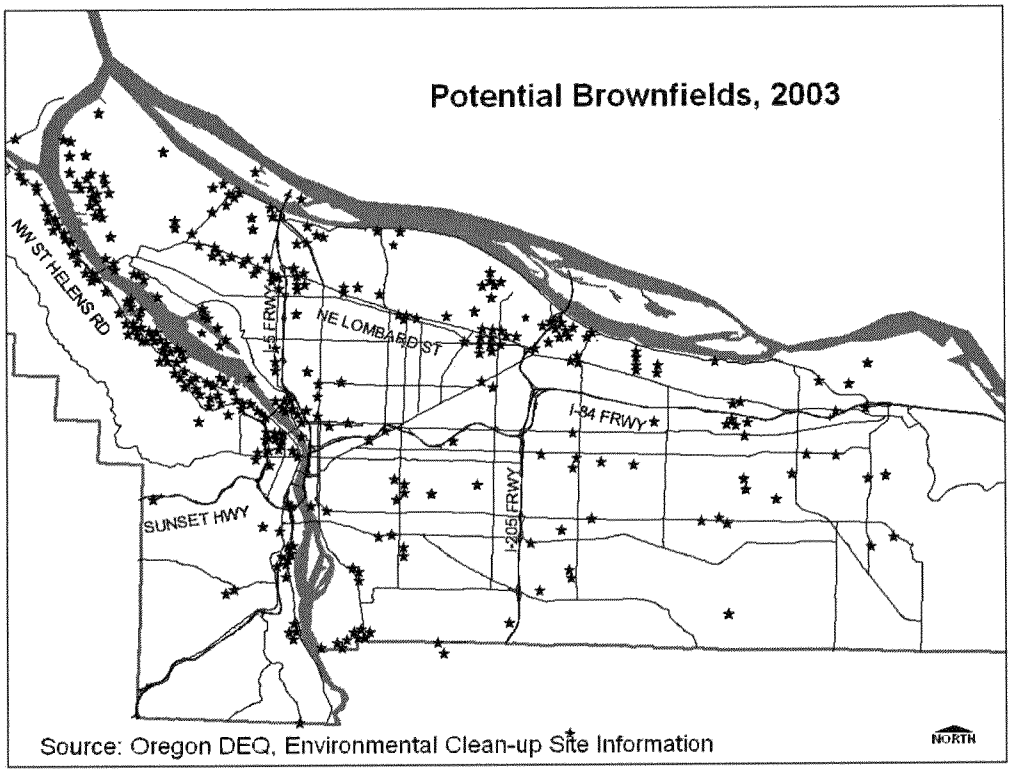
Source: U.S. Environmental Protection Agency, Oregon Department of Environmental Quality

There are currently 155 sites throughout Multnomah County with confirmed hazardous waste contamination.

Brownfields

A brownfield is any "abandoned, idled, or under-used industrial and commercial facility where expansion or redevelopment is complicated by real or perceived environmental contamination."[5] Oregon DEQ keeps track of approximately 2,900 sites throughout Oregon with suspected, confirmed or past hazardous wastes. Although the actual number of brownfields in Multnomah County is unknown, we can approximate the number using DEQ's Environmental Cleanup Site Information (ECSI) database, which tracks contaminated sites from 1989 to 2003. All sites listed, many of which are active businesses, have documented or suspected hazardous substance contamination (from solvents, metals, etc.) in soil, surface

water, groundwater, or sediments. Most sites listed were or are presently commercial or industrial properties that improperly handled hazardous wastes.[6] According to ECSI data, there are currently 155 sites in Multnomah County with confirmed hazardous wastes that may harm human health or the environment. Of these 155, 105 require further investigation and cleanup of the site. In addition, Multnomah County is home to an additional 254 sites suspected to have hazardous wastes. According to ECSI data, 143 sites have been cleaned up, and no further action is required. An examination of potential brownfields (see map) reveals that most sites are in the Northwest industrial, North and Northeast areas of Portland.



In Multnomah County, the majority of leaking underground storage tanks are heating oil tanks located at residential properties.

Leaking Underground Storage Tanks

As of March 2003, the Oregon DEQ had identified over 21,000 leaking underground storage tanks in Oregon that were reported or confirmed to be leaking hazardous wastes. In most cases, the substance was petroleum. In Multnomah County, 9,789 leaking underground storage tanks have been identified over the past 20 years, with cleanup completed on 6,837, or 70%. The vast majority of tanks – 8,344- are heating oil tanks, mostly located at residential properties. Cleanup has been completed on 82% (5,618) of heating oil tanks. About 1,400 regulated leaking storage tanks – mostly from industries and commercial businesses – have been identified, with cleanup completed on 1,165. There are close to 3,000 reported or confirmed leaking underground storage tanks in Multnomah County that have not been cleaned up. Most of these – 2,694 – are heating oil tanks, most likely located at private residences. [7]

Conclusion

There are many hazardous waste sites throughout the County - especially in Northwest Industrial, North, and Northeast Portland - that have contaminated the environment and may be posing human health risks. In many cases, health threats from hazardous waste are being reduced through state and federal programs charged with cleanup of hazardous waste sites. However, many hazardous waste sites remain. The human health impact to Multnomah County residents is unclear.

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2. Pew Charitable Trusts. Prepared by Princeton Survey Research Associates. National Survey of Public Perceptions of Environmental Health Risks: Report on the Findings. Washington, DC: Georgetown University. 2000.
3. Canada vs. the OECD: An Environmental Comparison: Hazardous Waste 2001. Organization for Economic Cooperation and Development (OECD). Accessed 04/18/2003. http://www.environmentalindicators.com.
4. National Biennial RCRA Hazardous Waste Report: Based on 1999 Data. U.S. Environmental Protection Agency: Washington, D.C. 2001.
5. Potential Brownfield Sites in Oregon from the Oregon Department of Environmental Quality's Environmental Cleanup Site Information (ECSI) and UST Cleanup Databases. Department of Environmental Quality: Portland, Oregon. 2003.
6. Frequently Asked Questions About ECSI – DEQ's Environmental Cleanup Site Information Database. Department of Environmental Quality: Portland, Oregon. 2003.
7. Oregon DEQ Facility Profiler 2.0. Oregon Department of Environmental Quality. Accessed 04/01/2003. http://deq12.deq.state.or.us/fp20/

Housing and Indoor Air Quality

Fast Facts

- In 2000, 1.1% (3,117 units) of housing stock in Multnomah County lacked complete kitchen facilities and 0.8% (2,252 units) lacked complete plumbing facilities.
- The percentage of overcrowding in renter-occupied units (8.7%) is higher than in owner-occupied units (2.9%).
- Lead-based paint is most prevalent in houses built before 1950. To a lesser extent, housing built between 1950 and 1978 may also have lead-based paint.
- There is a higher percentage of housing built in 1950 or earlier in the inner Northeast and Southeast neighborhoods.
- Radon levels in Oregon, according to the EPA, have been designated as of moderate or low concern.

Problem Statement

Adequate housing and good **indoor air quality** are important in providing a healthy environment for all individuals. People spend much of their time indoors. Some hazards associated with indoor environments include inadequate facilities, poor sanitation, **radon**, indoor tobacco smoke, and lead-based paint.

Radon is a colorless, naturally occurring, radioactive gas which in residential environments can be a potential source of illness for families. Radon has been directly linked to lung cancer and is estimated to cause thousands of deaths nationally each year.[1] Radon comes from the natural decay of uranium, which is found in the soils around a home. Radon can leak into the home through cracks or holes in the foundation.

Lead is poisonous to humans and exposure to lead can affect everyone, but it is especially dangerous for children aged six and younger.

Environmental tobacco smoke is defined as smoke given off by cigarettes, pipes, or cigars to which nonsmokers can be exposed. This type of **secondhand smoke** has been linked to many harmful and fatal diseases. Environmental tobacco smoke causes approximately 3,000 deaths each year among adult nonsmokers, serious lower respiratory tract infections and asthma among children, and has been linked to sudden infant death syndrome (SIDS) among infants.[2]

Lead is also a naturally occurring metallic element that has been mined for centuries for use in a variety of products. Lead is poisonous to humans. Exposure to lead can affect everyone, but it is especially dangerous for children aged six and younger. This is because children's developing brains and nervous systems are more sensitive to the damaging effects of lead. Lead-based paint is the most common source of lead exposure for children. Because they often put their hands and other objects in their mouths, small children are typically lead poisoned by swallowing household dust and soil contaminated with lead from old lead-based paint. The Centers for Disease Control and Prevention estimates that about half

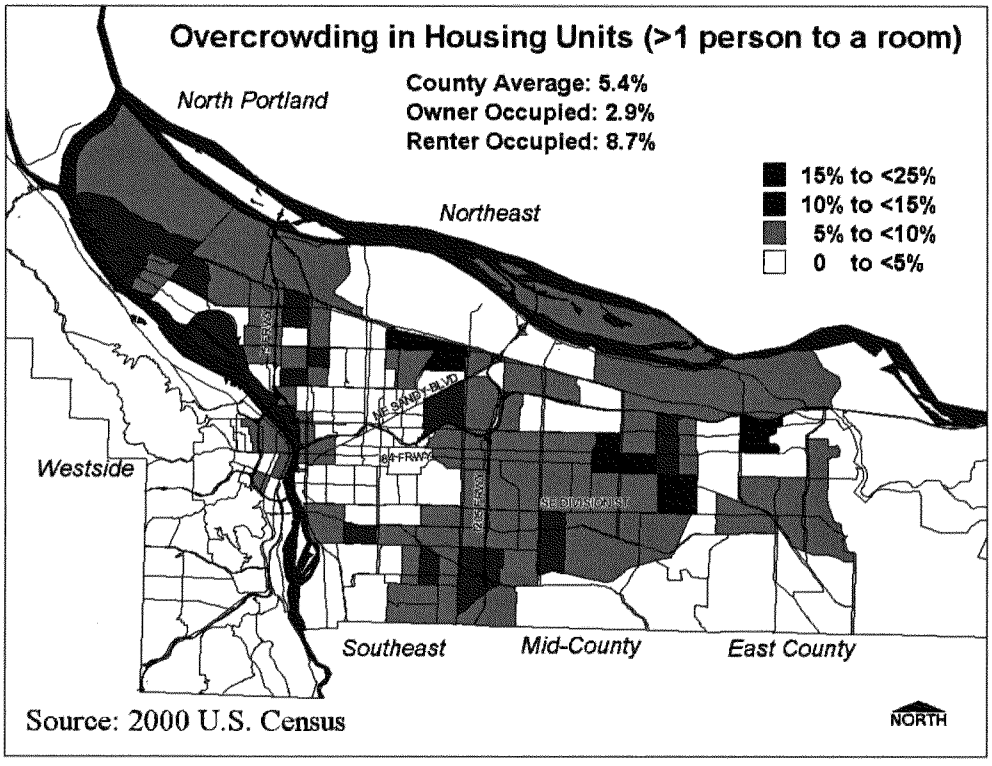
a million American children under the age of six have dangerously elevated levels of lead in their blood and that racial minority and poor children are disproportionately affected.[3]

A housing unit is considered overcrowded if it has more than one person to a room.

Inadequate Housing

Kitchen Facilities, Plumbing Facilities and Overcrowding. Data on housing quality is found in the 2000 U.S. Census. Complete kitchen facilities are defined as a sink with piped water, a range, and a refrigerator. Complete plumbing facilities are defined as hot and cold piped running water, a flush toilet, and a bathtub or shower. A housing unit is considered crowded if it has more than one person to a room.

Within the county, housing units that are considered overcrowded are primarily in North, Northeast and Mid-County. (see map)



Source: 2000 U.S. Census

In 2000, 1.1% (3,117 units) of housing stock in Multnomah County lacked complete kitchen facilities and 0.8% (2,252 units) lacked complete plumbing facilities. The percent of housing units in Multnomah County considered overcrowded is 5.4% (14,793 units). A lack of complete kitchen and plumbing facilities and overcrowding is higher among renters than among home owners. The percentage of housing without complete kitchen and plumbing facilities and those which are overcrowded is similar for Multnomah County, Oregon and the U.S. (Table 6)

Table 6
Measures of Housing Quality, 2000

	Multnomah County			Oregon	U.S.
	Owner Occupied	Renter Occupied	Total	Total	Total
Lack complete kitchen facilities	0.2%	1.9%	1.1%	1.3%	1.3%
Lack complete plumbing facilities	0.3%	1.2%	0.8%	0.9%	1.2%
Overcrowding in housing unit	2.9%	8.7%	5.4%	4.8%	5.7%

Source: Summary File 3, 2000 U.S. Census

Lead Exposure

Although testing for childhood blood lead has increased in the County, the average blood lead levels have shown a decline.

Lead Exposure Testing in Children. Children's blood lead level testing data, both public and private, is reported to the Oregon Department of Human Services Lead-Based Paint Program which provides the data on confirmed childhood lead poisoning cases. Although testing for childhood lead poisoning is available in Multnomah County, many at-risk children are never tested for lead exposure; the actual prevalence of lead poisoning in children in the County is unknown. Blood lead levels of 10 micrograms per deciliter (µg/dL) or more can adversely affect a child's intelligence, behavior and development. Testing for lead exposure in at-risk children is performed through the Multnomah County Health Department's Primary Care Clinics and Immunizations Program. In 2002, 3,184 blood lead tests were conducted through the Health Department. This number is up from 2,886 in 2001 and 1,936 in 2000. Children are also tested through private physicians and community-based screening clinics.

Testing of children through the Multnomah County Health Department indicates 1% of those children who are actually tested have confirmed elevated **blood lead levels.** The Oregon Department of Human Services, Lead-Based Paint Program tracks the number of children county-wide who have tested positive for elevated blood lead levels (Table 7). Although testing for childhood blood lead has increased in the County, the average blood lead levels have shown a decline. The Healthy People 2010 objective is to eliminate elevated blood lead levels in children age one to six.

Table 7
Confirmed Childhood Lead Poisoning Cases*, Multnomah County

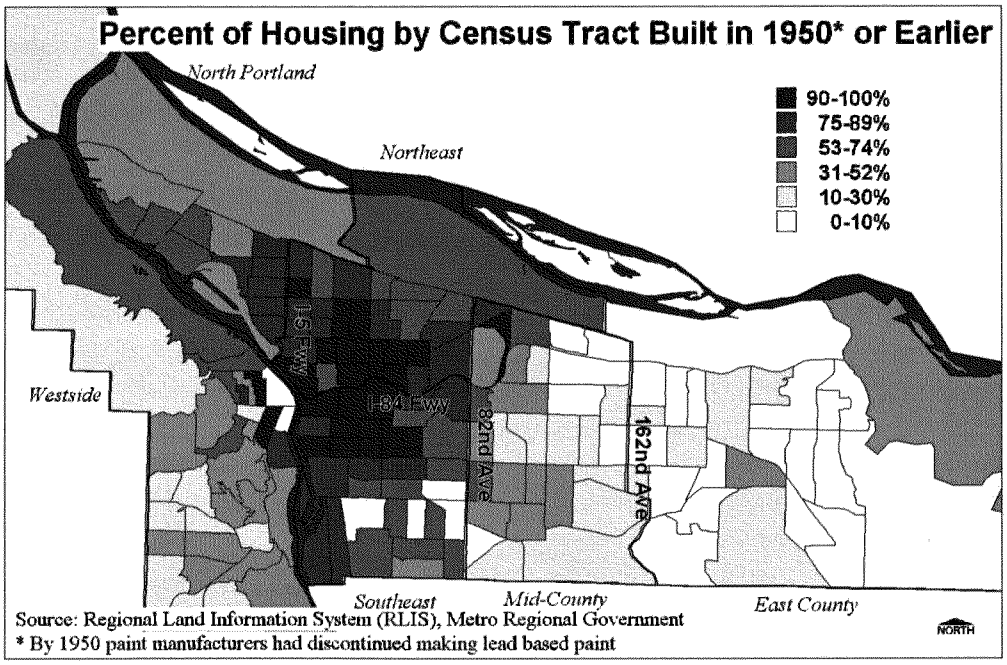
	1993	1994	1995	1996	1997	1998	1999	2000	2001
≥10_g/dL	94	90	63	49	39	58	56	64	44
≥15_g/dL	32	31	20	18	13	21	20	19	17

Source: Oregon Department of Human Services, Lead-Based Paint Program
*70% of the cases were determined to be caused by leaded house paint

Lead-based paint in housing. Lead-based paint is most prevalent in houses built before 1950. To a lesser extent, housing built between 1950 and 1978 may also have lead-based paint. By the early 1950's most paint manufacturers had discontinued producing lead-based paint. However, it was not until 1978 that a ban on manufacturing lead-based paint was enacted. According to the 2000 U.S. Census, 40% of Multnomah County's housing units were built before 1950 and 79.6% were built in 1979 or earlier.

The map below shows the percent of housing built in 1950 or earlier by census tract. In inner Northeast and Southeast neighborhoods there is a higher percentage of housing built in 1950 or earlier.

A February 2001 Multnomah County Health Department (MCHD) study looked at the prevalence of **household lead dust** hazards in North, Northeast and Southeast Portland housing built before 1930. It was found that 71% of homes in the study had lead dust levels that exceeded federal standards. It is important to note also that, at the time the study was conducted, the federal standards were 50% less stringent than they are today. The Healthy People 2010 objective recommends that 50% of people living in pre-1950s housing have their housing tested for the presence of lead-based paint.



Source: Regional Land Information System (RLIS), Metro Regional Government
* By 1950 paint manufacturers had discontinued making lead based paint

MCHD provides environmental lead investigations in those homes where a child has been identified with a confirmed blood lead level of 15 ug/dL or higher. The investigation is designed to assist the family in determining the source or sources of lead exposure, to make recommendations for exposure prevention, and

to identify resources available to the family for lead hazard reduction. MCHD also provides educational materials and resource referrals to families whose children are confirmed at 10 – 14 ug/dL or are unconfirmed at levels of 10 ug/dL or higher. The Health Department, in partnership with the City of Portland, provides lead poisoning prevention education, information, and referral to appropriate assistance programs through the LeadLine.

While childhood blood lead testing in Oregon has increased by approximately 44% between 1999 and 2001, average blood lead levels have shown a decline. However, there are still many at-risk children living in the County who are never tested for lead. Less than 5% of children less than 6 years of age are tested for blood lead.[4] Therefore, the actual prevalence of childhood lead poisoning in the County is unknown.

Indoor Air

Radon. Radon levels in Oregon, according to the EPA, have been designated as of moderate or low concern on a scale from low to moderate to high.[5] The EPA has designated Multnomah County of "Moderate Potential" for radon exposure. This means that the average radon measurements for homes in the region should be in the range of two to four picocuries per liter (pCi/L). Data available from Oregon Department of Human Services, Oregon State Radiation Protection Services show radon levels are within such a range. Of 998 homes tested in Multnomah County, the average level of radon was 3.1 pCi/liter. This is higher than the national average indoor radon level of 1.3 (pCi/L). There were 253 homes (25%) in Multnomah County which tested higher than 4 pCi/liter.[6] The Healthy People 2010 objective is to assure that 20% of the population live in homes that have been tested for radon concentrations and that there is an increase in the number of new homes constructed to be radon resistant.

Environmental Tobacco Smoke. Secondhand smoke has been linked to many harmful and fatal diseases. Children are especially vulnerable, and it has been estimated that 43% of those two months to 10 years live in a home where a tobacco smoker is present. Furthermore, 37% of adults lived in a home with at least one smoker.[7] An analysis by Oregon Public Health Services indicates that 24% of adults in Multnomah County are tobacco smokers. It has also been estimated that in a typical week, 28% of County residents are exposed to secondhand smoke and indoor air housing quality in Multnomah is generally good.[8]

Conclusion

Housing and indoor air quality in Multnomah County is generally good. Renter-occupied housing units have a higher percentage of a lack of complete kitchen and plumbing facilities and a higher percentage of overcrowding than owner-occupied housing. Potential exposure to radon has been deemed moderate for Multnomah County. Exposure to environmental tobacco smoke is of concern for

young children when there is a tobacco smoker in the home. While testing of childhood blood lead levels has increased, the incidence of lead poisoning has decreased. However, less than 5% of children recommended for testing are receiving blood lead testing.

1. *Indoor Air – Radon. A Citizen's Guide to Radon: The Guide to Protecting Yourself and Your Family From Radon (4th ed.).* U.S. Environmental Protection Agency. Accessed: 4/16/2003. http://www.epa.gov/iaq/radon/pubs/citguide.html.
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Land Use and Community Design

Fast Facts

- Community design is being increasingly viewed as a factor influencing the environmental quality and safety of cities, and may be partially responsible for the decline in physical activity and the increase in overweight and obesity among city inhabitants.
- In a 1994 Multnomah County survey, 13.6% of trips were made by walking or bicycling compared with 79% made by auto.
- While the rate of motor vehicle crash fatalities is consistently lower in Multnomah County than in Oregon and the U.S., motor vehicle accidents were the leading cause of death of Multnomah County and Oregon children age 1 to 17 years for the period 1997-2000.
- There has been a steady increase in recent years in the number of adults in Multnomah County, Oregon and the U.S. who are at risk of overweight-related health problems.
- Only one quarter of adults in Multnomah County participated in recommended physical activity of at least 30 minutes 5 times a week in 2000.
- Only 34% of 8th graders and 29% of 11th graders participated in moderate physical activity 5 times or more a week in 2001.

Problem Statement

Community design and transportation systems can significantly impact the lifestyle and personal health of individuals.

Understanding the environmental consequences of how we build our cities is an important public health issue. Community design and transportation systems can significantly impact the lifestyle and personal health of individuals. Up to twice as many people may walk or cycle in neighborhoods that have good public transportation than in neighborhoods that are designed for automobile use.[3] In neighborhoods with square city blocks, people walk up to three times more than in neighborhoods with cul-de-sacs or other features that keep streets from connecting.[3] Directly related to this is **physical activity**, which is one of the key elements in maintaining personal health. A 1996 surgeon general report concluded that a **sedentary lifestyle** is a primary factor in more than 200,000 deaths each year.[1] Cardiovascular disease, diabetes, hypertension, obesity and osteoporosis are linked to a sedentary lifestyle. At least one-third of all cancers are attributable to poor diet, physical inactivity, and being overweight.[2] In Multnomah County planners in the areas of transportation, land use design and public health are only just beginning to understand, analyze and evaluate the environmental and health impacts of the built environment.

Transportation

North Americans are much more likely to use a car for transportation than are Europeans. In 1996, for example, the car was the mode of transportation for 84% of all U.S. trips in urban areas compared to 36% of all trips within urban

areas in Sweden.[3] In the U.S., 25% of all trips made are less than one mile, and 75% of these trips are made with a car.[1]

Although auto use for commuting to work is high within Multnomah County, it is lower than auto use for commuting to work in the State and nationally. Multnomah County has a well-developed transit system, along with pedestrian and bicycle advocacy groups that promote walking and biking. Data on commuting patterns can be found in the 2000 U.S. Census. The data are based on the long form questionnaire which was distributed to 1 in 6 American households during 1999. The census reports that walking, bicycling or other means (scooters, skateboards, roller blades etc.) comprise 7 percent of work commute trips in Multnomah County compared to 4.1 percent of work commute trips nationwide (Table 8).

Table 8 shows Multnomah County has a higher percentage of commute trips for work made by single drivers than San Francisco County (principal city – San Francisco) but lower than Pierce County, Washington (principal city – Tacoma). San Francisco County has two and a half times the percentage of work commute trips by public transit and twice the percentage of trips by walking than Multnomah County. Compared to the Nation, Multnomah County has twice the number of work commute trips made by public transit and four times the percent of trips by bicycle.

Table 8
Commuting Patterns, Multnomah County and Select Counties, 2000

Work Commute Trips	Auto Alone	Auto Carpool	Public Transit	Walk	Bicycle	Motorcycle /Other	Work at home
San Francisco County, CA	41.1%	9.3%	32.1%	8.8%	1.8%	2.1%	4.8%
Multnomah County	65.2%	12.2%	11.9%	3.9%	1.9%	0.9%	4.2%
Pierce County, WA	77.8%	12.2%	3.5%	1.3%	0.7%	0.8%	3.6%
Oregon	73.6%	12.6%	3.8%	3.2%	1.2%	0.8%	4.5%
United States	75.7%	12.2%	5.2%	2.7%	0.4%	1.0%	3.2%

Source: 2000 U.S. Census Supplementary Survey

San Francisco, California and Pierce County, Washington were identified as peer counties to Multnomah County by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. Peer counties are based on population composition and selected demographics and can be used to compare differences in a community's health.

People who live in areas with **mixed use development** and good access to transit (bus, streetcar, light rail) are more likely to use alternative transportation. Mixed use development is land use development in which there are multiple uses in the

Mixed use development is land use development in which there are multiple uses- residential, commercial, light industrial- in the same development.

same development; this includes a commingling of residential, retail, commercial, light industrial, entertainment, and institutional development. In 1994, the Metro Regional Government surveyed 6,000 households in Clackamas, Multnomah, Washington and Clark Counties on their travel behavior. Households kept a two-day diary of activities and tracked how they traveled to those activities. The survey showed that areas with good transit and mixed-use development had a higher percentage of trips by walking or biking than did areas with good transit access and single use development (Table 9). Increasing physical activity through walking and biking as alternative forms of transportation can be supported through land use development and transportation design. The Healthy People 2010 objective is to increase the proportion of trips made by walking for adults by 25% and for children (age 5 to 15 years) by 50%. The objective to increase the proportion of trips made by bicycling is 2% for adults and 5% for children.

Table 9
Travel Behavior Survey Results (for all trip purposes), Multnomah County, 1994

All Trips	Auto	Transit	Walk	Bicycle	Other
Good Transit/ Mixed use	58.1%	11.5%	27.0%	1.9%	1.5%
Good Transit Only	74.4%	7.9%	15. 2%	1.4%	1.1%
All Land Use Types	79.0%	4.9%	12.0%	1.6%	2.5%

Source: Metro Regional Framework Plan, 1997

Motor Vehicle Accidents

In Multnomah County and the nation, the leading cause of unintentional injuries is motor vehicle accidents.

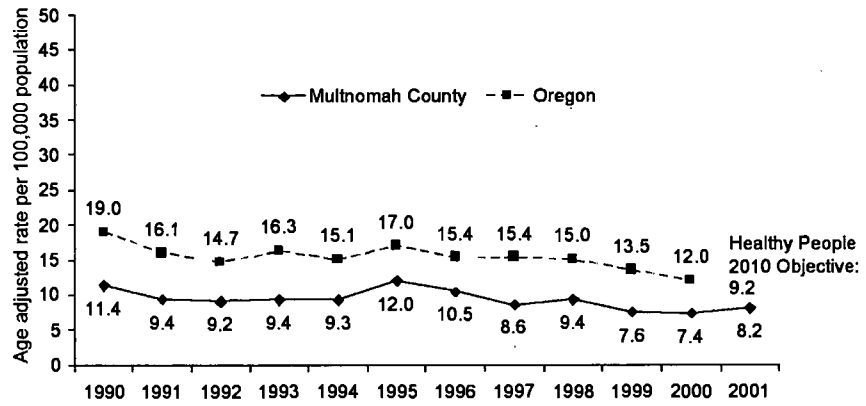
In Multnomah County and the Nation, the leading cause of unintentional injuries is motor vehicle accidents. Public health efforts to prevent motor vehicle injuries have been highly successful. According to the National Center for Injury Prevention and Control, 240,000 lives were saved between 1966 and 1990 because of improved motor-vehicle and highway design, increased use of safety belts and motorcycle helmets, and enforcement of laws regarding driving under the influence of alcohol and speeding.[4]

Most unintentional injury deaths are preventable. Compared to the United States, Oregon has a high motor vehicle safety restraint use, with 91% of adults and 69% of children aged 0-4 using safety restraints.[5] A new "booster seat" law became effective in Oregon on January 1, 2002 and requires drivers to use approved booster seats for children aged 4-6 years or 40-60 pounds.

Motor vehicle traffic deaths. Data on motor vehicle traffic deaths comes from Oregon Department of Human Services vital statistics records, which are maintained and reported by the Center for Health Statistics. The rate of motor vehicle traffic deaths in Oregon has declined since 1995. Multnomah County is

consistently lower in motor vehicle traffic deaths than Oregon and has met the Healthy People 2010 objective (Figure 11).

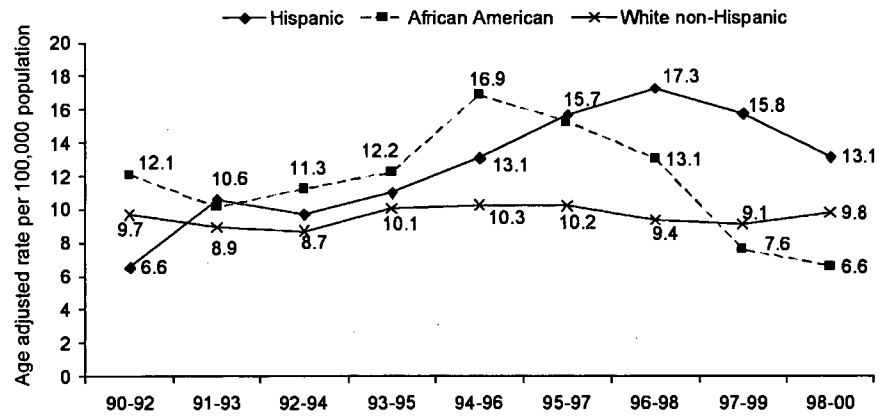
Figure 11
Motor Vehicle Traffic Death Rate, Multnomah County and Oregon



Source: Oregon Dept. of Human Services, Center for Health Statistics
NCHS comparability ratio applied to 1990-1998 data

Motor vehicle-related deaths. Motor vehicle-related deaths include both traffic and non-traffic deaths. Traffic accidents are accidents occurring on a public trafficway, while non-traffic accidents are vehicle-related accidents occurring any place other than a public trafficway. Motor vehicle-related deaths among the Hispanic population increased in the early 1990's, but have decreased in recent years; such deaths among Hispanics are still higher than other racial and ethnic groups (Figure 12). The rates for African American and Asians have decreased, while the rates for White non-Hispanic have remained relatively steady. There were too few American Indian motor vehicle-related deaths to calculate rates.

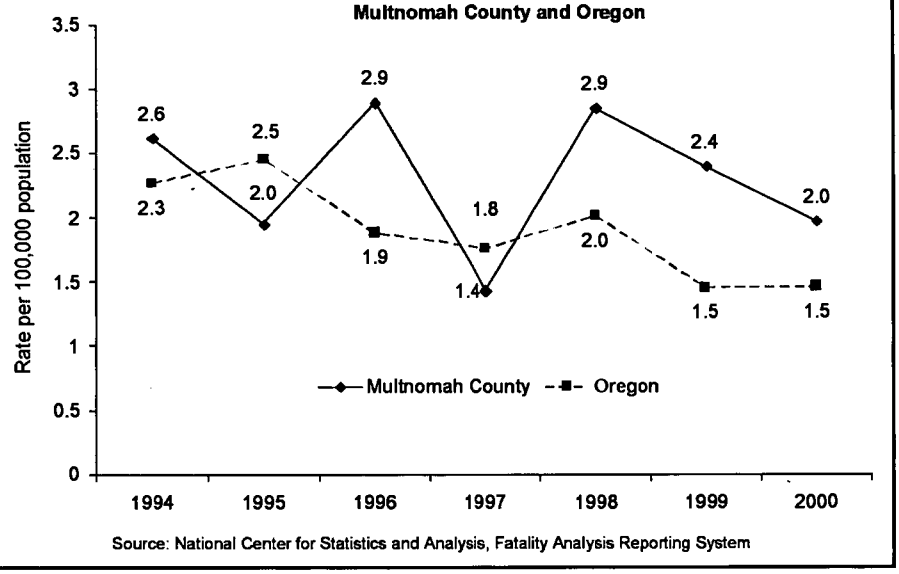
Figure 12
Motor Vehicle Related Deaths by Race/Ethnicity, Multnomah County



Source: Oregon Human Services, Center for Health Statistics
NCHS comparability ratio applied to 90-98 data.

Pedestrian deaths. Pedestrian fatalities resulting from a motor vehicle traffic accident are the second-leading cause of motor vehicle-related deaths, following occupant fatalities.[6] Pedestrian fatalities are monitored by the Fatality Analysis Reporting system of the National Center for Statistics and Analysis. The Fatality Analysis Reporting system defines a fatality as a police-reported crash involving a motor vehicle in transport on a trafficway in which at least one person dies within 30 days of the crash. A crash is defined as an event that produces injury and/or property damage, involves a motor vehicle in transport, and occurs on a trafficway or while the vehicle is still in motion after running off the trafficway.[7] Although pedestrian fatality rates have declined in Multnomah County since 1998, the rate is higher than the Healthy People 2010 objective of 1.0 pedestrian deaths per 100,000 population (Figure 13).

Figure 13
Pedestrian Fatality Rates
Multnomah County and Oregon



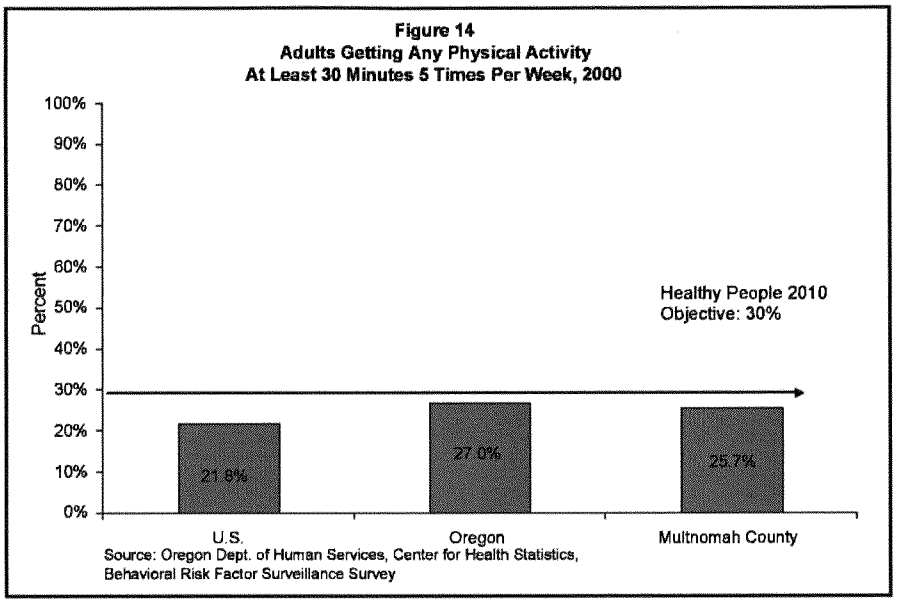
Source: National Center for Statistics and Analysis, Fatality Analysis Reporting System

In Multnomah County, only one quarter of adults participate in regular physical activity.

Physical Activity

The design of the built environment can determine the ease of walking and biking and can have an effect on the amount of physical activity people engage in.

Physical Activity in Adults. The Behavioral Risk Factor Surveillance Survey (BRFSS) is a telephone health survey of adults developed by the Centers for Disease Control and Prevention and conducted at the state level. The BRFSS collects information on nutrition, activity, health status and other topics. The 2000 BRFSS reports that, in Multnomah County, one quarter of adults participate in physical activity at least 30 minutes 5 times a week (Figure 14). Although higher than the nation wide percentage, Multnomah County, does not meet the Healthy People 2010 objective.

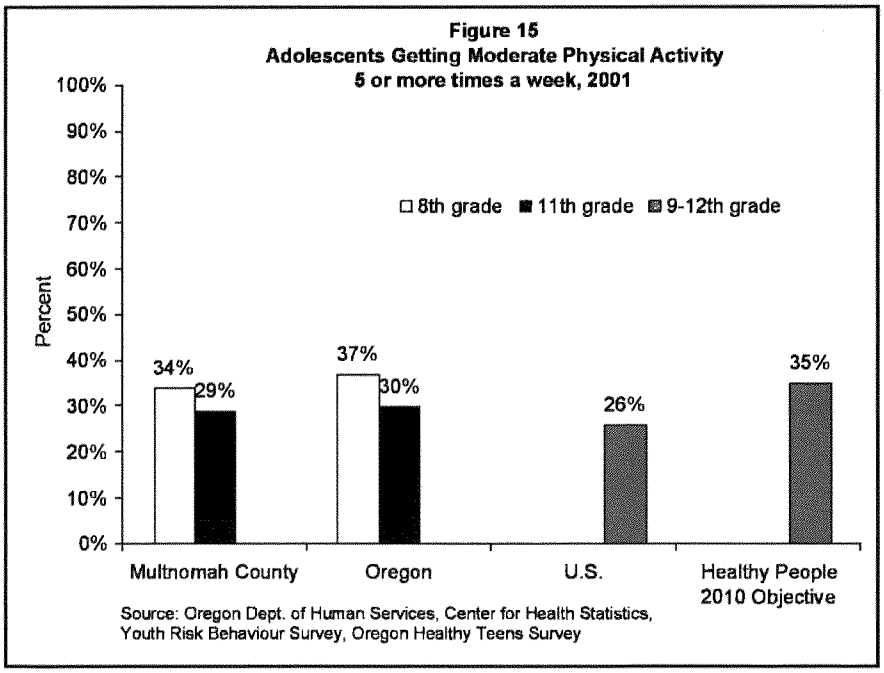


Physical Activity in Adolescents. The Youth Risk Behavior Survey (YRBS) is a voluntary health survey of 9th through 12th graders developed by the Centers for Disease Control and Prevention, and carried out every other year by the State of Oregon prior to 2001. In 2001, the Oregon Department of Human Services developed the Oregon Healthy Teens survey, a yearly survey combining the YRBS and the Student Use Survey conducted by the former Office of Alcohol and Drug Abuse Prevention. Oregon Healthy Teens reports data on 8th and 11th graders.

Moderate physical activity: Activities that use large muscle groups and are at least equivalent to brisk walking. Activities may include walking swimming, cycling, dancing, gardening and yard work.

Although the percentage of Multnomah County 8th and 11th graders participating in **moderate physical activity** for 30 minutes at least 5 days per week was somewhat higher than the national average in 2001, it did not meet the Healthy People 2010 objective and was lower than the state (Figure 15). Among the major barriers

With over half of the adult population at risk for health problems related to being overweight, Multnomah County is far from reaching the Healthy People 2010 objective of 60% of adults at a healthy weight.

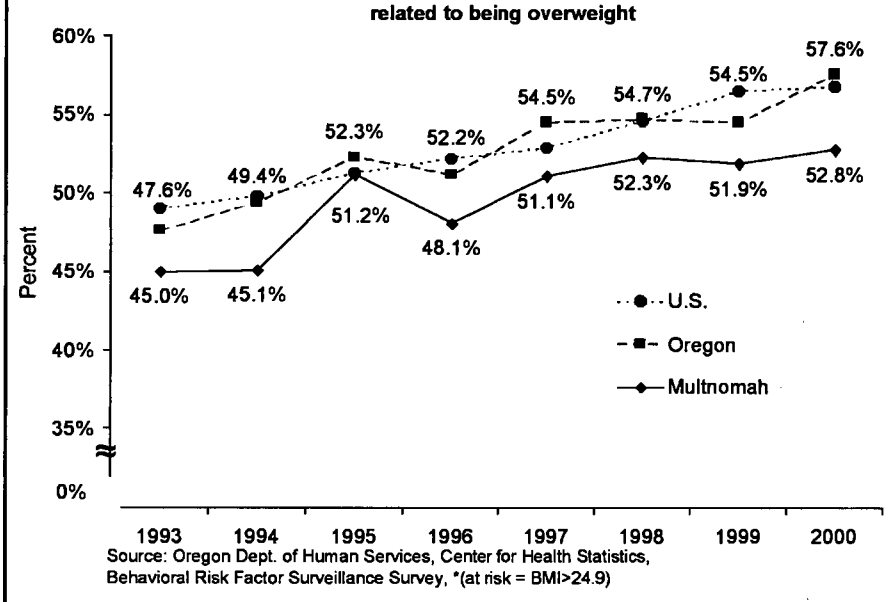


Healthy People 2010 identifies most adult and adolescent face when trying to increase phyical activity are lack of time, lack of access to convenient facilities, and lack of safe environments in which to be active.

Body Weight

Body Mass Index. **Body mass index (BMI)** is a method of estimating fitness based on a person's height and weight. There is consensus that a BMI of between 18.5 and 25 is a healthy weight range for adults (World Health Organization, National Institutes of Health, Department of Health and Human Services, U.S. Department of Agriculture). A BMI of 25 or greater can lead to health problems associated with being overweight or obese. Although the proportion of adults in Multnomah County who are at risk of health problems related to being overweight is consistently lower than Oregon and the Nation, there has been a steady increase in all population groups (Figure 16). With over half of the adult population at risk for health problems related to being overweight, Multnomah County is far from reaching the Healthy People 2010 objective of 60% of adults at a healthy weight. Among adolescents in 2001, 8.1% of 8th graders were overweight and 7% of 11th graders were overweight. The Healthy People 2010 objective is to reduce the proportion adolescents who are overweight or obese to 5%.

Figure 16
Adults at risk* for health problems related to being overweight



Source: Oregon Dept. of Human Services, Center for Health Statistics, Behavioral Risk Factor Surveillance Survey, *(at risk = BMI>24.9)

Conclusion

Public health has an important role to play in supporting land use development, transportation design and fostering opportunities for parks and recreation - all of which promote an increase in physical activity with support of alternative forms of transportation.

While motor vehicle traffic fatalities account for the largest percentage of unintentional injury deaths in Multnomah County, the rate of motor vehicle traffic fatalities is lower than both Oregon and the U.S. Motor vehicle-related death rates of Hispanics have decreased in recent years, however, they are still higher than for White non-Hispanics.

Physical activity is important in preventing and reducing injury and illness, including many chronic diseases. In Multnomah County, adolescents are doing better than adults at meeting physical activity objectives. Although the proportion of adults in Multnomah County who are at risk of health problems related to being overweight is consistently lower than Oregon and the U.S., there has been a steady increase in all population groups. Only one quarter of adults in Multnomah County participate in physical activity at least 30 minutes 5 times a week, while 34% of 8th graders and 29% of 11th graders are getting moderate physical activity 5 times a week or more.

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4. *National Center for Injury Prevention and Control.* Centers for Disease Control and Prevention. Accessed: 4/28/03. http://www.cdc.gov/ncipc/about/about.htm.
5. Boost 'Em Before You Buckle 'Em. *CD Summary.* Oregon Department of Human Services. October 23, 2001; Vol. 50: No. 23.
6. *Safety Facts: Pedestrians 1999.* Insurance Institute for Highway Safety (IIHS). Accessed: January 7, 2000. http://www.iihs.org/safety_facts/fatality_facts/peds.htm, *Fatality Analysis Reporting System (FARS) Web-Based Encyclopedia.* National Center for Statistics and Analysis, National Highway Traffic Safety Administration. Accessed: 4/1/03. http://www-fars.nhtsa.dot.gov/terms.cfm?stateid=0&year=2001.

Occupational Health

Fast Facts

- As of July 1, 2000, most businesses, including restaurants, are required to be smoke free throughout Multnomah County.
- There were a total of 6,115 accepted work related disabling claims in Multnomah County in 2001, down from a high of 8,366 claims in 1990.

Problem Statement

Workplace injuries and illness are significant issues in the United States. There were 3.8 deaths per 100,000 workers nationally, in 2000 and nearly 4 million American workers suffered disabling injuries on the job. Work injuries cost Americans $131.2 billion in 2000.[1] This amount included the sum of lost wages, lost productivity, administrative expenses, health care, and other costs. A **work related injury** is any personal injury incurred by a worker while on or off the work site but engaged in work-related activities. Injuries include cases such as a cut, fracture, sprain, or amputation. Illnesses include both acute and chronic illnesses, such as a skin disease, respiratory disorder, or systemic poisoning.[2]

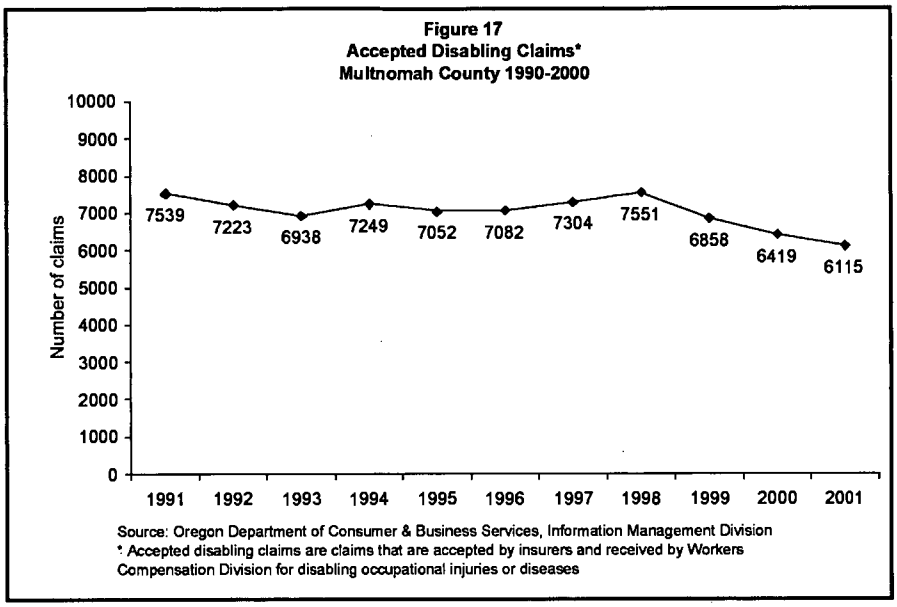
Occupational injury and illness rates drop: Nationally in 2000, occupational injury and illness rates dropped to their lowest level–6.1 injuries per 100 full time workers.

Researching and implementing effective prevention strategies to protect worker safety and health is an important public health function. In 2000, national occupational injury and illness rates dropped to their lowest level–6.1 injuries per 100 full time workers–since the data collection started. This drop continued an eight-year downward trend.[3] In Oregon the occupational injury and illness rate was 6.3 per 100 full time workers in 2000.

Work-related Injury and Fatality

Disabling claims. Disabling claims information is provided by Oregon Workers Compensation Division as reported by the Oregon Department of Consumer and Business Services, Information Management Division. There were 6,115 disabling claims accepted by workers compensation insurers in 2001 for injuries occurring in Multnomah County. There has been a decline in accepted disabling claims in both Oregon and Multnomah County in recent years (Figure 17). The decline could be due to a number of factors: declining numbers of accepted disabling claims from an expanding pool of workers; workers compensation reforms; and changes in claims handling procedures and claims management by insurers and employers. There has also been a shift in Oregon's economy, with fewer workers in the hazardous wood products industry and more workers in comparatively safer high-tech and service industries. Finally, an increased emphasis on safety and health among employers and workers may also be a factor in the decline.[4]

The majority, 81%, of all disabling claims were in one of five sectors: services, manufacturing, retail trade, transportation/public utilities and construction in



the county (Table 10). These five sectors accounted for the largest number of claims for the State in 2001.

Table 10
Disabling Claims by Sector

Sector	% Disabling Claims 2001	% Average Covered Employment* 2000
Services	22.6%	30.9%
Manufacturing	19.2%	11.4%
Retail Trade	16.3%	16.4%
Transportation/ public utilities	14.1%	7.4%
Construction	8.5%	4.8%
% of Total	**80.7%**	**70.9%**

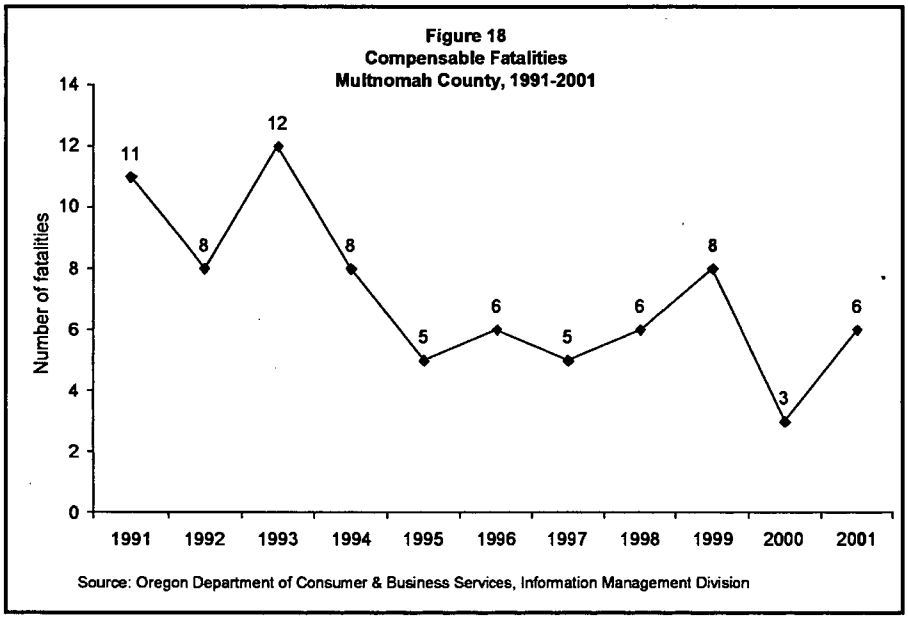
Source: Oregon Dept. of Consumer & Business Services, Information Management Division; Oregon Employment Dept. *Covered Employment refers to workers covered by unemployment insurance

The specific industries in each sector are as follows:

- Services: hotel, legal, health, educational, social, and auto.
- Manufacturing: logging, furniture, metal industries, fabrication, and industrial machinery.
- Retail trade: automotive dealers, apparel, furniture, and eating and drinking establishments.
- Transportation/public utilities: railroad, trucking, air, electric, gas and sanitary services.

While services, manufacturing, retail trade, transportation/public utility, and construction sectors make up 81% of injuries they also account for 71% of covered employment in the County in 2000. Covered employment refers to workers covered by unemployment insurance. There are twice as many claims as might be expected from the transportation/public utilities and construction sectors. Transportation/public utilities make up 7.4% of covered employment but their percent of disabling claims is 14% while construction makes up 4.8% of covered employment and 8.5% of disabling claims.

Workplace fatalities. There are very few deaths from work-related injuries in Multnomah County (Figure 18). Because the State does not calculate the total number of workers covered by workers compensation for each county, a county



fatality rate cannot be calculated. For Oregon in 2001, the rate of work related fatality was 3.1 per 100,000 workers. The U.S. rate in 2000 was 3.8 per 100,000 workers. The Healthy People 2010 objective for reducing deaths from work-related injuries is 3.2 per 100,000 workers aged 16 years and older.

Workplace Air Quality

Indoor air quality is associated with the environmental quality of a workplace. As of July 1, 2000, most businesses in Multnomah County, including restaurants, are required by county ordinance to be smoke free. The Countywide smoke free workplace ordinance exempts bars, bars in restaurants, bingo parlors, truck stops, racecourses, billiard halls, tobacco retail stores and rented hotel and motel sleeping rooms. The purpose of the ordinance is to protect workers from the known health dangers of secondhand smoke, which is classified by the EPA as a known human carcinogen. Compliance with the ordinance has been excellent. More than 47,000 businesses in Multnomah County are subject to the law. During the first year there were only 128 complaints. Most of these complaints were ameliorated by education resulting in only 19 citations. The following year, when fines were levied and implemented, there were 167 complaints resulting in only 5 citations. In 2002, a statewide smoke free workplace law went into effect on January 1. This statewide law further requires billiard halls, truck stops and racecourses in Multnomah County to be smoke free, thus enhancing smoke free workplace air quality. Efforts to promote voluntary smoke free workplace policies continue.

Conclusion

There has been a decline in accepted disabling claims in both Oregon and

Multnomah County in recent years. While the services and manufacturing sectors have the highest percentage of disabling worker claims and make up the largest percentage of covered employment in the county, transportation/public utilities and construction have twice the percentage of disabling claims as they do percentage of covered employment. As of July 1, 2000, most businesses, including restaurants, are required to be smoke free throughout the County.

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3. *Injuries, Illness, Fatalities.* U.S. Department of Labor. Bureau of Labor and Statistics. Accessed: 6/30/02. http://www.bls.gov/iif/home.htm#tables. Rate calculated (number of injuries and illness/total hours worked by all employees during the calendar year) x 200,000 base for 100 equivalent FTE.
4. Ross-Mota J. First Glance at Accepted Disabling Claims. Oregon Department of Consumer and Business Services. Information Management Division. 2001.

Outdoor Air Quality

Fast Facts

- Multnomah County has been in compliance with standards for select pollutants since 1997. By comparison, eight counties in Oregon, and 318 counties throughout the United States are not in compliance for select pollutants as of July 2002.
- Fourteen toxic outdoor air pollutants in the County exceed health-based benchmarks, with 6 pollutants more than 10 times the benchmark.
- Most of the County exceeds the federal cancer risk benchmark for toxic air pollutants, with many areas in North and Northeast Portland reaching cancer risk rates higher than 100 per million.
- Motor vehicles, especially cars, account for the vast majority of air pollutants in Multnomah County. In 1996 and 1999, they accounted for 52% of toxic air pollutants, and 77% of criteria pollutants, respectively.

Children, the elderly, and those living next to heavy traffic are especially vulnerable to diseases associated with bad air, including asthma.

Problem Statement

Air pollution can make people sick. It is estimated that up to 100,000 deaths per year in the United States are associated with air pollution.[1] Bad air has been linked to asthma, bronchitis, high blood pressure, heart disease and lung cancer.[2-5] Children, the elderly, and those living next to heavy traffic are especially vulnerable to diseases associated with bad air. One scientific study found that ground-level ozone (created mostly by vehicle exhaust) may be a contributing factor in the development of childhood asthma.[6] Cars and trucks are an important cause of air pollution. A recent study found that those living close to highways and major roads were twice as likely to die from heart and lung diseases as those who did not.[7]

According to the U.S. Environmental Protection Agency (EPA), more than 170 million tons of air pollutants are released into the air each year in the U.S., and more than 130 million people in 2001 lived in counties where air was unhealthy at times because of high levels of at least one of six principal air pollutants. Still, our air is cleaner now than in the past. Due in part to federal and state regulations designed to reduce air pollution, total emissions of select air pollutants in the U.S. between 1970 and 2001 have declined by 25%.[8]

Criteria pollutants: Carbon monoxide, ozone, nitrogen dioxide, particulate matter, sulfur dioxide, and lead. All known to be unhealthy at high levels or with prolonged exposure.

Criteria Pollutants

The federal Clean Air Act of 1970 seeks to protect people from the harmful effects of poor air quality, and calls upon the EPA to regulate air pollutants. This act sets standards for six pollutants, called **criteria pollutants**, which are known to be unhealthy at high levels or with prolonged exposure (Table 11). These criteria pollutants have very well known health effects. Exposure to such pollutants can cause respiratory and cardiovascular problems such as asthma, aggravation of heart disease, and lung cancer. Two criteria pollutants that stand out are **ozone** and

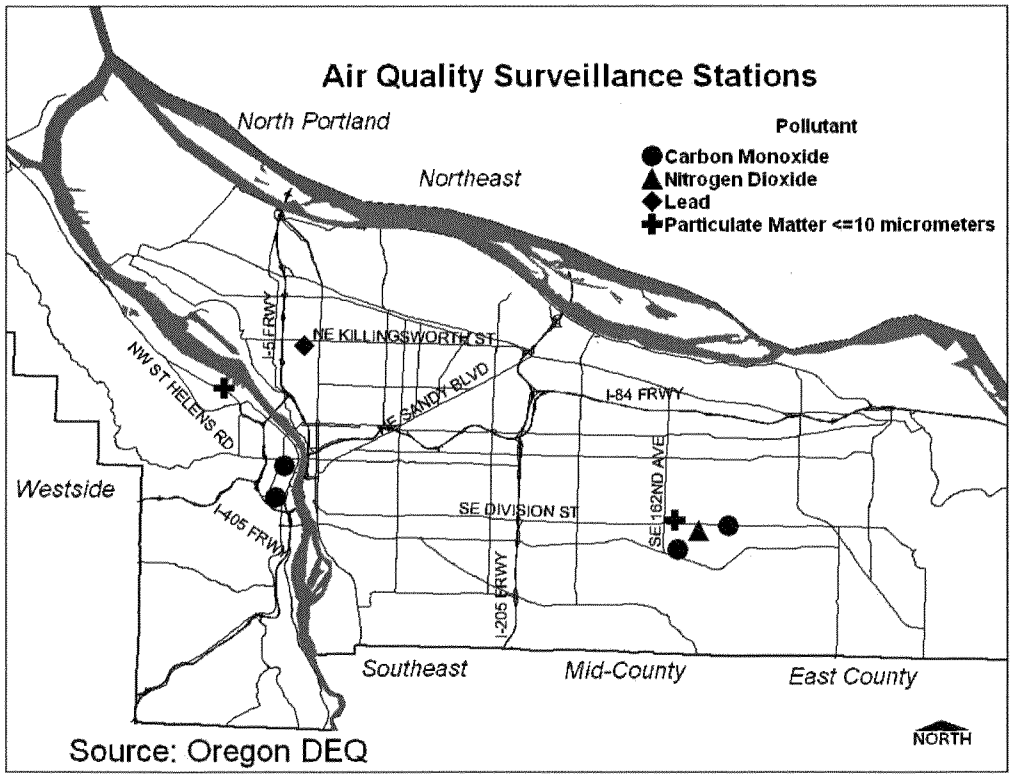
Table 11
The Six Criteria Pollutants

Pollutant	Major Sources	Health Effects
Carbon monoxide	Motor vehicles	Aggravation of cardiovascular diseases; visual impairment
Ozone	Motor vehicles, factories	Chest pain, cough, asthma
Nitrogen dioxide	Motor vehicles, power plants	Respiratory problems, and long-term respiratory infections; irreversible lung damage
Particulate matter	Motor vehicles, power plants, industrial facilities,	Heart and lung diseases; aggravation of asthma, bronchitis
Sulfur dioxide	Industrial facilities, coal-fired power plants	Respiratory problems, aggravation of cardiovascular diseases
Lead	Industrial facilities	Kidney, liver, nervous system damage; decreased IQ; high blood pressure

Source: Oregon Department of Environmental Quality

particulate matter. The vast majority of areas in the U.S. that had bad air days exceeded safe levels of one or both of these pollutants.[8]

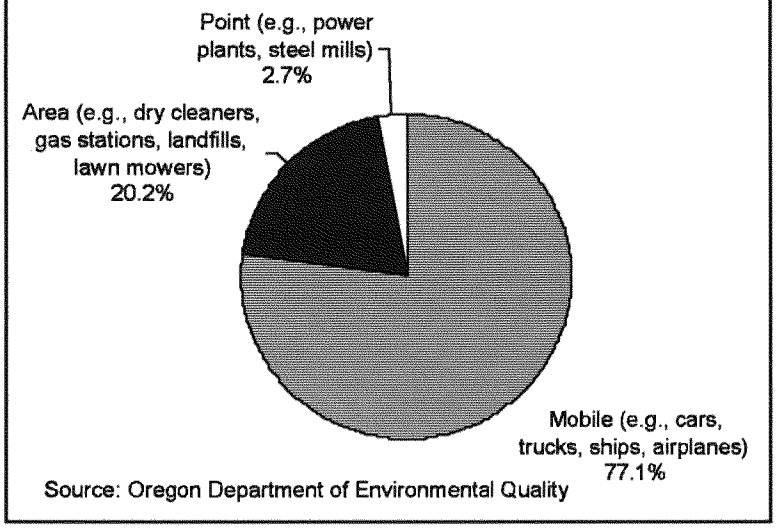
According to the Oregon State Department of Environmental Quality (DEQ), there are currently eight criteria air monitoring locations throughout Multnomah County, continually measuring levels of lead, particulate matter, carbon monoxide, and nitrogen dioxide (see map for locations).



Nonattainment areas: A locality where air pollution levels persistently exceed EPA's National Ambient Air Quality Standards.

Sources. Oregon DEQ data indicate that almost 290,000 tons of criteria air pollutants were released in Multnomah County in 1999, representing 8% of the Oregon total. Criteria air pollutants in Multnomah County are grouped into three sources, with the vast majority (77%) in 1999 – over 220,000 tons – coming from motor vehicles such as cars, trucks, ships, and airplanes. Area sources such as dry cleaners and gas stations contributed over 58,000 tons, about 20% of total criteria emissions. Point sources from industries contributed only 3% of criteria emissions, about 7,800 tons (Figure 19).

Figure 19
Sources of All Criteria Air Pollutants
Multnomah County, 1999



Source: Oregon Department of Environmental Quality

Multnomah County has acceptable levels of criteria air pollutants and has been in compliance with criteria pollutant standards since 1997.

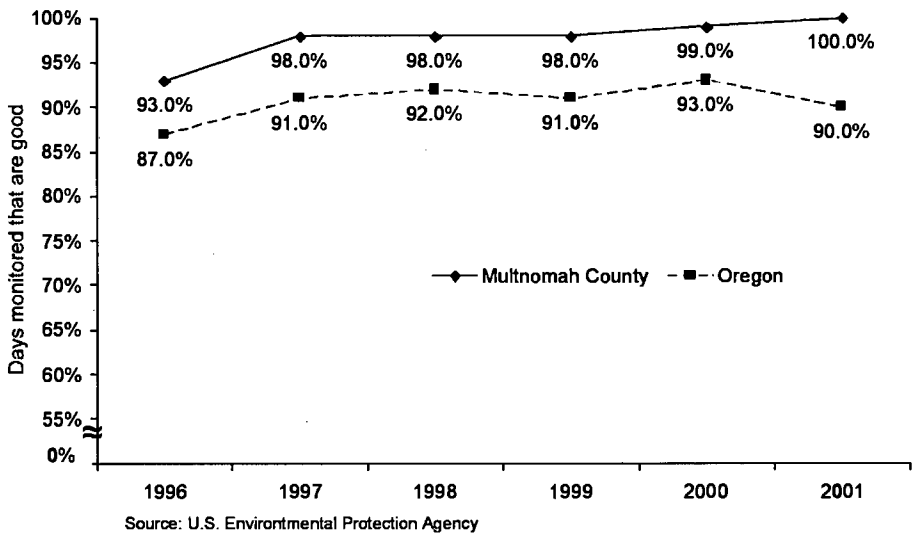
Nonattainment areas. The Oregon DEQ and the EPA closely monitor criteria pollutants, and place strict standards on their levels. As a result of violations of criteria pollutants, EPA designates counties (or parts of counties) as **nonattainment areas**. As of July 2002, Multnomah County had acceptable levels of criteria air pollutants and has been in compliance with criteria pollutant standards since 1997. The County, therefore, meets national Healthy People 2010 objective for criteria air pollutants (the objective is that no residents should breathe criteria air pollutants above the EPA standard). Eight counties in Oregon have a nonattainment designation in parts of their counties, mostly for violations of particulate matter levels. Six counties in Oregon are designated as nonattainment counties due to violations of particulate matter levels, and two counties are not in compliance with ozone and **carbon monoxide** standards. Nationwide, more than 300 counties were designated nonattainment areas as of July 2002.

Levels of carbon monoxide, ozone, and large particulate matter have declined or not changed between 1990 and 1999 in the Portland-Vancouver area, despite significant population growth.

Air data for the Portland-Vancouver area for 1990 – 1999 indicate that levels of three of the criteria pollutants – carbon monoxide, ozone, and large particulate matter – are declining or not changing, despite significant population growth in the region. Carbon monoxide levels, for example, have declined 40% between 1990 and 1999.[9]

Air Quality Index. The **Air Quality Index** combines the criteria pollutants into one value, ranging from 0 to 500, for each day of the year. Index values below 100 are considered satisfactory, while higher values are considered unhealthy. Index values less than 50 are considered good. In 2001, 100% of days in Multnomah County were good. The number of good air days in the County has been increasing since 1996, when 93% of days monitored were good (Figure 20). Oregon's overall percentage of good days in 2001 reached 90%.

Figure 20
Oregon Air Quality Index Scores
Multnomah County and Oregon



Source: U.S. Environtmental Protection Agency

Air Toxics

Air pollutants other than criteria air pollutants are also tracked, and are called **air toxics** or **toxic air pollutants.** These pollutants are known or suspected to cause cancer, as well as respiratory, reproductive, and developmental problems. The EPA tracks 188 air toxics, with the goal of reducing or eliminating human exposure. Table 12 shows the health effects of four select air toxics.

Air toxics: 188 pollutants tracked by the EPA known or suspected to cause cancer, respiratory, reproductive and developmental problems.

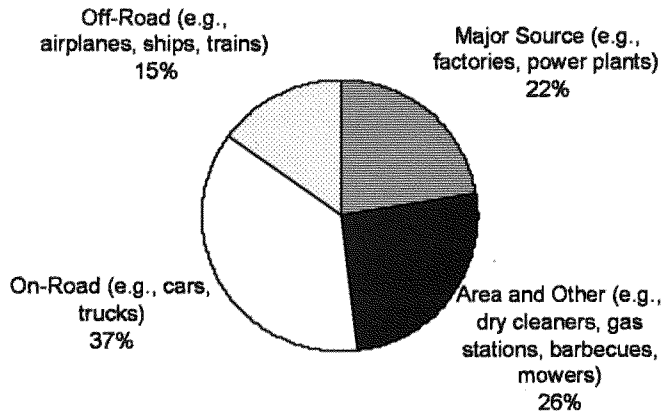
Table 12
Select Air Toxics

Pollutant	Major Sources	Health Effects
Benzene	Motor vehicle exhaust, gas fueling	Cancer, central nervous system depression
Formaldehyde	Motor vehicle exhaust, manufacturing, forest and wildfires	Cancer, respiratory damage
Acrolein	Motor vehicle exhaust, oil and coal burning, forest and wildfires	Kidney, liver, nervous system damage; decreased IQ; high blood pressure
Chloroform	Chrome plating, solid waste incineration, oil and coal burning	Cancer, central nervous system depression, liver damage

Source: Oregon Department of Environmental Quality

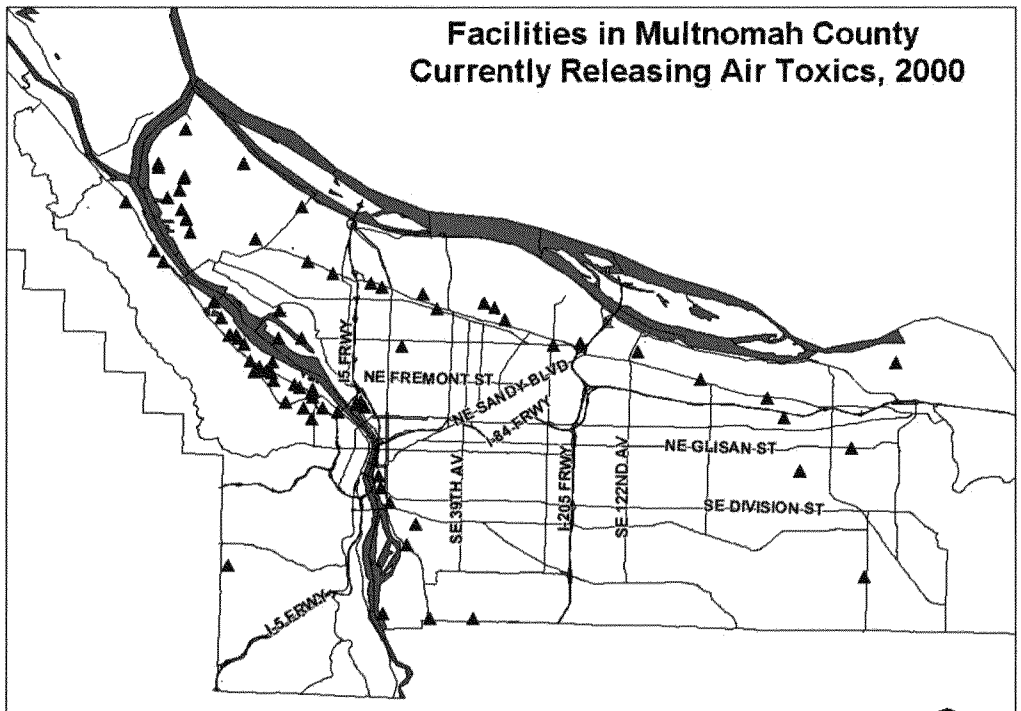
The highest percentage of air toxics in 1996 for Multnomah County comes from cars and trucks (Figure 21). Such vehicles are the cause of 37% of air toxics in Oregon.

Figure 21
Sources of Air Toxics
Multnomah County



Source: U.S. Environmental Protection Agency, National Toxics Inventory

The **National Air Toxics Assessment** (NATA) provides risk estimates of hazardous air emissions for 32 of the most dangerous air toxics, many of which are known or suspected to cause cancer. The purpose of the assessment is to measure the human health risk from exposure to these 32 air toxics. Analysis of the NATA data shows that Multnomah County released more than 2,400 tons of such air



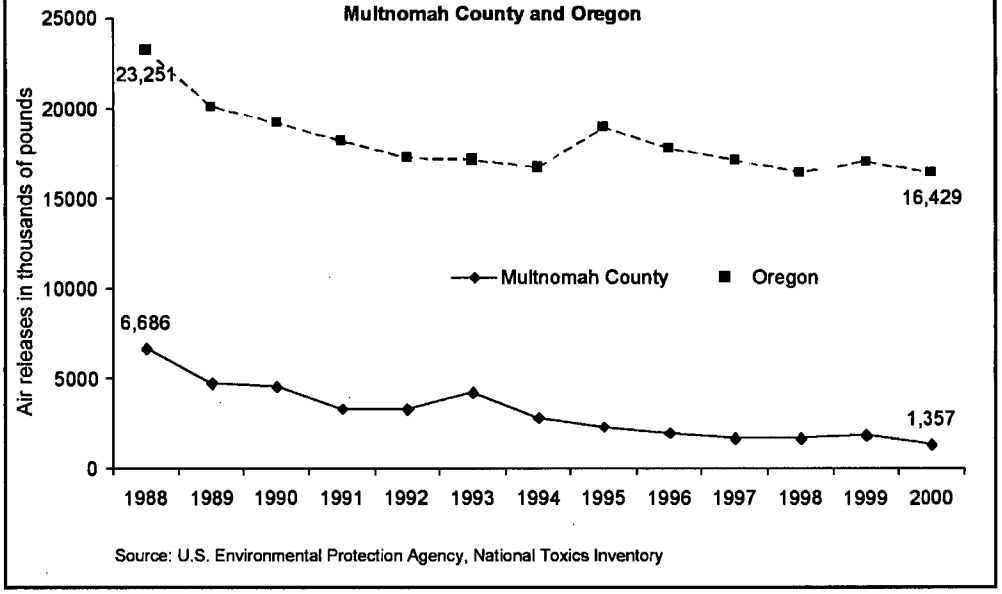
Source: EPA, Toxic Release Inventory

toxics in 1996, accounting for 11% of the Oregon total. Health risk calculations based on the NATA data are discussed in the "health effects" section below.

Industries – i.e., "major sources" – track their own air toxics on an annual basis, and report this information to the EPA. The EPA makes this information publicly available through the **Toxic Release Inventory**. The most recent available data show that 81 industrial facilities in the County released about 1.4 million pounds of air toxics in 2000.

Total air toxics from County industries have declined 80% since 1988 (Figure 22). There was a 30% decline in Oregon over the same time period (23.2 to 16.4 million pounds).

Figure 22
Industrial Air Emissions, Multnomah County and Oregon



Source: U.S. Environmental Protection Agency, National Toxics Inventory

Other Air Quality Indicators

Cars and trucks are the largest source of air pollution in the County, and programs that regulate vehicle emissions may significantly reduce air pollution. The Oregon DEQ inspects vehicles for emissions in the Portland area, and requires newer cars to be inspected every two years. The **Vehicle Inspection Program** identifies those vehicles in need of maintenance to reduce air pollutants. In the years 1998-1999, more than 130,000 vehicles (13%) failed emissions control tests in the Portland area. In 2000-2001, 158,000 vehicles (15%) failed. DEQ estimates that repairs on failed vehicles for 2000-2001 reduced air pollutants by 76 tons per day.[10]

Health-based benchmark: Federal Clean Air Act guidelines based on a one in a million cancer risk for a specific air pollutant.

Another indicator of air quality is the number of outdoor air complaints by citizens of Multnomah County. The Oregon DEQ tracks such complaints. From 1997 to 2001, outdoor air complaints declined from 545 to 449. Such complaints peaked in 2000, at 784, a 100% increase from the previous year.[11]

Health Effects of Air Pollution

Researchers throughout the world have shown that air pollution has many negative health effects. Although limited, available health indicators for the County may highlight possible areas of concern. There is evidence to indicate that non-whites and the poor are disproportionately affected by air pollutants [12], and such disparities will be discussed where data are available for Multnomah County.

*14 air toxics in the Northwest region of Oregon have been estimated to exceed **health-based benchmarks.***

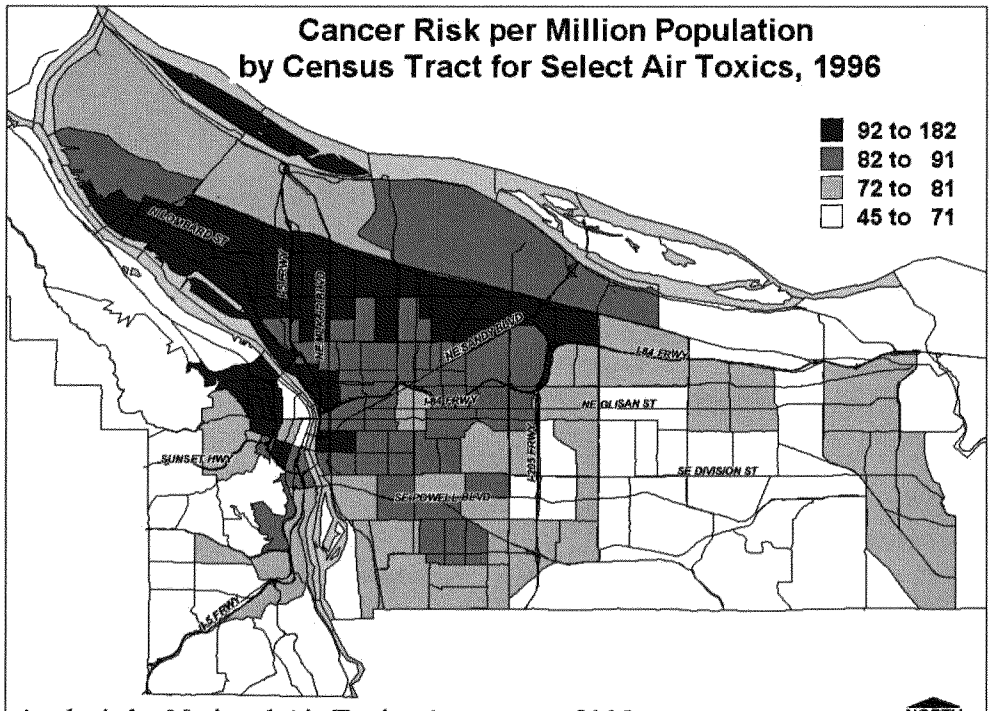
Air Toxics. Air quality data with the clearest link to human health for Multnomah County is found in the National Air Toxics Assessment (NATA). The assessment was conducted with 1996 data; it is unclear how current air toxics levels have changed since that time. Also, such risk estimates do not reflect exposures and risks from all compounds (for example, diesel) and may underestimate human risk from air toxics. Nonetheless, these data are the only know estimates available summarizing risks to air toxics.

Of the 14 air toxics exceeding health based benchmarks - six are more than 10 times the benchmark and four of these can be traced to motor vehicle emissions.

An examination of these data by the Oregon DEQ shows that 14 air toxics in the Northwest region of Oregon have been estimated to exceed **health-based benchmarks** (benchmarks are guidelines for safe levels). Multnomah is the only County in the region to exceed benchmarks for all 14 pollutants. In addition, emission levels in Multnomah County for six pollutants, including **benzene**, **chromium** and **chloroform**, are more than 10 times the benchmark. Four of these six pollutants can be traced mostly to motor vehicles such as cars, trucks, and airplanes.[13]

NATA also examines the cancer risk from air toxics. An analysis of 1996 emissions

Many areas in North and Northeast Portland have a higher cancer risk due to air toxics.

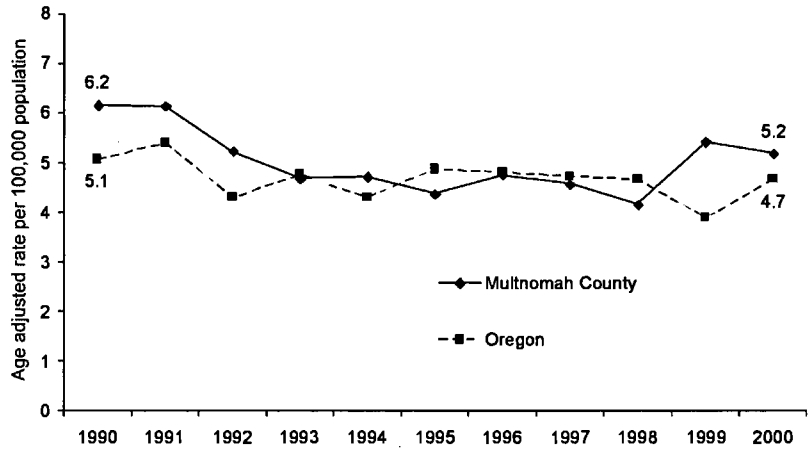


Analysis by National Air Toxics Assessment, 2002

data released in 2002, shows that for 33 of the most dangerous air toxics, the median cancer risk for Multnomah County residents – 82 in a million – is twice that for all Oregon residents (39 in a million). The national rate is 45 in a million. All areas of the County examined exceed the health-protective guideline for air toxics established under the Clean Air Act of a one in one million cancer risk. Furthermore, the cancer risk to Multnomah County residents varies based on where they live. Many areas in North and Northeast Portland have a higher cancer risk due to air toxics. Several census tracts in North and Northeast Portland have a cancer risk rate more than 100 per million. The highest cancer risk rate exists in an area in North Portland (180 per million), and is 4 times the rate for the lowest cancer risk rate in the County (46 in a million). As non-whites and those in poverty live in higher proportions in North and Northeast Portland, it is possible that racial minorities and the poor are more severely impacted by air toxics than other County residents. (see map)

Hospitalizations and Mortality. Air pollutants have been shown to cause hospitalizations and deaths, especially for diseases of the respiratory and circulatory systems. Of particular concern are air pollutants — such as particulate matter and benzene — which are associated with lung cancer. Available data show no indication that air pollution in the County is increasing hospitalizations or death rates for lung cancer. There were more than 330 non-smoking lung cancer deaths in Multnomah County between 1990 and 2000, and the rate declined 16% from 1990 to 2000 (Figure 23). There was no indication in the data of health disparities by ethnicity and race. Nonetheless, the risk for cancer from air toxics is highest in the most diverse areas of the County.

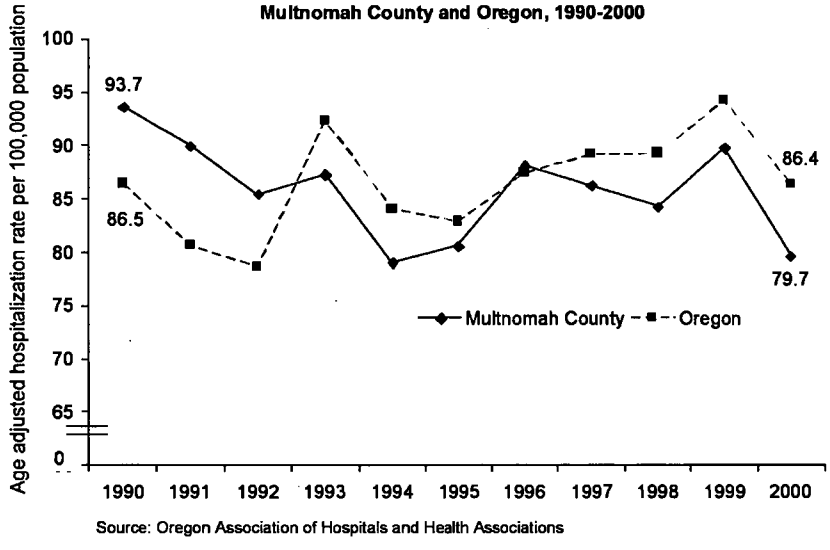
Figure 23
Non-Smoking Lung Cancer Death Rates
Multnomah County and Oregon, 1990-2000



Source: Oregon Dept. of Human Services, Center for Health Statistics

The rate of hospitalization for respiratory diseases in the County remained unchanged between 1990 and 2000 (Figure 24), while hospitalization rates for circulatory diseases declined 21% in the same period. Hospitalization data are not available by ethnicity and race, so health disparities are not explored.

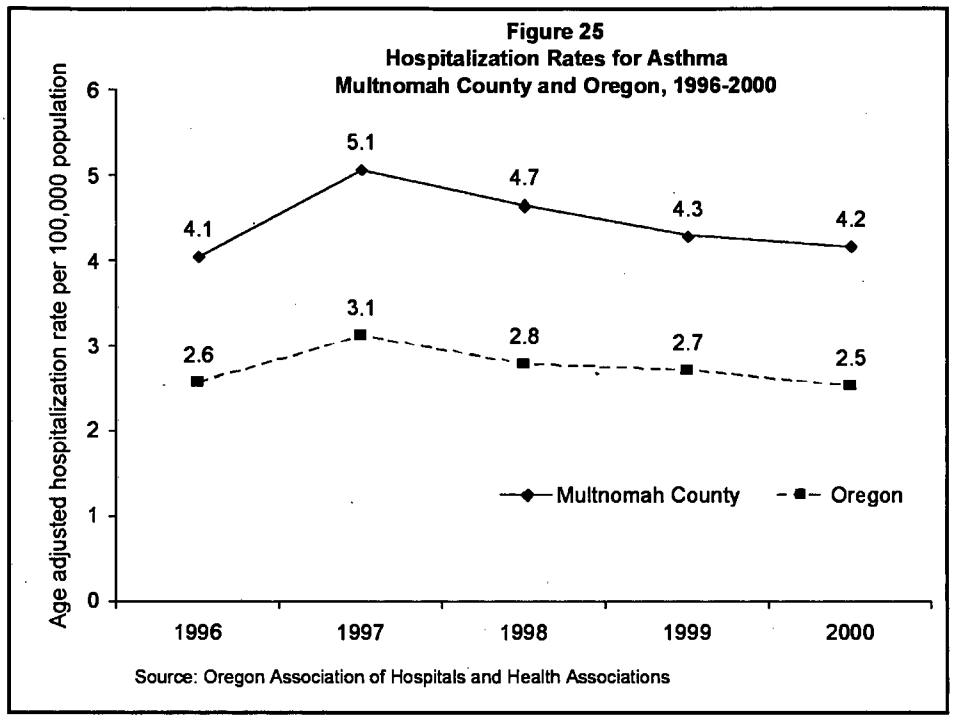
Figure 24
Hospitalization Rate for All Respiratory Diseases
Multnomah County and Oregon, 1990-2000



Source: Oregon Association of Hospitals and Health Associations

Asthma. Researchers have found evidence linking air pollution to asthma attacks, and some research indicates that air pollution can cause the development of asthma. Asthma affects more than 4.8 million U.S. children (7.5%), making it the most common serious and chronic disease among children. Asthma affects racial and ethnic minorities more than whites. It is estimated that asthma is 26% more prevalent in African American children than in White children.[14] In Multnomah County, an estimated 7% of children, and 9% of adults had asthma in 2000. There is some evidence to indicate that asthma rates are higher in areas of Multnomah County with poorer air quality. The Portland Neighborhood Survey - a recent survey of residents near the Northeast I-5 corridor in Portland (where NATA data shows that air toxics are emitted in higher concentrations) - has found that asthma rates are twice that of Multnomah County, Oregon (7.7%), and the Nation. Although these data should be viewed with caution due to small sample size, the survey found that 14.4% of residents had asthma. Nearly 50% of those reporting asthma in the survey were African American, possibly indicating that asthma rates for African Americans are higher in this area.[15]

According to data obtained from the Oregon Association of Hospitals, asthma hospitalization rates for asthma in Multnomah County are twice that for Oregon. Between 1996 and 2000, there were more than 1300 hospitalizations due to asthma (Figure 25).



Conclusion

Multnomah County has been in compliance for criteria pollutants since 1997, and has met Healthy People 2010 objective for criteria air pollutants. Air quality trends for the County indicate that air is better now than it was ten years ago. Similar to other large urban areas across the United States, air toxics remain a problem in Multnomah County. Finally, some evidence indicates that those living in North and Northeast Portland – areas where a higher proportion are poor or ethnic and racial minorities – may have poorer air quality, which may contribute to health disparities for these groups.

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Recreational Water Quality

Fast Facts

- Six of seven waterways examined in Multnomah County are ranked by the Oregon Department of Environmental Quality as poor or very poor. Five water bodies are in violation of federal and State water standards that protect beneficial uses.
- Combined-sewer overflow causes 3 billion gallons of rainwater and raw sewage to flow into the Willamette River every year.
- A section of the Willamette River, known as the Portland Harbor, is listed as a Superfund site.
- Rates for recreational waterborne disease are low for Multnomah County and the State. There were two outbreaks of waterborne disease in the County in the 1990s, affecting 149 people.
- The unintentional drowning rate in Multnomah County was 2.4 deaths per 100,000 in 2000, which does not meet the Healthy People 2010 target rate of 0.9 drowning deaths per 100,000.

Problem Statement

According to the U.S. Environmental Protection Agency (EPA), 40% of assessed rivers in the U.S. are "not clean enough to support uses such as fishing and swimming."[1] Oregon is no different. Many miles of rivers and creeks – and some lakes – are in violation of federal clean water standards, and may pose a threat to human health. Chief among these threats is microbial contamination of water, which poses threats to swimmers; and contaminants in fish, which may pose health threats to those who eat fish from contaminated waters.

There are over 100,000 miles of rivers in Oregon, and more than 6,200 lakes. Oregon residents depend on these waters to be safe and free of contaminants. But, the Oregon Department of Environmental Quality has found that 26% of assessed rivers and 50% of surveyed lakes in Oregon are considered polluted. [2] And 44% of assessed rivers pose a health threat to swimmers. Lastly, Oregon has the 10th highest drowning rate in the country.

Recreational Water Quality

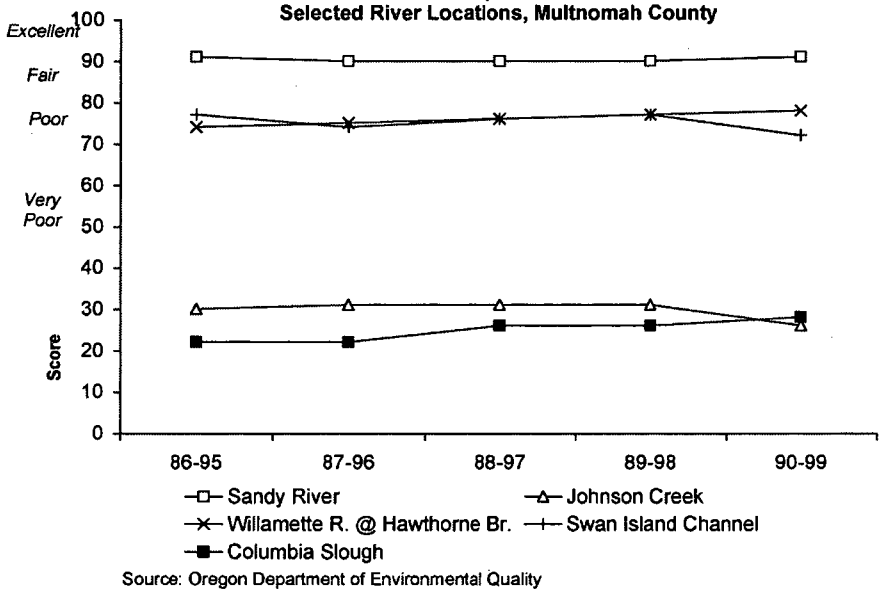
Recreational waters are regulated through the federal Clean Water Act, which sets standards for waters and waterways to ensure that they are, among other things, swimmable and fishable. The Oregon Department of Environmental Quality is responsible for setting and enforcing water quality standards for recreational waters, and develops lists of water bodies that do not meet federal and state standards. According to data from the Oregon DEQ, Multnomah County has lakes, creeks and rivers that do not meet water quality standards. Such water bodies in Multnomah County include Blue Lake, Smith and Bybee lakes, Columbia Slough, Fairview Creek, Johnson Creek, and the section of the Willamette River that runs through Portland.[3]

Water Quality Limited: Recreational water bodies that do not meet federal Clean Water Act standards.

Oregon's 2000 Water Quality Status Assessment Report identifies rivers, streams and lakes in Oregon that are impaired – or **water quality limited** - and may pose health threats from swimming and fishing. Unfortunately, the report does not list impaired waterways by county. Data for Oregon show that over 80% of river miles assessed, and 60% of lakes, have contaminated fish -mostly from mercury, dioxin and pesticides- that may pose a health threat. The Columbia Slough and part of the Lower Willamette River are included in this list. Over 40% of assessed rivers in Oregon are not safe for swimming, and those who do so have an increased risk of catching waterborne diseases. The Lower Willamette River, Fairview creek and the Columbia Slough are among those unsafe for swimming.[4] Unfortunately, only about half of river miles and lake acres have been assessed, so the actual extent of recreational water pollution in Oregon could not be calculated.

DEQ also tracks river systems using a water quality index, which combines many different measures of water quality into a general water quality score. The scores range from 10 (very poor water quality) to 100 (ideal water quality). Oregon DEQ data for the Willamette Basin indicate that seven waterways in Multnomah County are monitored and have been scored since 1986. Only one river is in excellent shape: the Sandy river at Troutdale bridge. Although the water quality index for the Columbia Slough has been increasing in quality between 1986 and 1999, water quality in the slough is the worst of all waterways measured for the County, and is ranked very poor. Johnson Creek is also ranked as very poor. Water quality in the Willamette River has changed very little in the time period examined, and the water quality in the Portland area is considered poor (Figure 26).

Figure 26
Water Quality Index Scores,
Selected River Locations, Multnomah County



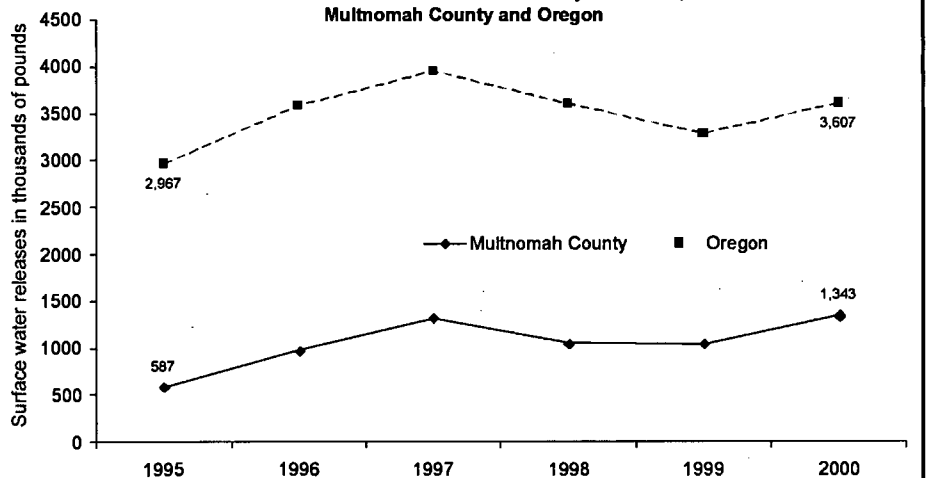
Source: Oregon Department of Environmental Quality

Water Pollution Sources

Pollution into Multnomah County water bodies is grouped into two categories. Non-point sources – from urban and agricultural runoff, primarily when it rains – are probably the most significant source of water pollution, but are difficult to quantify. It has been estimated that non-point sources account for 70-80% of recreational water pollution.[5] Point sources of pollution – usually wastewater entering rivers and streams via pipes – are the second source of water pollution. Wastewaters from industries are one point source of pollution. The EPA requires that industries report discharges of approximately 600 toxic chemicals into recreational waters such as streams and rivers. Analysis of such data for Multnomah County and Oregon reveals that industries – mostly manufacturing facilities – released over 1.3 million pounds of toxic chemicals into recreational waters in 2000, an increase of 128% from 1995, when such chemicals were first tracked (Figure 27).[6] Some have noted that industrial wastewater discharges are self-reported by industries, with minimal regulation to ensure accurate reporting, so wastewater amounts shown here may be an underestimate.

Combined sewer overflows (CSOs) are another point source of water pollution. Each year, about 2.8 billion gallons of CSOs - storm water mixed with raw sewage - flows into the Willamette River through 42 outfall pipes.[7] Such pollution increases waterborne disease risks to swimmers.

Figure 27
Water Releases of Toxic Chemicals by Industries, Multnomah County and Oregon



Source: U.S. Environmental Protection Agency, Toxics Release Inventory

Portland Harbor

The portion of the Willamette River - called the Lower Willamette - that runs through the center of Portland is a popular recreational area, especially for fishing. As mentioned above, the Lower Willamette is in violation of federal and state water quality standards, and has been given a poor quality ranking by the Oregon DEQ. In addition, six miles of the Willamette River - called the Portland Harbor

- are so heavily polluted that this stretch of river, roughly from the southern tip of Sauvie Island to Swan Island, is on the **National Priorities List** – commonly known as **Superfund**. It is a heavily industrialized section, and has high concentrations of metals, pesticides and industrial chemicals in its sediments. Such pollutants may make this section of the river unsafe for recreational use.

Public pools

The Multnomah County Health Department monitors water quality in public pools and spas to ensure that there are no contaminants (e.g., fecal contaminants) that would endanger public health. There were 543 inspections of public pools in Multnomah County in 2001, and 309 spa inspections. There were no closures of pools and spas in 2001 due to fecal contamination.

Waterborne disease outbreaks: Incidents of infectious agents or chemical poisoning in which two or more people experience a similar illness after consumption or use of water and evidence implicates water as the source of illness.

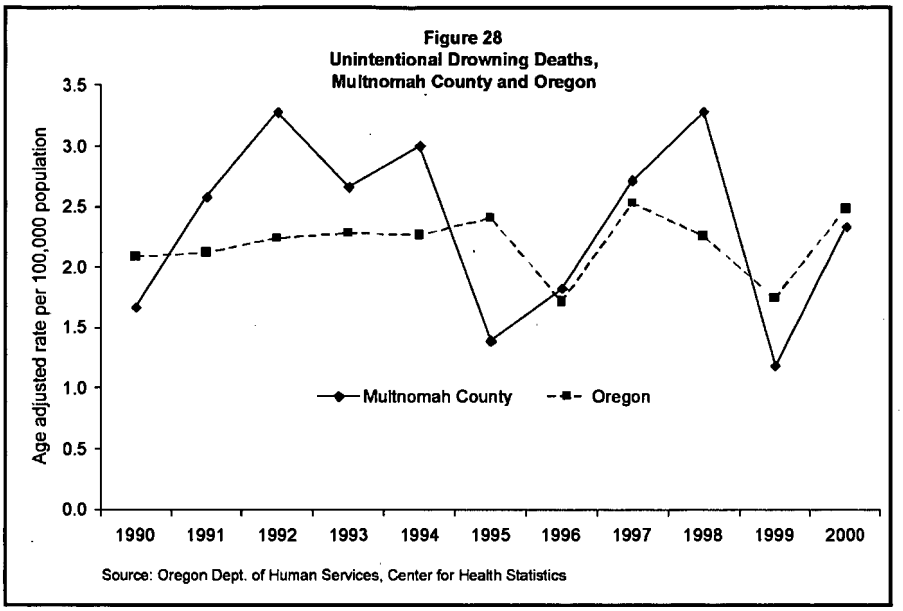
Health effects

Chronic disease. Recreational water pollution is difficult to link to specific chronic health problems such as cancer and liver diseases. The extent of chronic illness to Multnomah County residents from recreational water use – e.g., swimming and fishing – is unknown.

Waterborne disease. Waterborne disease outbreaks in recreational water usually cause gastrointestinal illnesses in humans, and are an acute health threat to those exposed. Such disease outbreaks are caused by bacterial contamination of water bodies. According to data from the U.S. Centers for Disease Control and Prevention, there were eight recreational waterborne disease outbreaks in Oregon between 1991 and 1998, affecting 800 people. Two of those outbreaks occurred in Multnomah County: one was an **E. coli** outbreak affecting about 80 people in Blue Lake in 1991, and the second was a **Cryptosporidiosis** outbreak at a community pool that affected 69 people in 1998. Rates of illness due to E. coli in Multnomah County declined 75% between 1991 and 2000, and were generally lower than Oregon for most years examined. In 2000, 11 cases of E. coli illness (1.7 cases per 100,000) were reported, compared to 41 cases in 1991 (6.8 per 100,000). Rates for Cryptosporidiosis have remained fairly stable since 1992, apart from the outbreak in 1998. There were 1.1 cases per 100,000 in Multnomah County in 2000, compared to 0.6 per 100,000 in Oregon in the same year.

Rates of illness due to E. coli in Multnomah County declined 75% between 1991 and 2000, and were lower than Oregon for most years examined.

Unintentional drowning. The Oregon State Center for Health Statistics tracks death data indicating there were 758 unintentional drownings in Oregon between 1990 and 2000, with 22%, or 165 cases, occurring in Multnomah County. The rate per 100,000 in Multnomah County for 2000 was 2.42, a 29% increase in unintentional drownings since 1990 (Figure 28). The drowning rate for Multnomah County and Oregon is higher than the national rate, and Oregon has one of the highest drowning rates in the Nation.[8] Multnomah County does not meet the Healthy People 2010 target rate of 0.9 drowning deaths per 100,000.



The drowning rate for Multnomah County and Oregon is higher than nationally, and Oregon has one of the highest drowning rates in the nation.

In Oregon, 68 drownings, or 47% of drownings, occurred in natural waters (lakes, ocean, river, stream) between 1999 and 2000. In Multnomah County for these years, 42% or 10 drowning deaths occurred in natural waters. Unintentional drowning in swimming pools were rare events in Oregon for 1999-2000. There were four deaths in Oregon in 1999-2000, with none occurring in Multnomah County.

Water-related injury. The number of hospitalizations- obtained from the Oregon Association of Hospitals- for near drowning are low in Multnomah County and Oregon. There were 26 hospitalizations for near-drowning in Oregon in 2001, seven of these occurred in Multnomah County. The 26 near-drownings in Oregon in 2001 account for less than 1% of injury-related hospitalizations. Between 1996 and 2001, there were 32 hospitalizations for near drowning in Multnomah County, with eight related to recreational waters.

Hospitalizations related to boating accidents were low in number in Oregon and Multnomah County. There were 40 hospitalizations in 2001 for Oregon, seven from Multnomah County. Between 1996 and 2001, there were a total of 50 boating-related hospitalizations in Multnomah County.

Conclusion

Some water bodies in Multnomah County have poor water quality (particularly the Willamette River and the Columbia Slough), with real health risks to those swimming, boating, and fishing in recreational waters. Unintentional drowning in Multnomah County and Oregon remains unacceptably high, and does not meet Healthy People 2010 objectives. Water-borne outbreaks in recreational waters were rare events in the years examined, but there were two outbreaks in Multnomah County- one in a lake, the other in a public pool.

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Solid Waste and Wastewater Quality

Fast Facts

- Multnomah County is home to the St. Johns landfill, in operation for 50 years, and closed since 1991. It has known leaks of hazardous substances.
- 3 billion gallons of combined sewer overflow are released into the Willamette River each year.
- Portland's recycling rate is 54%, the best in the country. This rate meets the Healthy People 2010 objective of 27%.

Problem Statement

The control of infectious diseases, partly though proper disposal of solid waste and sewage, is considered a significant public health achievement of the twentieth century.[1] Still, much can be done in Multnomah County and Oregon to reduce the impacts that solid waste disposal and wastewater have on the environment and human health. Some of the public concerns involve aesthetics (looking at and smelling waste), but improper solid waste and wastewater disposal can pollute groundwater, rivers, and streams, and can attract vectors such as rodents and insects.[3] Pollution of air and waterways through such waste can adversely affect human health.

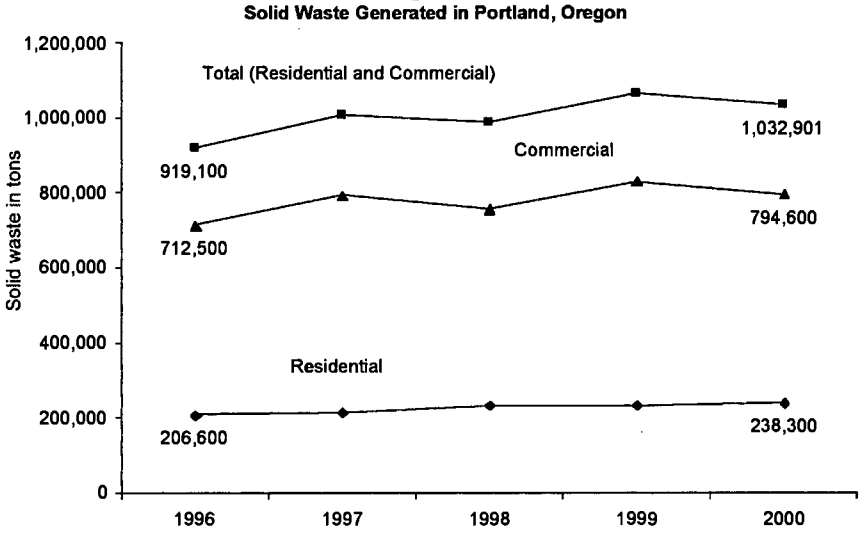
Solid waste: Common garbage or trash generated by industries, businesses, institutions and homes.

Solid Waste

Solid waste (or garbage) for Multnomah County is disposed of mostly in landfills. In 2000, the tri-county region generated about 1.4 million tons of solid waste that was disposed of in landfills. In 2000, Portland residents and commercial activities generated more than 1 million tons of solid waste (Figure 29), up 12% from 1996. Almost 77% of the waste generated in 2000 can be attributed to commercial activity. Close to 54% of the solid waste in 2000 was recovered

Close to 54% of the solid waste in 2000 was recovered (recycled), which appears to be the best recycling rate in the country among the 20 largest metropolitan regions.

Figure 29
Solid Waste Generated in Portland, Oregon

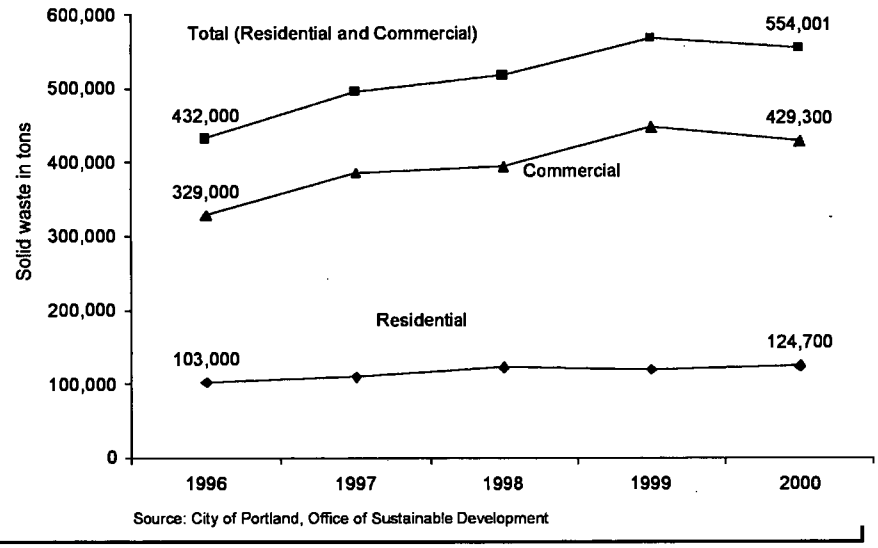


Source: City of Portland, Office of Sustainable Development

(recycled), which appears to be the best recycling rate in the country among the 20 largest metropolitan regions.[2] This rate meets the Healthy People 2010 solid waste recycling objective of 27%.

The amount of recycled material has risen steadily since 1996 (Figure 30), when only 47% of solid waste was recovered (and kept out of landfills).

Figure 30
Recycled Solid Waste in Portland, Oregon



Source: City of Portland, Office of Sustainable Development

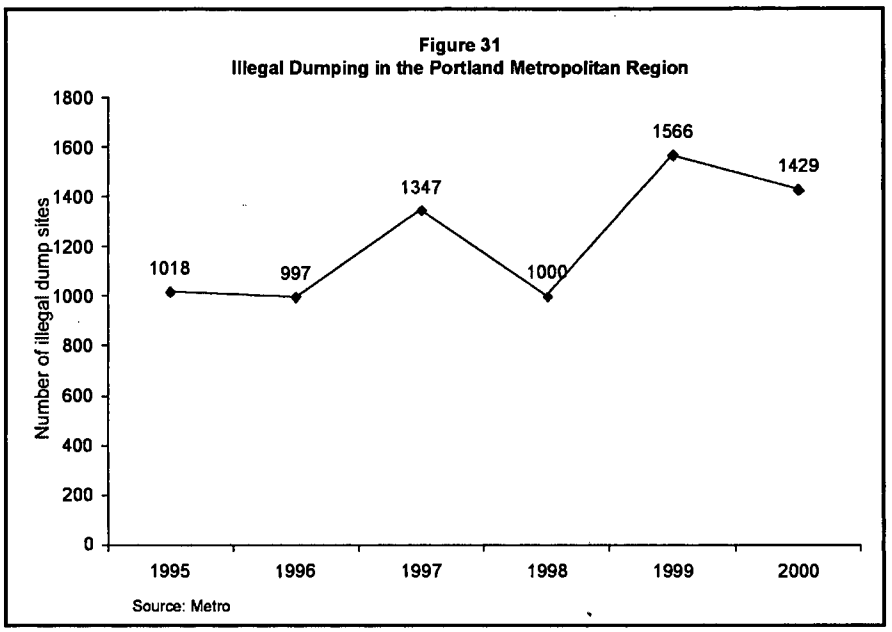
There are 12 solid waste facilities in Multnomah County, according to the Oregon Department of Environmental Quality. Of these 12, six are landfills, while the rest are transfer stations, treatment facilities, or material recovery facilities. Three are industrial waste landfills, two are construction landfills, and one is a municipal solid waste landfill - a landfill where residential garbage goes. All six Multnomah County landfills have groundwater monitoring that tests for leakages of hazardous substances from a landfill.

St. Johns landfill has confirmed leaks of hazardous substances, and some of these substances are making their way into the Columbia Slough.

The municipal solid waste landfill is located in St. Johns, near Smith and Bybee lakes and the Columbia Slough. It was the primary landfill for Portland's waste for 50 years until it closed in 1991. While in operation, this landfill accepted residential and industrial waste. Industrial waste included approximately 5,000 drums of pesticide manufacturing waste, disposed of in the early 1960's [3]. St. Johns landfill has confirmed leaks of hazardous substances, and some of these substances are making their way into nearby lakes (Smith and Bybee lakes), streams (e.g., the Columbia Slough), and groundwater. These hazardous substances are potentially harmful to human health.

Illegal dumping. Illegal dumping remains a problem in the County, as it does in counties throughout the U.S. Aside from the mess, illegal dumping can attract rodents and other animals, which can spread disease. In 1995, 1,018 illegal

dumpsites were identified in the tri-county area. In 2000, that number increased 40% to 1,429, representing more than 200 tons of waste (Figure 31).



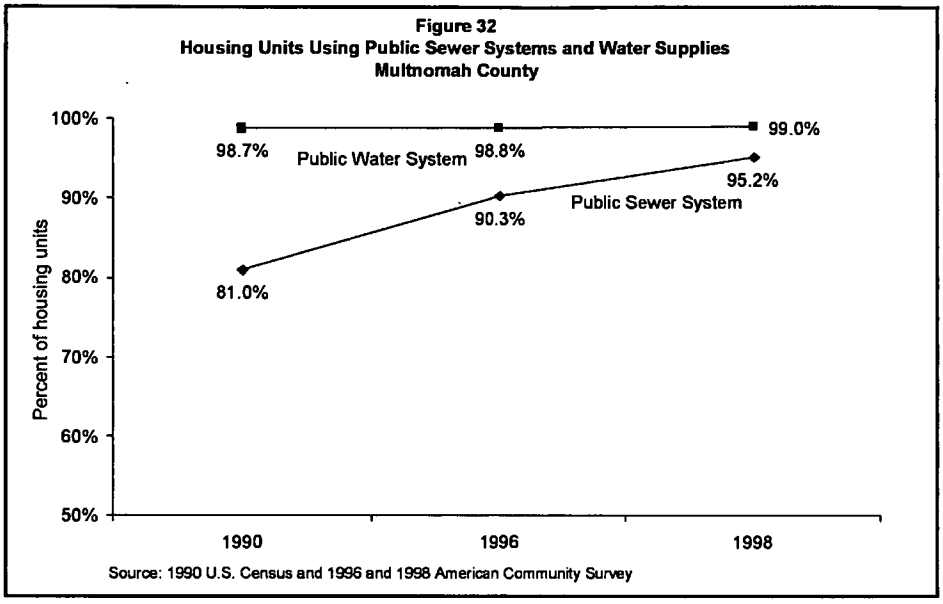
Wastewater

Wastewater, if not properly disposed of or treated, can contaminate drinking water and waterways, and can cause illness to those exposed. Therefore, it is essential that such waste be treated properly. One way to assure proper disposal of wastewater is to treat it at a public wastewater treatment facility. Private wastewater systems – commonly known as septic tanks - are considered more liable to cause illness, because they are more likely, for example, to leak into groundwater. Such contamination of groundwater can lead to waterborne illnesses such as Cryptosporidiosis. Many precautions must be taken to ensure that private septic systems are built correctly and maintained regularly to prevent illness. In 1990 an estimated 81% of Multnomah County housing units were connected to public sewer systems compared to 70% of the entire state. In 1998 this number increased to 95% in Multnomah County.

A higher number of housing units in Multnomah County are connected to public water systems. In 1998, 99% of housing units in the County were connected to public water systems, with an estimated 2400 housing units with individual wells (Figure 32). Therefore, the risk of contamination of groundwater by septic systems in Multnomah County is small.

According to data provided by the U.S. Geological survey, Multnomah County had 5 wastewater treatment facilities in 1999, which returned 92 million gallons per day of treated wastewater to the Willamette River and other waterways. Untreated wastewater is also being released into waterways in Multnomah County.

Combined sewer overflow: Discharge of a mixture of storm water and domestic waste when the flow capacity of a sewer system is exceeded during rainstorms.



Sewer water and storm water flow into the same sewer pipes creating a combined sewer system. When it rains, storm water combines with sewer water and can overflow directly to rivers and sloughs – this is called combined sewer overflow. There are 55 outfall pipes, or "relief valves," which release this combined sewer overflow directly to the Willamette River and the Columbia Slough. The untreated waste carries many microbes that may cause illness, and is a threat to public health. According to the Oregon DEQ, "those people most likely affected by this sewage include water skiers, swimmers, people who fish, and other people involved in water contact sports.[4]" In 1991, six billion gallons of combined sewer overflow went into Portland waterways. The city of Portland is currently working to eliminate combined sewer overflow, and is working to finish by 2011. Much work has already been done to reduce the amount of combined sewer overflow. By 2000, the amount of combined sewer overflow was reduced to 3.4 billion gallons, a decline of 43% from 1991.

The amount of combined sewer overflow in Portland was reduced from 6 to 3.4 billion gallons from 1991 to 2000.

Conclusion

The infrastructure in place in Multnomah County for treating and disposing of solid waste and wastewater has been working effectively to minimize public health threats for many years. However, problems still remain. Billions of gallons of combined sewer overflow (which includes untreated sewage) are released into the Willamette each year. Multnomah County is known to have at least one landfill - the St. Johns landfill - that is leaking hazardous substances, and is probably contributing to the contamination of the Columbia Slough and other waterways.

1. Achievements in Public Health, 1990-1999: Control of Infectious Diseases. Morbidity and Mortality Weekly Report (MMWR). Centers for Disease Control and Prevention. 1999;48: (29): 621-629.

2. Solid Waste and Recycling Division: Management Report for 2000 Activities. City of Portland, Office of Sustainable Development: Portland, Oregon. 2001
3. St. Johns Landfill: Cleanup Project Status Report. Oregon Department of Environmental Quality: Portland, Oregon. 2003.
4. Combined Sewer Overflows. Fact Sheet. Oregon Department of Environmental Quality: Portland, Oregon. 2001.

Vector-Borne Diseases

Fast Facts

- Multnomah County experiences only one or two cases of vector borne illness a year.
- As of the beginning of 2003, mosquitoes tested in Multnomah County had not been found to carry the West Nile virus, St. Louis encephalitis, or Western Equine encephalitis.
- In the nine years between 1991 and 2000, only four animals tested positive for rabies in the County.

Problem Statement

A vector (or carrier) is any organism capable of transmitting disease. Some examples of vectors are mosquitoes, rodents, fleas and ticks. Vectors are able to spread disease to humans by biting, burrowing or contaminating living spaces.

Some examples of vectors are mosquitoes, rats, fleas, and ticks.

West Nile virus is a disease new to the United States. It was first identified in the eastern U.S. in 1999, and it is moving across the U.S.[1] The virus has been found in mosquitoes as far south as Texas and as far north as North Dakota in early 2002. Multnomah County has surveyed for West Nile virus since 2001 and recently received funding to increase staff and materials for prevention, with additional surveillance and suppression activities of this virus.

Vector Control Activity

Mosquito Control. Diseases caused by mosquitoes can be prevented in one of two ways. The first is through personal protective measures, and the second is by public health measures to reduce the population of infected mosquitoes. Personal measures include: reducing time outdoors, particularly in early evening hours; wearing long pants and long sleeved shirts; applying mosquito repellent to exposed skin areas; and eliminating areas of standing water. Public health measures often require spraying of insecticides to kill juvenile (larvae) and adult mosquitoes.

Vector and Nuisance Control in the Environmental Health Section of the Multnomah County Health Department monitors and investigates complaints and conducts mosquito surveillance in the County. The **Vector Control** unit conducts adult mosquito surveillance between April and October. Mosquitoes are captured in traps baited with dry ice, which releases carbon dioxide and mimics the breathing of humans and other animals. The mosquitoes are collected, counted and identified to monitor the fluctuation in mosquito populations and species diversity. Some species of mosquitoes collected are then tested for St. Louis encephalitis, Western Equine encephalitis, and West Nile virus. St. Louis encephalitis, Western Equine encephalitis and West Nile virus are types of mosquito-borne viruses that most often cause no symptoms or a mild illness in an individual who has been bitten by an infected mosquito. In very rare instances,

a Western Equine encephalitis or West Nile virus infection can cause fatal illness or coma.

There are approximately 20 species of mosquitoes in Multnomah County. Each species differs in appearance and habitat preference. Multnomah County Vector Control currently treats approximately 3,000 acres for mosquitoes yearly. A large part of the treatment program centers on the floodplains along the Willamette and Columbia Rivers that seasonally fill with water when river levels rise due to snowmelt runoff, heavy rain, and controlled water release for salmon migration, typically April through June.

Known mosquito breeding sites are checked throughout the summer. Other typical sources checked and treated include roadside ditches, sloughs, marshes and all complaint calls from the public concerning mosquitoes. An active treatment program runs year round.

Rodent Abatement. Annually, Multnomah County Vector Control baits approximately 1,000 manholes for rodents and carries out other efforts in rodent control as well as responding to citizen rodent complaints. The number of rodent complaints fluctuates yearly. Rodent complaints by year from 1997 to 2001 are shown in Table 13. Rodent complaints peak April through October. Complaints are frequently property or sewer-related. Food sources such as pet food, wild animal food, or compost contributes to rodent infestation. In addition, broken or open sewer pipes or other building openings can provide rats access to property. Furthermore, debris or refuse accumulation as well as firewood or stored lumber can harbor rats.

Table 13
Rodent Complaints by Citizens,
Multnomah County

	1997	1998	1999	2000	2001
Number of complaints	1320	1939	1331	1257	1348
Rate per 1,000 population	2.1	3.0	2.1	1.9	2.0

Source: Multnomah County Health Department, Vector Control
Population: PSU Population Research Center

Vector Borne Disease Incidence. Multnomah County Communicable Disease Control Program monitors and reports vector borne disease incidence. There are only one or two cases of vector borne disease acquired in Multnomah County each year (Table 14). Vector borne disease is primarily acquired outside of Multnomah County and the predominate disease acquired is malaria.

Vector borne disease: Illnesses that are transmitted to people by organisms, such as insects and rodents.

The Multnomah County Health Department and Multnomah County Animal Services respond to animal bites or exposures to humans from animals. The number and types of animal bites or exposures is shown in Table 15. Bites from dogs are consistently half of all bites reported. The health concern of animal bites is due to

Table 14
Vector Borne Disease Incidence, Multnomah County

	1993	1994	1995	1996	1997	1998	1999	2000	2001
Cases acquired in Multnomah County	0	0	1	1	0	2	2	2	1
Cases imported from elsewhere	**4**	**4**	**12**	**12**	**7**	**6**	**11**	**25**	**6**
Total	**4**	**4**	**13**	**13**	**7**	**8**	**13**	**27**	**7**

Source: Multnomah County Health Department, Communicable Disease Control

Table 15
Animal Bites or Exposure to Humans*, Multnomah County

	1998	1999	2000	2001
Bat	4	7	4	3
Cat	8	17	15	8
Dog	28	36	36	41
Ferret	2	1	0	0
Raccoon	3	6	0	2
Other	9	10	5	7
Total Cases	**54**	**77**	**60**	**61**

* Responded to by MCHD or Animal Control
Source: Multnomah County Health Department, Communicable Disease Control

the wide variety of bacteria found in animal saliva. The bacteria can be transmitted into a wound through the bite. The consequences of infection can range from mild discomfort to life-threatening complications. Nationally, as well as in the County, rabies cases are rare. In the nine years between 1991 and 2000, only 4 animals tested positive for rabies in the County.

Conclusion

Vector borne disease incidence is very low in the County. As of the end of 2002, mosquitoes tested in Multnomah County have not been found to carry the West Nile virus. However, Oregon and Multnomah County anticipate the presence of West Nile virus in 2003. In preparation significant effort is being performed to increase public awareness of mosquito-borne disease risk and what people can do to limit their risk, and to prepare for the county government's role in West Nile virus surveillance and control.

The Health Department responds to all citizen complaints about rats and performs rodent control efforts through the county. The number of rodent complaints by citizens has remained relatively steady between 1999 and 2001. The number of animal bites or exposures to humans from animals is low and dog bites consistently make up half of all bites reported.

1. *West Nile Virus.* Centers for Disease Control and Prevention. Accessed: 7/1/02. http://www.cdc.gov/ncidod/dvbid/westnile/index.htm

Glossary

Air toxics: Also know as toxic air pollutants, are 188 pollutants tracked by the EPA known or suspected to cause cancer, respiratory, reproductive and developmental problems.

Air Quality Index: An assessment that combines criteria pollutants into one value of air quality for each day of the year.

Benzene: A colorless volatile flammable toxic liquid used in organic synthesis, as a solvent, and as a motor fuel.

Blood lead level: The concentration of lead in a sample of blood. The concentration is expressed in micrograms per deciliter (ug/dL).

Body Mass Index (BMI): A method of estimating fitness based on a person's height and weight. BMI = weight in kilograms/height in meters^2.

Brownfields: Abandoned, idle, or underused industrial or commercial sites that raise concern in nearby community that any expansion or redevelopment could contaminate the environment.

Campylobacteriosis: An illness caused by bacteria that lives in the intestines of health birds that can make people ill if ingested.

Carbon monoxide: A colorless, odorless, poisonous gas produced by incomplete fossil fuel combustion.

Chloroform: A colorless volatile heavy toxic liquid with an ether odor used especially as a solvent or as a veterinary anesthetic.

Chromium: A heavy metal that can damage living things at low concentrations and tends to accumulate in the food chain.

Combined sewer overflow: Discharge of a mixture of storm water and domestic waste when the flow capacity of a sewer system is exceeded during rainstorms.

Community water system: A public water system that provides water to at least 15 service connections used by year-round.

Conditionally Exempt Generator: Any business that produces less than 2,200 pounds of hazardous waste, less than 2.2 pounds of acute hazardous waste, or less than 220 pounds of spilled hazardous waste per month. Conditionally exempt generators are not required by law to report their hazardous waste production.

Criteria pollutants: A set of six air pollutants which are known to be unhealthy at high levels or with prolonged exposure. Carbon monoxide, ozone, nitrogen dioxide, particulate matter, sulfur dioxide, and lead. Major sources of criteria pollutants are vehicles - cars, trucks, ships and airplanes.

Cryptosporidium: A protozoan microbe associated with the disease cryptosporidiosis. The disease can be transmitted through ingestion of drinking water, person-to-person contact, or other pathways.

Cryptosporidiosis: A gastrointestinal illness caused by the cryptosporidium parasite.

E. coli: A bacteria commonly found in cattle. E. coli is also infrequently found in drinking water.

Environmental tobacco smoke: Smoke given off by cigarettes, pipes, or cigars to which nonsmokers can be exposed.

Foodborne illness: Infection caused by microbial or chemical contaminants in foods. Some foodborne illness can be caused by a single helping or less of a food that contains a contaminant. Other foodborne illnesses result from eating compounds in foods over a long periods of time.

Foodborne disease outbreak: The occurrence of two or more cases of the same illness among people from different households resulting from the ingestion of the same food.

Giardia lamblia: Protozoan in the feces of humans and animals that can cause severe gastrointestinal ailments. It is a common contaminant of surface waters.

Giardiasis: A gastrointestinal illness caused by the giardia parasite.

Hazardous substances: any substance that possesses properties that can cause harm to human health and ecologic systems.

Hazardous waste: Potentially harmful substances that have been released or discarded into the environment.

Health-based benchmark: Federal Clean Air Act guidelines based on a one in a million cancer risk for a specific air pollutant.

Healthy People 2010: A report from the U.S. Department of Health and Human Services which provides 467 objectives in 28 focus areas to target national health improvement activities.

Household lead dust: Very fine particles containing lead that are usually caused by the deterioration of lead paint.

Indoor air quality: The overall state of the air inside a building as reflected by the presence of pollutants, such as dust, fungi, animal dander, volatile organic compounds, carbon monoxide, and lead.

Large Quantity Generators: Any business that produces more than 2,200 pounds of hazardous waste, more than 2.2 pounds of acute hazardous waste, or more than 220 pounds of spilled hazardous waste per month.

Mixed use development: Land use development in which there are multiple uses: residential, retail, commercial, light industrial, entertainment, institutional.

Moderate physical activity: Activities that use large muscle groups and are at least equivalent to brisk walking. Activities may include walking swimming, cycling, dancing, gardening and yard work.

National Air Toxics Assessment: Provides risk estimates of hazardous air emissions for 32 of the most dangerous air toxics.

National Priorities List: EPA's list of the most serious uncontrolled or abandoned hazardous waste sites identified for possible long-term cleanup under Superfund.

Nonattainment area: A locality where air pollution levels persistently exceed EPA's National Ambient Air Quality Standards.

Ozone: In the stratosphere ozone is a natural form of oxygen that provides a protective layer shielding the earth from ultraviolet radiation. In the troposphere (the layer extending up 7 to 10 miles from the earth's surface), ozone is a chemical oxidant and major component of smog.

Particulate matter: Fine liquid or solid particles such as dust, smoke, mist, fumes, or smog, found in air or emissions.

Pathogens: Microorganisms (e.g., bacteria, viruses, or parasites) that can cause disease in humans, animals and plants.

Physical activity: Bodily movement that is produced by the contraction of skeletal muscle and that substantially increases energy expenditure.

Radon: A colorless, naturally occurring radioactive gas found in some soils and rocks.

Recreational waters: Recreational water bodies include lakes, rivers, streams, and public swimming pools.

Salmonella: A bacteria that is frequently found in birds as well as other animals.

Secondhand smoke: A mixture of the smoke exhaled by smokers and the smoke that comes from the burning end of the tobacco product.

Sedentary lifestyle: A person who is relatively inactive and has a lifestyle characterized by a lot of sitting.

Small Quantity Generator: Any business that produces between 100 and 2,200 pounds of hazardous waste per month.

Solid waste: Common garbage or trash generated by industries, businesses, institutions, and homes.

Superfund: A program operated under the legislative authority of Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) and Superfund Amendments and Reauthorization Act (SARA) that funds and carries out EPA solid waste emergency and long-term removal or remedial activities. Superfund sites are uncontrolled or abandoned places where hazardous waste is located.

Toxic air pollutants (air toxics): EPA's list of 188 pollutants known or suspected to cause cancer, respiratory, reproductive and developmental problems.

Toxic Release Inventory: EPA's list of more than 600 designated chemicals that threaten health and the environment. Authorized under the Emergency Planning and Community Right-To-Know Act (EPCRA) of 1986, this system requires manufacturers to report releases of these chemicals to EPA and State governments.

Vector borne diseases: Illnesses that are transmitted to people by organisms, such as insects.

Vector control: Control of any object, organism or thing that transmits disease from one host to another.

Vehicle Inspection Program: A vehicle emissions inspection program operated by the Oregon Department of Environmental Quality in the Portland and Rogue Valley areas. The program is intended to reduce vehicle emissions.

Wastewater: The spent or used water from a home, community, farm, or industry that contains dissolved or suspended matter.

Waterborne disease outbreak: Incidents of infectious agents or chemical poisoning in which two or more people experience a similar illness after consumption or use of water and evidence implicates water as the source of illness.

Water quality limited: Recreational water bodies which do not meet federal Clean Water Act standards.

West Nile virus: A mosquito-borne disease new to the U.S. that was first identified in the eastern U.S. in 1999. Most people who become infected with West Nile virus will have either no symptoms or only mild ones. However, on rare occasions, West Nile virus infection can result in severe and sometimes fatal illnesses.

Work related injury (fatal or nonfatal): Any personal injury incurred by a worker while on or off the worksite but engaged in work-related activities. Work-related injuries may be unintentional or intentional (i.e. homicide or assault).

Data Sources

Drinking Water Quality

Drinking Water Program. Oregon Department of Human Services.
www.ohd.hr.state.or.us/dwp/swp.cfm

U.S. Environmental Protection Agency *Envirofacts Data Warehouse.* U.S. Environmental Protection Agency.
www.oaspub.epa.gov/enviro/ef_home2.water

Acute and Communicable Disease Program. Oregon Department of Human Services.
www.dhs.state.or.us/publichealth/acd/about.cfm

National Water Use Information Program. U.S. Geological Survey.
www.water.usgs.gov/watuse/

City of Portland Water Bureau.
www.water.ci.portland.or.us/

Food Safety

Acute and Communicable Disease Program. Oregon Department of Human Services.
www.dhs.state.or.us/publichealth/acd/about.cfm

FoodNet. Foodborne and Diarrheal Diseases Branch. Centers for Disease Control and Prevention.
www.cdc.gov/foodnet/

Hazardous Waste

DEQ Environmental Profiler. Oregon Department of Environmental Quality.
deq12.deq.state.or.us/fp20/

Environmental Cleanup Site Information (ECSI). Oregon Department of Environmental Quality.
www.deq.state.or.us/wmc/ecsi/ecsiquery.htm

Agency for Toxic Substances and Diseases Registry. Centers for Disease Control.
www.atsdr.cdc.gov/

Superfund Program. U.S. Environmental Protection Agency.
www.epa.gov/superfund/

Housing and Indoor Air Quality

Summary File 3. 2000 U.S. Census. U.S. Census Bureau.
www.factfinder.census.gov/servlet/BasicFactsServlet

Lead-Based Paint Program. Oregon Department of Human Services.
www.ohd.hr.state.or.us/leadpaint/index.cfm

Regional Land Information System (RLIS). Metro Regional Government.
www.metro-region.org/article.cfm?articleid=593

U.S. Environmental Protection Agency.
www.epa.gov/iaq/radon/zonemap/oregon.htm

Radiation Protection Services, Oregon Public Health Services, Oregon Department of Human Services.
www.dhs.state.or.us/publichealth/rps/radon/county.cfm

Tobacco Prevention and Education Program. Oregon Public Health Services.
www.ohd.hr.state.or.us/tobacco/fctsheet/mult.htm.

Land Use and Community Design

Supplementary Survey. 2000 U.S. Census. U.S. Census Bureau.
Metro Regional Framework Plan. Metro Regional Government.
www.metro-region.org/
Vital Statistics. Center for Health Statistics. Oregon Department of Human Services.
www.ohd.hr.state.or.us/chs/vstats.cfm
Fatality Analysis Reporting System. National Center for Statistics and Analysis.
www-fars.nhtsa.dot.gov/
Behavioral Risk Factor Surveillance Survey. Center for Health Statistics, Oregon Department of Human Services.
www.ohd.hr.state.or.us/chs/brfsdata.cfm
Youth Risk Behavior Survey, Oregon Healthy Teens. Center for Health Statistics, Oregon Department of Human Services.
www.ohd.hr.state.or.us/chs/yrbsdata.cfm#yrbs

Occupational Health

Information Management Division. Oregon Department of Consumer and Business Services.
www.cbs.state.or.us/external/imd/
Covered Employment and Payroll. Oregon Employment Department.
www.qualityinfo.org/olmisj/CEP

Outdoor Air Quality

National Emissions Inventory. U.S. Environmental Protection Agency.
www.epa.gov/ttn/chief/trends/index.html
AirData. U.S. Environmental Protection Agency.
www.epa.gov/air/data/index.html
Air Quality Index (or *Pollutant Standards Index*). U.S. Environmental Protection Agency.
www.epa.gov/airdatamonpsi.html
Green Book. U.S. Environmental Protection Agency.
http://www.epa.gov/oar/oaqps/greenbk/index.html
DEQ Environmental Profiler. Oregon Department of Environmental Quality.
www.deq12.deq.state.or.us/fp20/
National Air Toxics Assessment. U.S. Environmental Protection Agency.
www.epa.gov/ttn/atw/nata/nsata1.html
Oregon DEQ Air Program. Oregon Department of Environmental Quality.
www.deq.state.or.us/aq/
Toxic Release Inventory. U.S. Environmental Protection Agency.
www.epa.gov/triexplorer/introduction.htm

Vehicle Inspection Program. Oregon Department of Environmental Quality.
www.deq.state.or.us/aq/vip/

Recreational Water

Water Quality Program. Oregon Department of Environmental Quality.
www.deq.state.or.us/wq/
Oregon Water Quality Index. Oregon Department of Environmental Quality.
www.deq.state.or.us/lab/wqm/wqimain.htm
Combined Sewer Overflow Program. Environmental Services, City of Portland.
www.cleanrivers-pdx.org/what_we_do/cso_program.htm
Water Quality Division. U.S. Environmental Protection Agency.
www.epa.gov/OWOW/monitoring/
Center for Health Statistics. Oregon Department of Human Services.
www.ohd.hr.state.or.us/chs/

Solid Waste and Wastewater Quality

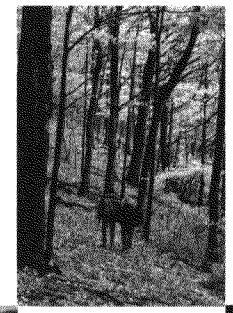
Office of Sustainable Development. City of Portland.
www.sustainableportland.org/
Environmental Management Department. Metro Regional Government.
www.metro-region.org/pssp.cfm?ProgServID=1
Environmental Services. City of Portland.
www.cleanrivers-pdx.org/
Solid Waste Program. Oregon Department of Environmental Quality.
www.deq.state.or.us/wmc/solwaste/rsw.htm

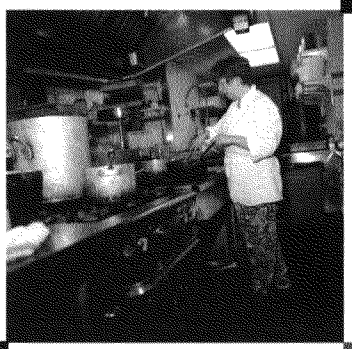
Vector-Borne Diseases

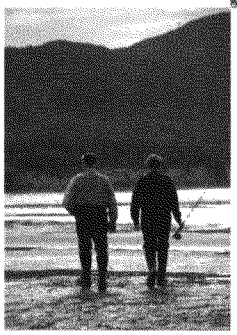
Environmental Health Section - Vector and Nuisance Control. Multnomah County Health Department.
www.mchealthinspect.org/vector/
Communicable Disease Control. Multnomah County Health Department.

Website Resources

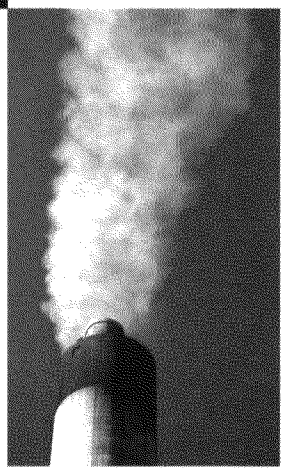
Oregon Dept. of Human Services, Acute and Communicable Disease Program	www.ohd.hr.state.or.us/acd
Centers for Disease Control and Prevention	www.cdc.gov
City of Portland Office of Sustainable Development	www.sustainableportland.org
Oregon Department of Environmental Quality	www.deq.state.or.us
Institute of Medicine	www.iom.edu
Metro	www.metro-region.org
Multnomah County Animal Control	www.co.multnomah.or.us/dscd/pets
Multnomah County Health Department	www.co.multnomah.or.us/health
Multnomah County Vector and Nuisance Control	www.mchealthinspect.org/vector
National Center for Statistics and Analysis, Fatality Analysis System	www-fars.nhtsa.dot.gov/
National Institutes of Health	www.nih.gov
National Center for Health Statistics	www.cdc.gov/nchs/
Oregon Association of Hospitals & Health Associates	www.oahhs.org
Oregon Department of Human Services	www.ohd.hr.state.or.us
Oregon Dept. of Consumer and Business Services	www.cbs.state.or.us/external/dfcs
Oregon Dept. of Human Services, Center for Health Statistics	www.ohd.hr.state.or.us/chs
Oregon Dept. of Human Services, Lead Paint Program	www.ohd.hr.state.or.us/esc/lead
Oregon Employment Department	www.emp.state.or.us
Oregon Workers Compensation Division	www.cbs.state.or.us/external/wcd
Pew Charitable Trusts	www.pewtrusts.com
Population Research Center, Portland State University	www.upa.pdx.edu/cprc
Portland Water Bureau	www.water.ci.portland.or.us
U. S. Census Bureau	www.census.gov
U. S. Department of Agriculture	www.usda.gov
U. S. Department of Health and Human Services	www.hhs.gov
U. S. Environmental Protection Agency	www.epa.gov
U. S. Food and Drug Administration	www.fda.gov
U.S. Geological Survey	www.usgs.gov/
World Health Organization	www.who.int







MULTNOMAH COUNTY
Health Department



Office of Planning and Development
Health Research and Assessment

1120 SW 5th Ave, 14th Floor,
Portland, Oregon 97204

503-988-3663 x29055
www.co.multnomah.or.us/health

AGENDA PLACEMENT REQUEST

BUD MOD #:

Board Clerk Use Only:

Meeting Date: October 2, 2003
Agenda Item #: R-7
Est. Start Time: 10:35 AM
Date Submitted: 09/08/03

Requested Date: October 2, 2003 **Time Requested:** 15 mins

Department: Health Department **Division:**

Contact/s: Carol M. Ford

Phone: 503-988-3674 **Ext.:** 22797 **I/O Address:** 106/14/1400

Presenters: Dan Kaplan, Carol Ford

Agenda Title: Approval of Transfer of Medicaid Funds from Multnomah County to CareOregon and to the Oregon Community Health Information Network (OCHIN)

NOTE: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide clearly written title.

---

1. **What action are you requesting from the Board? What is the department/agency recommendation?**

   The Health Department recommends that the Board of County Commissioners approve a Transfer of Funds agreement with CareOregon and the Oregon Community Health Information Network (OCHIN). These Medicaid funds support the CareOregon spin-off of OCHIN to a separate not-for-profit organization that will continue to provide the Multnomah County Health Department with clinical practice management information services. This is part of the County's mainframe migration plan.

2. **Please provide sufficient background information for the Board and the public to understand this issue.**

   Oregon Community Health Information Network (OCHIN)
   OCHIN is a collaboration involving Oregon's Safety Net health providers and the State of Oregon to develop and operate a joint management services organization, designed to

improve the operational effectiveness of member organizations through the provision of high quality infrastructure services. Multnomah County originally proposed this collaboration and continues to provide leadership and to receive the majority of services.

OCHIN is currently comprised of Multnomah, Clackamas and Tillamook county public health departments, private, non-profit Federally Qualified Health Centers (FQHCs); the State of Oregon's largest Medicaid-only health plan (CareOregon); and several State agencies, including the Oregon Medical Assistance Program (OMAP, the State's Medicaid agency), and the State Health Division.

How OCHIN Got Started

In late 1999, safety net health clinics across the State were falling behind in their efforts to remain viable. Although clinics and supporting agencies shared common problems, there was no effort to act cohesively or collaboratively. At the same time, the Multnomah County Health Department was in the midst of a difficult process to replace its legacy clinical information system due to large costs of a system that would meet our needs.

Using the County's planned information system replacement as leverage, the Health Department helped mobilize safety net clinics and related State agencies in a community building approach to solving a common set of problems. The outcomes were impressive:

- Safety net clinics partnered in development of a jointly operated management services organization – OCHIN. Clinics and State agencies began acting as a community in this and other initiatives
- OCHIN was awarded a federal CAP grant in October 2000 for about $2 million.
- CareOregon agreed to be the home for OCHIN.

Multnomah County has benefited greatly from its participation in OCHIN. A new clinical practice management system has been implemented as part of the County's mainframe migration plan. OCHIN has allowed Multnomah County to:

- Achieve economies of scale not possible alone.
- Accelerate the planning and installation of electronic medial records (EMR) system.
- Improve support for clinical and informational customers.
- Build a community around safety net health services (State involvement, breaking down the urban / rural divide, an empowered safety net)
- Increase resources for infrastructure through grants and other resources.

OCHIN Spin-off to Not-for-Profit Organization

Due to significant financial difficulty in 2003, CareOregon determined the need to spin-off OCHIN as a separate not-for-profit. This was because OCHIN's practice management services are outside CareOregon's primary business as a fully capacitated health plan and OCHIN was requiring management and financial resources that CareOregon needed to deal their financial problems.

At the same time, OCHIN Advisory Board worried that if CareOregon went into bankruptcy, OCHIN would be an asset that they would lose control over, resulting in significant disruption of their practice management information services. The OCHIN Advisory Board made up of organizations getting services from OCHIN (including Tom Fronk and Carol Ford from Multnomah County) and the CareOregon Board (including Lillian Shirley, Dr. Patsy Kullberg and Tom Fronk) agreed to collectively pursue OCHIN spin-off. There is agreement that:

- OCHIN would separate from CareOregon and become an independent not-for-profit corporation.
- OCHIN would contract directly with the OCHIN partners to provide practice management services.

OCHIN Spin-off Benefits to Multnomah County

It is important to make sure the original Multnomah County advantages from OCHIN participation are maintained. Through the OCHIN collaboration, County has invested over $2 million into the installation of the new practice management system. Annual operating service costs are about $600,000. Spin-off assures that Multnomah County maintains maximum oversight and management control of that asset.

The next technology step that the Health Department plans is the installation of an electronic medical records (EMR) system. This will greatly increased the efficiency and effectiveness in managing clinical services, leading to greater access and quality of services. EMR systems are very expensive and OCHIN spin-off can increase our opportunities to obtain outside resources.

Transfer of Funds Agreement to Fund the Spin Off

The proposed arrangement between CareOregon, OCHIN Non-Profit Board, and the OCHIN Partners

- CareOregon would receive consideration of $2.5 million.
- OCHIN would receive $2.0 million of working capital.
- If additional money is available (see below), it can be used to fund implementation of an electronic medical records system (EMR).

There are two sources of federal Medicaid money for the spin-off. Since most of the resources passes through Multnomah County, a transfer of funds agreement is needed. The two sources are:

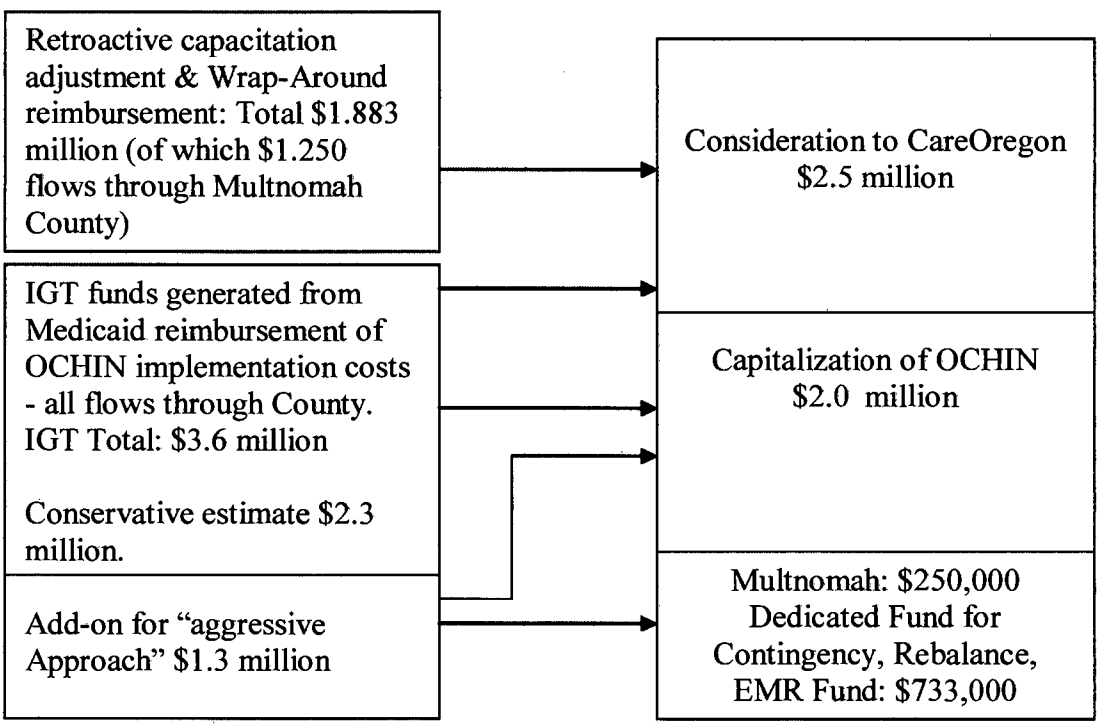
- **Retroactive capacitation rate adjustment for Oregon Health Plan services and Enhanced Medicaid Wrap-Around Reimbursement.**
  During the period January 2002 through February 2003, CareOregon paid Federally Qualified Health Centers (FQHCs) including Multnomah County, a capacitated rate for assigned OHP members. As part of its financial recovery plan, CareOregon switched its payment mechanism starting in March 2003, from paying a capitation rate (the same rate for all visits regardless of complexity) to paying for service on a per relative value unit basis (takes into account the complexity of the visit). With agreement from the State and the FQHCs, FQHCs will receive less from CareOregon but make up the difference

through the FQHC reimbursement system. Changing the rate retroactively back to January 2002 means that Multnomah County and other OCHIN partners were overpaid and to repay CareOregon, we will use increased Medicaid Wrap-Around reimbursements (making it cost neutral since we will repay CareOregon only after we have received the additional reimbursements).

- **Intergovernmental Transfer agreement (IGT) reimbursement for costs incurred by OCHIN (CareOregon) and the OCHIN Partners to implement the Practice Management System.**
  The State Department of Human Services has agreed to reimburse, through Multnomah County, the costs of implementing a statewide practice management system that are attributable to the Medicaid program. Multnomah County will collect data on its implementation costs and the implementation cost of other OCHIN partners and CareOregon. Through an Intergovernmental Transfer agreement, Multnomah County pays the state's federal match share and the remaining amount reimbursement is available to Multnomah County and OCHIN spin-off funding.

How the Money Will Flow to Fund the OCHIN Spin-off

To make the OCHIN spin-off happen, Multnomah County will be involved in receiving and transferring roughly $4.85 million. This money will come to Multnomah County from the retroactive capacitation adjustment and IGT sources described above and will be transferred to CareOregon and OCHIN. CareOregon estimates that it will receive $633,000 from other OCHIN partners from the retroactive capacitation adjustment that will also be used in funding the OCHIN spin-off.



Summary of OCHIN Spin-off Finances

TO:		SOURCE:
CareOregon:	**$2,500,000**	
	$1,833,000	Retro capacitation adjustment & Wrap-Around reimbursements ($1.25 million from Multnomah County and $633,000 from other CareOregon participants)
	$ 617,000	Multnomah County IGT
OCHIN:	**$2,000,000**	Multnomah County IGT
Multnomah County Health	**$250,000**	Multnomah County IGT
Dedicated Fund for Contingency, Rebalance, EMR Fund	**$ 7333,000**	Multnomah County IGT

- CareOregon & OCHIN to approve spin-off agreement by October 1, 2003
- Multnomah County Board to approve Transfer of Funds agreement October 2, 2003
- Multnomah County Board to approve a Health Department bud mod to record the receipt and transfer out of funds (October 2003).
- CareOregon to reassign Multnomah's practice management contract to new OCHIN (October 2003).

3. **Explain the fiscal impact (current year and ongoing).**

See above.

NOTE: If a Budget Modification or a Contingency Request attach a Budget Modification Expense & Revenues Worksheet and/or a Budget Modification Personnel Worksheet.

If a budget modification, explain:

- **What revenue is being changed and why?**
- **What budgets are increased/decreased?**
- **What do the changes accomplish?**
- **Do any personnel actions result from this budget modification? Explain.**
- **Is the revenue one-time-only in nature?**
- **If a grant, what period does the grant cover?**
- **When the grant expires, what are funding plans?**

NOTE: Attach Bud Mod spreadsheet (FORM FROM BUDGET)

If a contingency request, explain:

- **Why was the expenditure not included in the annual budget process?**
- **What efforts have been made to identify funds from other sources within the Department/Agency to cover this expenditure?**
- **Why are no other department/agency fund sources available?**

- ❖ **Describe any new revenue this expenditure will produce, any cost savings that will result, and any anticipated payback to the contingency account.**
- ❖ **Has this request been made before? When? What was the outcome?**

If grant application/notice of intent, explain:

- ❖ **Who is the granting agency?**
- ❖ **Specify grant requirements and goals.**
- ❖ **Explain grant funding detail – is this a one time only or long term commitment?**
- ❖ **What are the estimated filing timelines?**
- ❖ **If a grant, what period does the grant cover?**
- ❖ **When the grant expires, what are funding plans?**
- ❖ **How will the county indirect and departmental overhead costs be covered?**

4. Explain any legal and/or policy issues involved.

See Above.

It is important to support the OCHIN spin-of in order to assure that the Health Department maintains maximum control over these vital information systems. Collaboration with OCHIN has allowed us to replace the old mainframe system with a new practice management information system that we could not afford to acquire and maintain on our own.

The transfer of funds agreement directs the Medicaid funds that pass through Multnomah County to the appropriate spin-off parties, starts an EMR reserve, and limits the County's future liabilities.

5. Explain any citizen and/or other government participation that has or will take place.

The State's Department of Human Services/Office of Medicaid Assistance Programs and the Oregon Primary Care Association are partners of the OCHIN collaborative along with Multnomah County, other county health departments and non-profit private safety net clinics.

Required Signatures:

Department/Agency Director: Lillian Shirley **Date: 09/15/03**

Budget Analyst
By: _____ **Date:**

Dept/Countywide HR
By: _____ **Date:**

BOGSTAD Deborah L

From: WEBER Jacquie A
Sent: Tuesday, September 30, 2003 2:35 PM
To: BOGSTAD Deborah L
Cc: FORD Carol M
Subject: FW: wraparound changes

Importance: High

Deb, as you can see by the email trail below, both Clackamas County and Klamath have just now informed us that their number are different than in the Fund Allocation Agreement that we sent you as the final for the Board agenda on Thursday. Is it at all possible to make the change, since it does not affect the County's numbers, or the bottom line of amounts to be distributed to CareOregon and OCHIN? I am happy to do the paper work down here.
-----Original Message-----
From: FORD Carol M
Sent: Tuesday, September 30, 2003 1:34 PM
To: WEBER Jacquie A
Subject: FW: wraparound changes
Importance: High

Per my telephone call. Sorry - I'm on the way out of the office. Talk to you tomorrow.

Thanks.... Carol
-----Original Message-----
From: Abigail Sears [mailto:searsa@careoregon.org]
Sent: Tuesday, September 30, 2003 1:18 PM
To: Erich Merrill; Brian Harris; Marina Stansell; Gil Munoz (E-mail); Carol Ford; abe.cable@millernash.com
Cc: Michael Leahy
Subject: wraparound changes
Importance: High

Erich,

I spoke with Gil, Marina and Brian. Here are the correct numbers to put in the funds allocation agreement.

Clackamas	348,259
Klamath	58,813
VG	no change

I suggested that they would each get a new funds allocation agreement tonight or tomorrow morning, hope this was a correct assumption.

Abby

FUNDS ALLOCATION AGREEMENT

This is an agreement among Multnomah County, Oregon ("Multnomah"), CareOregon, Inc., an Oregon nonprofit corporation ("CareOregon"), and Oregon Community Health Information Network Inc., an Oregon nonprofit corporation ("OCHIN"), Clackamas County Health Department, Virginia Garcia Memorial Health Clinics, and Klamath Open Door Clinic.

BACKGROUND

Multnomah provides or oversees the provision of health care to indigent populations as part of its operations. In order to better serve those populations, Multnomah has urged and supported the establishment of a computerized health practice management system.

CareOregon operates a health plan established primarily to serve indigent populations. With the support of Multnomah and other entities providing indigent care, CareOregon established a computerized health practice management system for use by multiple clinics (the "Practice Management System") in 2001. CareOregon has experienced losses in operating the Practice Management System and intends to divest the Practice Management System and related operations in a transfer of assets and contract obligations to OCHIN (the "OCHIN Spin-Off"). CareOregon has obtained an independent appraisal that found that the Practice Management System had no value as an independent business. Multnomah believes it is in its own best interests, and the interests of indigent care clinics, for OCHIN to obtain and operate the Practice Management System on a not-for-profit basis.

Multnomah is a party to an intergovernmental transfer agreement (the "IGT") with the Oregon Department of Human Services, providing for reimbursement of costs incurred to establish the Practice Management System. Multnomah anticipates receiving up to $3.6 million in payments under the IGT, and would like to allocate the IGT funds among itself, CareOregon, and OCHIN, in a manner to facilitate the OCHIN Spin-Off and fund the initial operations of OCHIN. It is important to Multnomah as a user of the Practice Management System that the Practice Management System remain available.

As a health plan, CareOregon pays health care providers for services to covered individuals. The clinics that use the Practice Management System include Multnomah County Health Department, CareOregon, Inc., Oregon Community Health Information Network Inc., Clackamas County Public Health Division, Virginia Garcia Memorial Health Center, and Klamath Open Door Clinic, all of which are federally qualified health care centers (FQHCS) that bill CareOregon for services to indigent populations. CareOregon is in the process of retroactively adjusting certain reimbursement rates for payments previously made to providers. As a result of this adjustment, participating providers are expected to receive up to $1.883 million from the federal government as FQHC wrap around funds (the "Wrap Around Funds"), which in turn will be refunded to CareOregon.

TERMS

In consideration of the benefits to accrue to the providers from the continued availability of the Practice Management System, the benefits to CareOregon of no longer having to fund operations of the Practice Management System, and the mutual covenants set forth below, the

parties agree as follows:

A. Allocation of Funds by Multnomah County. Multnomah will allocate the funds it receives under the IGT relating to the Practice Management System (the "IGT Funds"), and Wrap Around Funds among the parties as follows:

1. Multnomah will allocate and pay to CareOregon IGT Funds and Wrap Around Funds of an estimated $1.9 million. The exact amount will be determined by the difference between $2.5 million and the amounts specified in C below.

2. Multnomah will allocate and pay $2.0 million of the IGT Funds as received by Multnomah under the current IGT contract to OCHIN.

B. Payment of allocated funds by Multnomah County. Multnomah will pay allocated funds to OCHIN and CareOregon as follows:

1. Multnomah will transfer to CareOregon upon the effective date of this agreement Wrap Around Funds in the amount of $500,000. Additional Wrap Around Funds will be transferred to CareOregon as Multnomah receives them

2. Multnomah will retain for its own use the first $250,000 in IGT Funds.

3. Multnomah will pay IGT Funds to OCHIN as they are received in excess of $250,000, up to $2.0 million.

4. Multnomah will pay IGT Funds received in excess of $2.25 million to CareOregon up to $700,000.

5. Any IGT funds received by Multnomah County in excess of $2.95 million will be retained in a dedicated fund to be established by OCHIN and Multnomah County and held specifically for IGT audit contingency and to support the implementation of an Electronic Medical Record system by OCHIN.

C. Wrap Around Funds to be allocated and paid by other CareOregon parties. Other CareOregon parties will allocate and pay to CareOregon Wrap Around Funds in the following approximate amounts, as each party receives such funds (with the exact amount to be the Invoiced Wrap Around Amount, as defined below):

1. Clackamas County Public Health Division $395,500

2. Virginia Garcia Memorial Health Center $146,130

3. Klamath Open Door Clinic $56,800

D. Invoiced Amount. As soon as practicable, CareOregon will notify all parties of the total amount of Wrap Around Funds for which it has sent invoices to each party (the "Invoiced Wrap Around Amount").

E. Condition. It is a condition to payment of any IGT Funds under this agreement that CareOregon and OCHIN shall have entered into a binding agreement to implement the OCHIN Spin-Off.

F. General Provisions

1. Additional Documents. Each party will execute such additional documents as are reasonably requested by any other party in order to complete or confirm the transactions contemplated by this agreement.

2. Arbitration. Any dispute concerning this agreement will be finally settled by arbitration using the rules of Arbitration Service of Portland, Inc., or the commercial arbitration rules of the American Arbitration Association, at the election of the party initiating the arbitration. Arbitration will be conducted in Portland, Oregon, before a single arbitrator. The parties will be entitled to conduct discovery in accordance with the Federal Rules of Civil Procedure as in effect where arbitration occurs, limited to document production and depositions and subject to further limitation by the arbitrator to secure just and efficient resolution of the dispute. If the amount in controversy exceeds $10,000, the arbitrator's decision must include a statement specifying in reasonable detail the basis for and computation of the award, if any. Judgment upon the award may be entered in any court having jurisdiction. Nothing herein, however, prevents either party from resort to a court of competent jurisdiction solely to seek injunctive relief.

3. Assignment. No party may assign any rights or obligations under this agreement without all other parties' consent.

4. Counterparts. This agreement may be executed in counterparts, which together will constitute one agreement. Fax or other electronic transmission of any signed original document, and re-transmission of any signed fax or other electronic transmission, will be deemed equivalent to delivery of an original. At the request of any party, the parties will confirm fax or other electronically transmitted signatures by signing an original document.

5. Entire Agreement. This agreement constitutes the entire agreement and understanding between the parties with respect to its subject matter and supersedes any prior agreement or understanding.

6. Governing Law. This agreement is governed by Oregon law without regard to principles of conflicts of law.

7. Modification and Waiver. No amendment of this agreement or any waiver of its provisions will be deemed to have occurred unless expressed in a writing signed by the party to be bound.

8. Notices. Notices under this agreement must be in writing and will be deemed given when delivered in person or by facsimile transmission promptly

confirmed by mail, one business day after being sent by overnight courier, or four business days after being mailed by registered or certified mail, in each case to the appropriate address below:

Multnomah County Health Department
1120 S.W. Fifth Avenue, 14th Floor
Portland, Oregon 97204
Attention: Carol Ford
Fax: (503) 988-4117

CareOregon, Inc.
522 S.W. Fifth Avenue, Suite 200
Portland, Oregon 97227
Attention: Dave Ford
Fax: (503) 416- 3720

Oregon Community Health Information Network Inc.
522 S.W. Fifth Avenue, Suite 400
Portland, Oregon 97227
Attention: Mike Leahy
Fax: (503) 416-1437

Clackamas County Public Health Division
821 Main St., Ste. 200
Oregon City, OR 97045
Attention: Marina Stansell
Fax: (503) 722-6252

Virginia Garcia Memorial Health Center
85 N 12th St.
PO Box 567
Cornelius, OR 97113
Attention: Gil Munoz
Fax: (503) 357-4371

Klamath Open Door Clinic
3810 South 6th St.
Klamath Falls, OR 97603
Attention: Brian Harris
Fax: (541) 851-8114

Any party may change its address for notices by giving notice of the change to the other parties.

Dated as of the ___ day of October, 2003.

MULTNOMAH COUNTY

By: _____
Carol Ford 9/22/03

Title: Program Manager

By: _____
Lillian Shirley 9-22-03

Title: Health Department Director

By: _____
Jacqueline A. Weber

Title: Assistant County Attorney

BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

_____
Diane M. Linn, Multnomah County Chair

APPROVED : MULTNOMAH COUNTY
BOARD OF COMMISSIONERS
AGENDA #_____DATE_____
DEBORAH L. BOGSTAD, BOARD CLERK

CAREOREGON, INC.

By: _____

Title: _____

OREGON COMMUNITY HEALTH INFORMATION NETWORK INC.

By: _____

Title: _____

CLACKAMAS COUNTY PUBLIC HEALTH DIVISION

By: _____

Title: _____

VIRGINIA GARCIA MEMORIAL HEALTH CENTER

By: _____

Title: _____

KLAMATH OPEN DOOR CLINIC

By: _____

Title: _____

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5. Any IGT funds received by Multnomah County in excess of $2.95 million will be retained in a dedicated fund to be established by OCHIN and Multnomah County and held specifically for IGT audit contingency and to support the implementation of an Electronic Medical Record system by OCHIN.

C. Wrap Around Funds to be allocated and paid by other CareOregon parties. Other CareOregon parties will allocate and pay to CareOregon Wrap Around Funds in the following approximate amounts, as each party receives such funds (with the exact amount to be the Invoiced Wrap Around Amount, as defined below):

1. Clackamas County Public Health Division	348,259
2. Virginia Garcia Memorial Health Center	$146,130
3. Klamath Open Door Clinic	58,813

D. Invoiced Amount. As soon as practicable, CareOregon will notify all parties of the total amount of Wrap Around Funds for which it has sent invoices to each party (the "Invoiced Wrap Around Amount").

E. Condition. It is a condition to payment of any IGT Funds under this agreement that CareOregon and OCHIN shall have entered into a binding agreement to implement the OCHIN Spin-Off.

F. General Provisions

1. Additional Documents. Each party will execute such additional documents as are reasonably requested by any other party in order to complete or confirm the transactions contemplated by this agreement.

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5. Entire Agreement. This agreement constitutes the entire agreement and understanding between the parties with respect to its subject matter and supersedes any prior agreement or understanding.

6. Governing Law. This agreement is governed by Oregon law without regard to principles of conflicts of law.

7. Modification and Waiver. No amendment of this agreement or any waiver of its provisions will be deemed to have occurred unless expressed in a writing signed by the party to be bound.

8. Notices. Notices under this agreement must be in writing and will be deemed given when delivered in person or by facsimile transmission promptly

confirmed by mail, one business day after being sent by overnight courier, or four business days after being mailed by registered or certified mail, in each case to the appropriate address below:

Multnomah County Health Department
1120 S.W. Fifth Avenue, 14th Floor
Portland, Oregon 97204
Attention: Carol Ford
Fax: (503) 988-4117

CareOregon, Inc.
522 S.W. Fifth Avenue, Suite 200
Portland, Oregon 97227
Attention: Dave Ford
Fax: (503) 416- 3720

Oregon Community Health Information Network Inc.
522 S.W. Fifth Avenue, Suite 400
Portland, Oregon 97227
Attention: Mike Leahy
Fax: (503) 416-1437

Clackamas County Public Health Division
821 Main St., Ste. 200
Oregon City, OR 97045
Attention: Marina Stansell
Fax: (503) 722-6252

Virginia Garcia Memorial Health Center
85 N 12th St.
PO Box 567
Cornelius, OR 97113
Attention: Gil Munoz
Fax: (503) 357-4371

Klamath Open Door Clinic
3810 South 6th St.
Klamath Falls, OR 97603
Attention: Brian Harris
Fax: (541) 851-8114

Any party may change its address for notices by giving notice of the change to the other parties.

Dated as of the ___ day of October, 2003.

MULTNOMAH COUNTY

By: _____

Title: _____

CAREOREGON, INC.

By: _____

Title: _____

OREGON COMMUNITY HEALTH INFORMATION NETWORK INC.

By: _____

Title: _____

CLACKAMAS COUNTY PUBLIC HEALTH DIVISION

By: _____

Title: _____

VIRGINIA GARCIA MEMORIAL HEALTH CENTER

By: _____

Title: _____

KLAMATH OPEN DOOR CLINIC

By: _____

Title: _____

MULTNOMAH COUNTY CONTRACT APPROVAL FORM

Contract #: 4600004506

Pre-approved Contract Boilerplate (with County Attorney signature) ☒Attached ☐Not Attached Amendment #:

CLASS I	CLASS II	CLASS III A
Contracts $75,000 and less per 12 month period	Contracts over $75,000 per 12 month period	☐ Government Contracts (190 Agreement)
☐ Professional Services Contracts ☐ PCRB Contracts ☐ Maintenance Agreements ☐ Licensing Agreements ☐ Public Works Construction Contracts ☐ Architectural & Engineering Contracts ☐ Revenue Contracts ☐ Grant Contracts ☐ Non-Expenditure Contracts	☒ Professional Services Contracts ☐ PCRB Contracts ☐ Maintenance Agreements ☐ Licensing Agreements ☐ Public Works Construction Contracts ☐ Architectural & Engineering Contracts ☐ Revenue Contracts ☐ Grant Contracts ☐ Non-Expenditure Contracts	☐ Expenditure ☐ Non-Expenditure ☐ Revenue **CLASS III B** ☐ Government Contracts (Non-190 Agreement) ☐ Expenditure ☐ Non-Expenditure ☐ Revenue ☐ Interdepartmental Contracts

Department: Health Department Division: Directors Office Date: 09/18/03
Originator: Carol Ford Phone: x22797 Bldg/Rm: 106/14
Contact: LaRisha Baker Phone: x27499 Bldg/Rm: 106/14
Description of Contract: Contract providdes for OCHIN to obtain and operate the Practice Management System on a not-for-profit basis.

RENEWAL: ☐ PREVIOUS CONTRACT #(S):
RFP/BID: RFP/BID DATE:
EXEMPTION #: ORS/AR #:
EFFECTIVE DATE: EXPIRATION DATE:
CONTRACTOR IS: ☐ MBE ☐ WBE ☐ ESB ☐ QRF State Cert# or ☐ Self Cert ☐ Non-Profit ☒ N/A (*Check all boxes that apply*)

Contractor	CareOregon
Address	522 SW 5th Ave., Suite 200
City/State	Portland, OR
ZIP Code	97227
Phone	
Employer ID# or SS#	20-0195556
Contract Effective Date	10/02/03 Term Date 10/01/03
Amendment Effect Date	New Term Date
Original Contract Amount	$1,867,000
Total Amt of Previous Amendments	$
Amount of Amendment	$
Total Amount of Agreement $	$1,867,000

Dave Ford, CareOregon
Remittance address
(If different)
Payment Schedule / Terms
☐ Lump Sum $ ☐ Due on Receipt
☐ Monthly $ ☐ Net 30
☐ Other $ ☐ Other
☐ Requirements Funding Info:

Original Requirements Amount	$
Total Amt of Previous Amendments	$
Requirements Amount Amendment	$
Total Amount of Requirements	$

REQUIRED SIGNATURES:

Department Manager	Gillian Shirley	DATE 9/24/03
Purchasing Manager		DATE
County Attorney		DATE 9/24/03
County Chair		DATE 10.2.03
Sheriff		DATE
Contract Administration		DATE

COMMENTS:

APPROVED : MULTNOMAH COUNTY
BOARD OF COMMISSIONERS
AGENDA # R-7 DATE 10.02.03
DEBORAH L. BOGSTAD, BOARD CLERK

MULTNOMAH COUNTY CONTRACT APPROVAL FORM

Contract #: 4600004508

Pre-approved Contract Boilerplate (with County Attorney signature) ☒Attached ☐Not Attached Amendment #:

CLASS I	CLASS II	CLASS III A
Contracts $75,000 and less per 12 month period	Contracts over $75,000 per 12 month period	☐ Government Contracts (190 Agreement)
☐ Professional Services Contracts ☐ PCRB Contracts ☐ Maintenance Agreements ☐ Licensing Agreements ☐ Public Works Construction Contracts ☐ Architectural & Engineering Contracts ☐ Revenue Contracts ☐ Grant Contracts ☐ Non-Expenditure Contracts	☒ Professional Services Contracts ☐ PCRB Contracts ☐ Maintenance Agreements ☐ Licensing Agreements ☐ Public Works Construction Contracts ☐ Architectural & Engineering Contracts ☐ Revenue Contracts ☐ Grant Contracts ☐ Non-Expenditure Contracts	☐ Expenditure ☐ Non-Expenditure ☐ Revenue **CLASS III B** ☐ Government Contracts (Non-190 Agreement) ☐ Expenditure ☐ Non-Expenditure ☐ Revenue ☐ Interdepartmental Contracts

Department: Health Department Division: Directors Office Date: 09/18/03
Originator: Carol Ford Phone: x22797 Bldg/Rm: 106/14
Contact: LaRisha Baker Phone: x27499 Bldg/Rm: 106/14
Description of Contract: Contract provides for OCHIN to obtain and operate the Practice Management System on a not-for-profit basis.

RENEWAL: ☐ PREVIOUS CONTRACT #(S):
RFP/BID: RFP/BID DATE:
EXEMPTION #: ORS/AR #:
EFFECTIVE DATE: EXPIRATION DATE:
CONTRACTOR IS: ☐ MBE ☐ WBE ☐ ESB ☐ QRF State Cert# or ☐ Self Cert ☐ Non-Profit ☒ N/A (*Check all boxes that apply*)

Contractor	Oregon Community Health Information Network Inc.		
Address	522 SW 5th Ave., Suite 400		
City/State	Potland, OR		
ZIP Code	97227		
Phone	Fax (503) 416-1437		
Employer ID# or SS#	20-195556		
Contract Effective Date	10/02/03	Term Date	10/01/04
Amendment Effect Date		New Term Date	
Original Contract Amount	$2,000,000		
Total Amt of Previous Amendments	$		
Amount of Amendment	$		
Total Amount of Agreement $	$2,000,000		

Mike Leahy, OCHIN
Remittance address
(If different)

Payment Schedule / Terms
☐ Lump Sum $ ☐ Due on Receipt
☐ Monthly $ ☐ Net 30
☐ Other $ ☐ Other

☐ Requirements Funding Info:

Original Requirements Amount	$
Total Amt of Previous Amendments	$
Requirements Amount Amendment	$
Total Amount of Requirements	$

REQUIRED SIGNATURES:

Department Manager	Colleen Shelley	DATE 9/24/03
Purchasing Manager		DATE
County Attorney		DATE 9/24/03
County Chair		DATE 10.2.03
Sheriff		DATE
Contract Administration		DATE

COMMENTS:

APPROVED : MULTNOMAH COUNTY
BOARD OF COMMISSIONERS
AGENDA # R-7 DATE 10.02.03
DEBORAH L. BOGSTAD, BOARD CLERK

FUNDS ALLOCATION AGREEMENT

This is an agreement among Multnomah County, Oregon ("Multnomah"), CareOregon, Inc., an Oregon nonprofit corporation ("CareOregon"), and Oregon Community Health Information Network Inc., an Oregon nonprofit corporation ("OCHIN"), Clackamas County Health Department, Virginia Garcia Memorial Health Clinics, and Klamath Open Door Clinic.

BACKGROUND

Multnomah provides or oversees the provision of health care to indigent populations as part of its operations. In order to better serve those populations, Multnomah has urged and supported the establishment of a computerized health practice management system.

CareOregon operates a health plan established primarily to serve indigent populations. With the support of Multnomah and other entities providing indigent care, CareOregon established a computerized health practice management system for use by multiple clinics (the "Practice Management System") in 2001. CareOregon has experienced losses in operating the Practice Management System and intends to divest the Practice Management System and related operations in a transfer of assets and contract obligations to OCHIN (the "OCHIN Spin-Off"). CareOregon has obtained an independent appraisal that found that the Practice Management System had no value as an independent business. Multnomah believes it is in its own best interests, and the interests of indigent care clinics, for OCHIN to obtain and operate the Practice Management System on a not-for-profit basis.

Multnomah is a party to an intergovernmental transfer agreement (the "IGT") with the Oregon Department of Human Services, providing for reimbursement of costs incurred to establish the Practice Management System. Multnomah anticipates receiving up to $3.6 million in payments under the IGT, and would like to allocate the IGT funds among itself, CareOregon, and OCHIN, in a manner to facilitate the OCHIN Spin-Off and fund the initial operations of OCHIN. It is important to Multnomah as a user of the Practice Management System that the Practice Management System remain available.

As a health plan, CareOregon pays health care providers for services to covered individuals. The clinics that use the Practice Management System include Multnomah County Health Department, CareOregon, Inc., Oregon Community Health Information Network Inc., Clackamas County Public Health Division, Virginia Garcia Memorial Health Center, and Klamath Open Door Clinic, all of which are federally qualified health care centers (FQHCS) that bill CareOregon for services to indigent populations. CareOregon is in the process of retroactively adjusting certain reimbursement rates for payments previously made to providers. As a result of this adjustment, participating providers are expected to receive up to $1.883 million from the federal government as FQHC wrap around funds (the "Wrap Around Funds"), which in turn will be refunded to CareOregon.

TERMS

In consideration of the benefits to accrue to the providers from the continued availability of the Practice Management System, the benefits to CareOregon of no longer having to fund operations of the Practice Management System, and the mutual covenants set forth below, the

parties agree as follows:

A. Allocation of Funds by Multnomah County. Multnomah will allocate the funds it receives under the IGT relating to the Practice Management System (the "IGT Funds"), and Wrap Around Funds among the parties as follows:

1. Multnomah will allocate and pay to CareOregon IGT Funds and Wrap Around Funds of an estimated $1.9 million. The exact amount will be determined by the difference between $2.5 million and the amounts specified in C below.

2. Multnomah will allocate and pay $2.0 million of the IGT Funds as received by Multnomah under the current IGT contract to OCHIN.

B. Payment of allocated funds by Multnomah County. Multnomah will pay allocated funds to OCHIN and CareOregon as follows:

1. Multnomah will transfer to CareOregon upon the effective date of this agreement Wrap Around Funds in the amount of $500,000. Additional Wrap Around Funds will be transferred to CareOregon as Multnomah receives them

2. Multnomah will retain for its own use the first $250,000 in IGT Funds.

3. Multnomah will pay IGT Funds to OCHIN as they are received in excess of $250,000, up to $2.0 million.

4. Multnomah will pay IGT Funds received in excess of $2.25 million to CareOregon up to $700,000.

5. Any IGT funds received by Multnomah County in excess of $2.95 million will be retained in a dedicated fund to be established by OCHIN and Multnomah County and held specifically for IGT audit contingency and to support the implementation of an Electronic Medical Record system by OCHIN.

C. Wrap Around Funds to be allocated and paid by other CareOregon parties. Other CareOregon parties will allocate and pay to CareOregon Wrap Around Funds in the following approximate amounts, as each party receives such funds (with the exact amount to be the Invoiced Wrap Around Amount, as defined below):

1. Clackamas County Public Health Division 348,259

2. Virginia Garcia Memorial Health Center $146,130

3. Klamath Open Door Clinic 58,813

D. Invoiced Amount. As soon as practicable, CareOregon will notify all parties of the total amount of Wrap Around Funds for which it has sent invoices to each party (the "Invoiced Wrap Around Amount").

E. Condition. It is a condition to payment of any IGT Funds under this agreement that CareOregon and OCHIN shall have entered into a binding agreement to implement the OCHIN Spin-Off.

F. General Provisions

1. Additional Documents. Each party will execute such additional documents as are reasonably requested by any other party in order to complete or confirm the transactions contemplated by this agreement.

2. Arbitration. Any dispute concerning this agreement will be finally settled by arbitration using the rules of Arbitration Service of Portland, Inc., or the commercial arbitration rules of the American Arbitration Association, at the election of the party initiating the arbitration. Arbitration will be conducted in Portland, Oregon, before a single arbitrator. The parties will be entitled to conduct discovery in accordance with the Federal Rules of Civil Procedure as in effect where arbitration occurs, limited to document production and depositions and subject to further limitation by the arbitrator to secure just and efficient resolution of the dispute. If the amount in controversy exceeds $10,000, the arbitrator's decision must include a statement specifying in reasonable detail the basis for and computation of the award, if any. Judgment upon the award may be entered in any court having jurisdiction. Nothing herein, however, prevents either party from resort to a court of competent jurisdiction solely to seek injunctive relief.

3. Assignment. No party may assign any rights or obligations under this agreement without all other parties' consent.

4. Counterparts. This agreement may be executed in counterparts, which together will constitute one agreement. Fax or other electronic transmission of any signed original document, and re-transmission of any signed fax or other electronic transmission, will be deemed equivalent to delivery of an original. At the request of any party, the parties will confirm fax or other electronically transmitted signatures by signing an original document.

5. Entire Agreement. This agreement constitutes the entire agreement and understanding between the parties with respect to its subject matter and supersedes any prior agreement or understanding.

6. Governing Law. This agreement is governed by Oregon law without regard to principles of conflicts of law.

7. Modification and Waiver. No amendment of this agreement or any waiver of its provisions will be deemed to have occurred unless expressed in a writing signed by the party to be bound.

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confirmed by mail, one business day after being sent by overnight courier, or four business days after being mailed by registered or certified mail, in each case to the appropriate address below:

Multnomah County Health Department
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CareOregon, Inc.
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Portland, Oregon 97227
Attention: Dave Ford
Fax: (503) 416- 3720

Oregon Community Health Information Network Inc.
522 S.W. Fifth Avenue, Suite 400
Portland, Oregon 97227
Attention: Mike Leahy
Fax: (503) 416-1437

Clackamas County Public Health Division
821 Main St., Ste. 200
Oregon City, OR 97045
Attention: Marina Stansell
Fax: (503) 722-6252

Virginia Garcia Memorial Health Center
85 N 12th St.
PO Box 567
Cornelius, OR 97113
Attention: Gil Munoz
Fax: (503) 357-4371

Klamath Open Door Clinic
3810 South 6th St.
Klamath Falls, OR 97603
Attention: Brian Harris
Fax: (541) 851-8114

Any party may change its address for notices by giving notice of the change to the other parties.

Dated as of the ___ day of October, 2003.

MULTNOMAH COUNTY

By: _____

Title: Diane M. Linn
Multnomah County Chair

REVIEWED:
AGNES SOWLE, COUNTY ATTORNEY
FOR MULTNOMAH COUNTY
BY _____
ASSISTANT COUNTY ATTORNEY
DATE 10/02/03

APPROVED : MULTNOMAH COUNTY
BOARD OF COMMISSIONERS
AGENDA # R-7 DATE 10-02-03
DEBORAH L. BOGSTAD, BOARD CLERK

CAREOREGON, INC.

By: _____

Title: _____

OREGON COMMUNITY HEALTH INFORMATION NETWORK INC.

By: _____

Title: _____

CLACKAMAS COUNTY PUBLIC HEALTH DIVISION

By: _____

Title: _____

VIRGINIA GARCIA MEMORIAL HEALTH CENTER

By: _____

Title: _____

KLAMATH OPEN DOOR CLINIC

By: _____

Title: _____

AGENDA PLACEMENT REQUEST

BUD MOD #:

Board Clerk Use Only:

Meeting Date: October 2, 2003
Agenda Item #: R-8
Est. Start Time: 10:50 AM
Date Submitted: 09/23/03

Requested Date: October 2, 2003 **Time Requested:** 90 mins

Department: Non-Departmental **Division:** Chair's Office

Contact/s: Diane Luther

Phone: 503.988-3308 **Ext.:** 84463 **I/O Address:** 503/600

Presenters: Diane Luther, Linda Kaeser, Beth Kaye

Agenda Title: RESOLUTION Accepting the Report of the Special Needs Committee of the Housing and Community Development Commission, and Implementing the Recommendations Therein

---

1. **What action are you requesting from the Board? What is the department/agency recommendation?**
   To accept the report of the Special Needs Committee and authorize implementation of the recommendations contained therein.

2. **Please provide sufficient background information for the Board and the public to understand this issue.**
   The Special Needs Committee has issued a report assessing the need for Special Needs Housing and making recommendations for use of resources and systems change to create more housing for special needs populations served by Multnomah County.

3. **Explain the fiscal impact (current year and ongoing).**
   None.

   If a budget modification, explain:
   - **What revenue is being changed and why?**
   - **What budgets are increased/decreased?**

- **What do the changes accomplish?**
- **Do any personnel actions result from this budget modification? Explain.**
- **Is the revenue one-time-only in nature?**
- **If a grant, what period does the grant cover?**
- **When the grant expires, what are funding plans?**

NOTE: Attach Bud Mod spreadsheet (FORM FROM BUDGET)

If a contingency request, explain:

- **Why was the expenditure not included in the annual budget process?**
- **What efforts have been made to identify funds from other sources within the Department/Agency to cover this expenditure?**
- **Why are no other department/agency fund sources available?**
- **Describe any new revenue this expenditure will produce, any cost savings that will result, and any anticipated payback to the contingency account.**
- **Has this request been made before? When? What was the outcome?**

4. **Explain any legal and/or policy issues involved.**
No legal issues. Policy issues described in the Report and in the Resolution include prioritizing use of resources for special needs housing; and making changes in our service systems and housing finance systems to provide services related to housing success.

5. **Explain any citizen and/or other government participation that has or will take place.**
The Special Needs Committee is a subcommittee of the Housing and Community Development Commission, a citizens' oversight group. The Committee is made up of a cross section of representatives of City, County and State government, and includes several citizen and nonprofit advocates.

Required Signatures:

Department/Agency Director: _____ **Date: 09/23/03**

Budget Analyst

By: _____ **Date:**

Dept/Countywide HR

By: _____ **Date:**

Housing and Community Development Commission

Special Needs Committee Report

July 2, 2003

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This is the first report of the Special Needs Committee (SNC), of the Housing and Community Development Commission (HCDC) for Multnomah County.

Our community is experiencing a crisis in special needs housing. People with special needs, some of the most vulnerable members of our community, are unable to find safe, decent housing linked with the appropriate level of service. For lack of suitable supportive housing, too many people with special needs become inpatients at hospitals, are incarcerated, or enter the homeless system. This is neither humane nor financially prudent.

We believe that, if we can provide an adequate supply of supportive housing, we can ease the pressure on the mental health system, the corrections system, and the homeless system, as well as provide people with the homes and services they need and deserve. We can refocus resources in a more compassionate and economically efficient way.

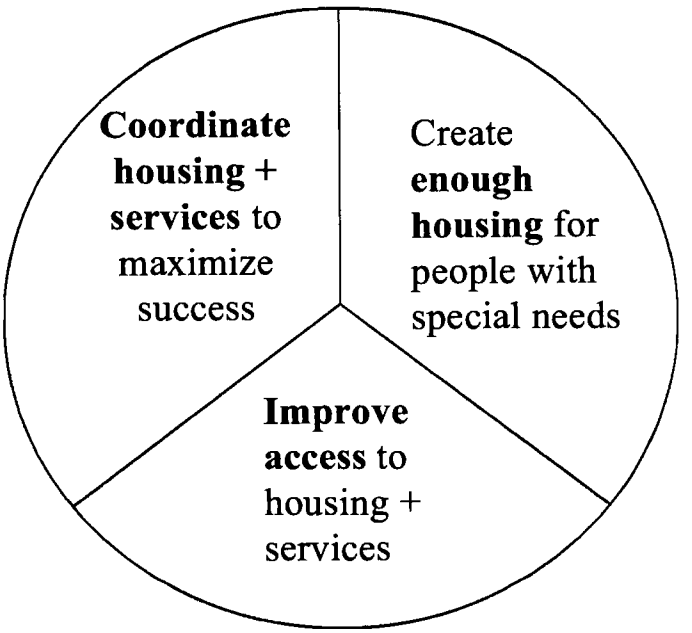
Throughout this report, we have used two important terms:

> **People with Special Needs**: are those with a severe and persistent mental illness, a substance abuse disability, a developmental disability, a serious physical disability, or a combination of these resulting in serious functional impairment. In this report, we focus on people who: meet these special needs criteria, are low income, do not have permanent housing, and will need some type of support to succeed in housing.
>
> **Housing + Services**: means the provision of permanent housing and support services in a linked or coordinated manner, although not necessarily by the same provider.

Over the past year there were almost 8,000 people with special needs in Multnomah County who needed – but did not have – permanent housing for all or part of the year. Of these, 3,500 were chronically homeless. People with special needs are more likely to have repeated episodes of homelessness and to remain homeless for longer periods.

Significant barriers stand in the way of developing and maintaining an adequate supply of special needs housing: lack of housing and service resources; lack of a shared understanding between housing experts and service experts; and lack of public awareness and support for vulnerable people and their housing needs.

The Special Needs Committee recommends an approach to reducing these barriers that requires improvements in three areas:



Public policy that supports **coordinating services with housing** will assist individuals with special needs to succeed in housing, and will encourage housing providers to make units available to people with special needs. Focusing mainstream services on the hardest-to-house can reduce homelessness. Cross training of housing managers and case managers strengthens both the service and housing systems.

We can **create enough housing for people with special needs** over time by increasing the proportion of housing resources – development funds and rent assistance – allocated to people with special needs. We can dedicate an "express lane" in the development pipeline for projects that package housing funds and service commitments. We can leverage more public and private resources.

We can **improve access to housing and services** by providing a comprehensive and culturally competent service plan to each individual, addressing housing, services, and food security needs. We can work with people with special needs who are currently hospitalized or incarcerated to make sure they have a service plan in place prior to discharge.

We believe that achieving success in all three areas will result in Multnomah County becoming a community where people with special needs live in decent, stable and affordable housing that is coupled with the support they need.

PROCESS

In late 2001, the Housing and Community Development Commission[1] (HCDC) assembled a Special Needs Committee (SNC) comprised of people knowledgeable about the current systems and with enough authority to direct and implement changes. The group included senior policy makers, funders, housing providers, service providers, and advocates. A list of members appears on the last page of this Report.

In spring of 2002, the Multnomah County Commission, the Portland City Council, and the Housing Authority of Portland Board of Directors charged the Housing and Community Development Commission's Special Needs Committee, through parallel resolutions (Appendix A), to:

- Assess the need for special needs housing Countywide, including the specific housing needs of individual special needs populations;
- Coordinate housing and service resources to stimulate development of special needs housing;
- Develop hard, realistic, and measurable targets for additional housing for persons with special needs;
- Leverage new resource streams for special needs housing development and operation; and
- Create models for special needs housing development and operation;
- Make policy recommendations to advance the development of special needs housing.

The Special Needs Committee met monthly from January 2002 through June 2003. The first meetings were devoted to an exchange of basic information about the affordable housing world and the discrete service systems for people with severe and persistent mental illness, physical disabilities, developmental disabilities, and/or substance abuse disabilities. The SNC also received information about the challenges faced by people with special needs in the corrections and community justice systems. The result of these discussions is a committee whose members now have a more holistic view of the challenges in special needs housing, and a common language for discussing them.

Tools developed to analyze the current situation include:

- Review of housing need and homelessness data for people with special needs and an inventory of special needs housing. (Appendix B summarized in Table 1, p. 16)

[1] HCDC is a fifteen-member volunteer citizen advisory Commission serving Multnomah County, the City of Portland and the City of Gresham. HCDC is designated as "the primary public forum in which policy development, resource coordination, and civic leadership are provided to address the County's affordable housing problems."

- Matrices of resources for: housing development, emergency housing, housing subsidies, and services.[2]
- An analysis of barriers to special needs housing. (Appendix C)

Based on this foundation, the committee developed:

- The Committee's vision, goals and long-term strategies for special needs housing. (Appendix D)
- Priorities for funding decisions about new housing projects, emphasizing housing for those with: the lowest income; the greatest risk of inappropriate institutionalization in shelters, hospitals, jails, or nursing facilities; and the greatest degree of disability. *See p. 24.*
- Criteria for allocation of project-based Section 8 resources, at the request of the Housing Authority of Portland, based upon SNC priorities but factoring in the risk of displacement. (Appendix E)
- Input on preserving facilities threatened with closure, including the Taft, Hoodview Residential Care Facility, and William-Elaine Residential Care Facility. (These projects also provided good "case studies" of special needs housing challenges, and catalyzed dialogue and increased understanding of the housing/social service relationship.)
- A Long-Range Goal Matrix, setting out the long-range goals and identifying strategies, and outcomes. (Appendix F)

Along with this Report, current initiatives of the SNC and its members include:

- Support of, and participation in, the application for the federal Interagency Council on Homelessness (ICH) grant, the "Collaborative Initiative to Help End Chronic Homelessness." If funded, mental health and addiction treatment, health care, and permanent housing with support services would be provided for 150 people.
- Participating with the Multnomah County Department of Community Justice in developing the "Social Security Income Continuum" project, along with representatives of other federal, state and county agencies. The SSI Continuum will connect disabled prison and jail inmates to entitlements before discharge, enabling them to receive benefits within 30-60 days after release. Access to SSI and Medicaid resources will enable special needs offenders to receive the housing and services they need to live stable, crime-free lives.

[2] The Committee intends to convert these matrixes to web-based resources that can be updated. Copies of the matrixes are available upon request.

- The City of Portland, Portland Development Commission, and the Housing Authority of Portland ("HAP") released a first-ever joint Solicitation of Interest for Special Needs and Affordable Housing Development, Columbia Villa Off-Site Replacement Housing, and a Project-Based Section 8 Pilot Project. This marks a concerted effort by the funders in our community to allocate a variety of scarce housing resources to special needs housing. These projects will inaugurate an "express lane" for special needs housing in the housing development pipeline for projects that package housing development dollars and service funding.
- HCDC has received a $5,000 grant from Eli Lilly and Company for a symposium to explore new ways to bridge housing and services resources to expand the supply of service enriched housing for people with special needs.
- Multnomah County Department of Human Services has agreed to work with affordable housing providers to help special need residents succeed and housing projects to remain stable. If a resident is experiencing a mental health crisis and is at risk of losing housing, the housing provider can use the Call Center to obtain emergency mental health services for the resident.

A major success for our community has resulted from the SNC committee's partnership with Multnomah County, the City of Portland, and other key stakeholders in a successful application to the Corporation for Supportive Housing (CSH) for a "Taking Health Care Home" grant funded by the Robert Wood Johnson Foundation.

This grant will fund systems change directed at ending chronic homelessness. The target population is people who have experienced long-term and episodic homelessness and have disabling health conditions, which is a significant cohort of the special needs population.

After this report has been accepted, the chartering jurisdictions will be asked to adopt a joint memorandum of understanding that will guide implementation of the recommendations in this report.

POPULATION

The Committee has focused on special needs populations who are the most *under-housed:* meaning those who do not have a place to live where they can remain indefinitely. The most under-housed special needs groups are extremely low-income[3] adults between the ages of 18 and 64, and unaccompanied minors. Their low incomes, service needs and problematic behaviors create challenges in obtaining and retaining housing. While most of the people in this group live in households of one, some live in families with minor children or with other household members. Because extremely low-income seniors 65+ are significantly under-served in mental health and addiction services, and have trouble accessing services if their disability is due to mental illness (other than dementia) or substance abuse, they are also included as a focus population.

DEFINITION:

A PERSON WITH SPECIAL NEEDS is an individual with a severe and persistent mental illness, substance abuse disability, developmental disability, serious physical disability, or multiple disabilities.

Focus Populations for the Special Needs Committee

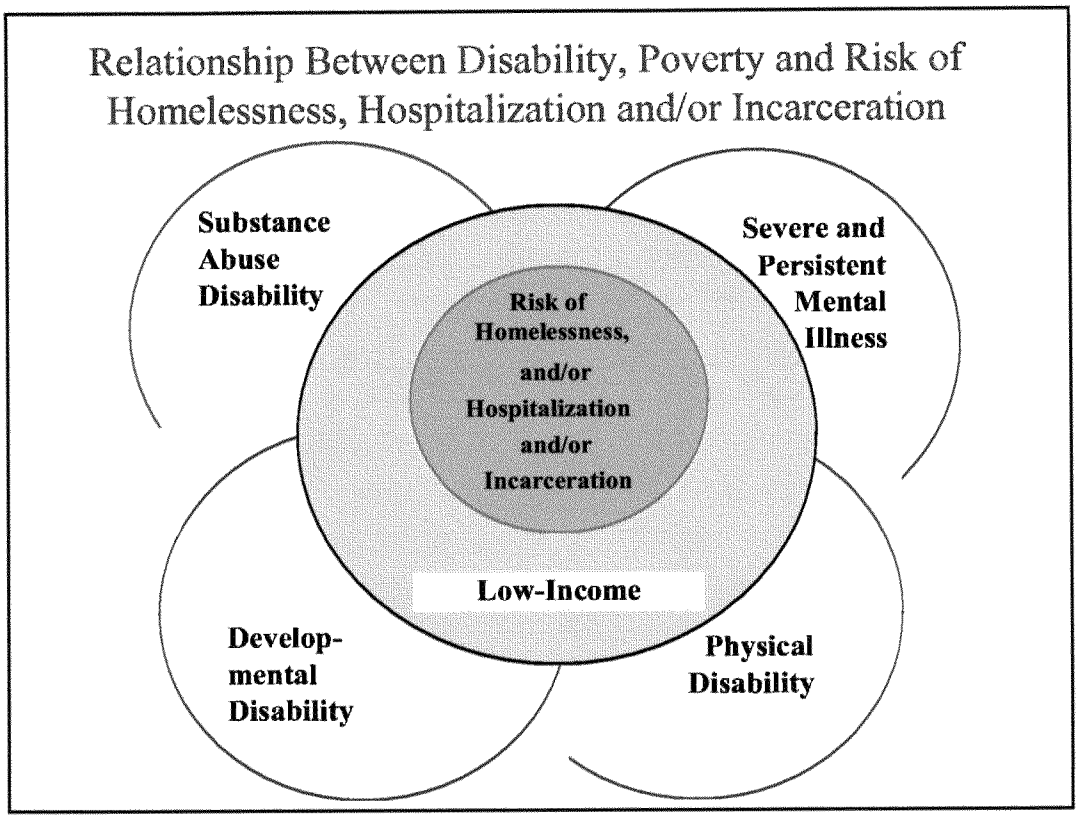
Focus Populations	Special Needs
Unaccompanied Minors	☑ Severe and Persistent Mental Illness ☑ Substance Abuse Disability ☑ Developmental Disability ☑ Serious Physical Disability ☑ Multiple Disabilities: two or more of the above
Extremely Low-Income Adults Age 18-64	☑ Severe and Persistent Mental Illness ☑ Substance Abuse Disability ☑ Developmental Disability ☑ Serious Physical Disability ☑ Multiple Disabilities: two or more of the above
Extremely Low-Income Seniors Age 65+	☑ Severe and Persistent Mental Illness ☑ Substance Abuse Disability ❑ Developmental Disability[4] ❑ Serious Physical Disability[4] ☑ Multiple Disabilities: two or more of the above

[3] HUD defines low-income as a household with income up to 50% of the Median Family Income (MFI). Extremely low-income households have incomes up to 30% MFI. MFI is set by HUD annually for the Portland Metropolitan Statistical Area. *See* Appendix H. For 2003, the MFI is $46,050 for a single person and $ 65,800 for a family of four. The 2003 federal poverty level for a household of one is $8,980 and a household of four is $18,400. This is equivalent to 20% MFI for a single person household and 28% MFI for a household of four. *See* discussion on "Effect of Poverty," p. 19.

[4] Services, often linked with housing, for these populations are funded by Medicaid community-based waivers, through County Developmental Disabilities and Aging & Disability Services.

These focus populations include individuals who often find themselves on the streets, or in the community justice system, homeless shelters, or hospitals. Lack of stable, affordable housing with adequate supports is a major contributor to homelessness and recidivism. An adequate supply of housing coordinated with services would reduce pressure on the jails, shelters, and hospitals of Multnomah County.

FIGURE 2



It is difficult enough to cope with a disability. This figure shows that, when disabilities overlap, or are combined with poverty, the risk of homelessness, hospitalization and/or incarceration increases sharply.

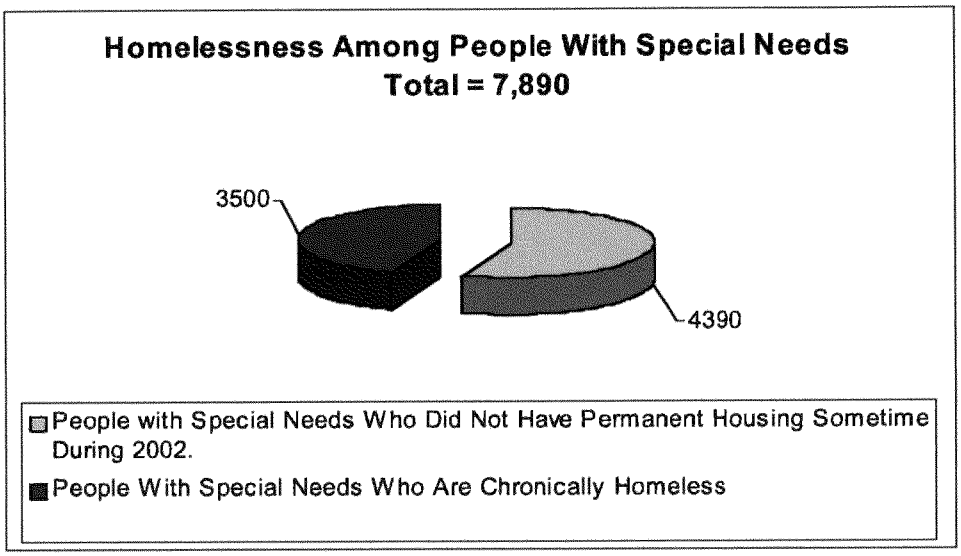
ESTIMATE OF NEED FOR HOUSING LINKED WITH SERVICES

Multnomah County is home to a large number of people with severe and persistent mental illness, physical disabilities, developmental disabilities, and/or substance abuse disabilities, many of whom have multiple disabilities.

The SNC has had difficulty collecting and analyzing data related to these populations. Each housing and service system uses different definitions and maintains different types of data. Additionally, clients often use multiple resources. Although the data below builds on reliable sources and attempts to unduplicate client counts, it lacks the certainty we would prefer. Nevertheless, our research clearly shows the lack of permanent housing and the extent of homelessness for those with special needs.

HOMELESSNESS AND SPECIAL NEEDS: During 2002, 7,890 County residents with special needs did not have permanent housing for part or all of the year, including about 3,500 persons experiencing chronic homelessness.[5] Chronic homelessness means a person has been homeless for more than a year or more than four times in a three-year period.[6]

FIGURE 3



Not only are a large number of people with special needs without stable housing, but people with disabilities are also greatly over-represented among the chronically homeless. They are more likely to have repeated episodes of homelessness and to remain homeless for longer periods.

A survey was taken of those seeking emergency shelter on March 27, 2002. Twenty-nine percent reported that they were eligible for services directed to the psychiatrically disabled, developmentally disabled, substance abusing and dual-diagnosed populations. Fifty-five percent of households of every size, and sixty percent of single adults, indicated a disability as the primary reason for their homelessness (e.g., substance abuse, mental illness, or a medical problem).[7]

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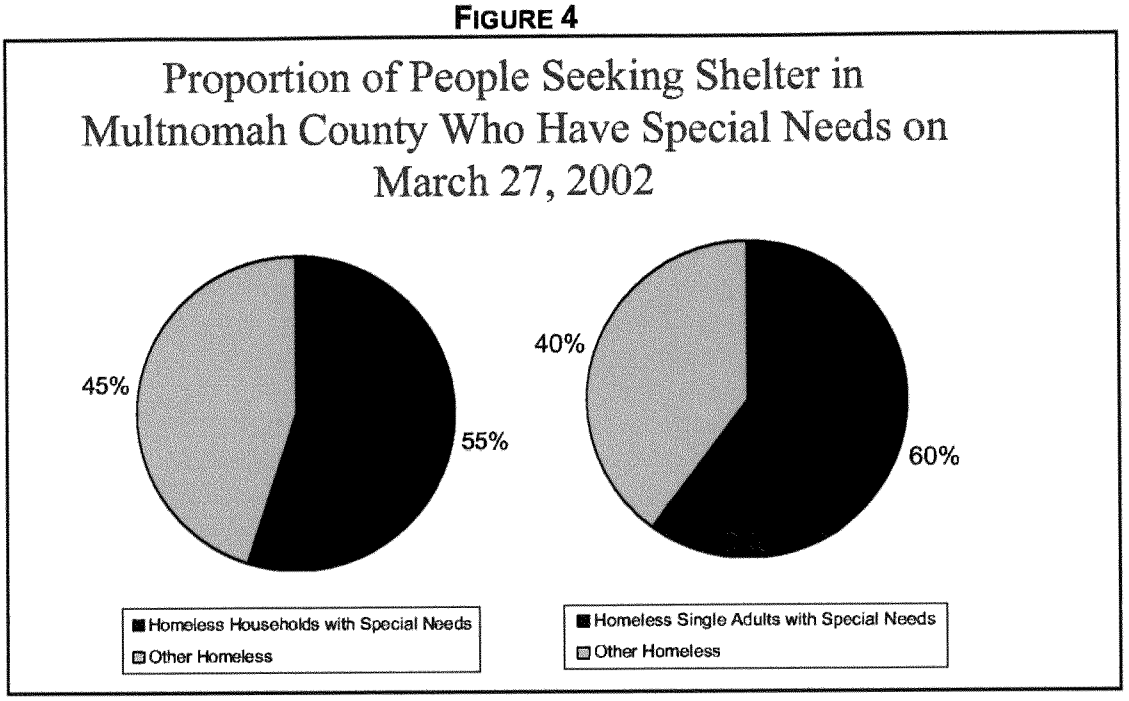
[5] This estimate is a blend of point-in-time and annualized data, as those who experience homelessness multiple times in a year are likely over-represented in point-in-time data.

[6] The federal definition of a Chronically Homeless Person is "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three years. To be considered chronically homeless, persons must have been sleeping in a place not meant for human habitation (*i.e.* streets) and/or in an emergency homeless shelter during that time."

[7] March 27, 2002 One Night Shelter Count, Multnomah County Office of School and Community Partnerships

FIGURE 4



A discouraging picture thus emerges of the shelter system as one of our main resources for housing low-income people with special needs.

LACK OF SHELTER: On any given night, our current homeless system is unable to serve approximately 17 percent of homeless people who seek assistance.[8] A street count found 1,672 unduplicated people sleeping outside on April 22, 2002.[9] One survey of Safe Haven in Portland showed the average length of time people with severe and persistent mental illness were homeless was 49 weeks, while the longest was 36 years.[10]

OFFENDERS WITH SPECIAL NEEDS: A study conducted on a small number of "the most frequently booked" in jails determined that about a fifth of these "frequent flyer" inmates were homeless and repeatedly cycled through jails, hospitals and shelters.[11] Other studies have confirmed that persons with disabilities are disproportionately represented in jails. Of the 1,010 offenders served by the Department of Community Justice Transitional Services Unit (TSU), 802 of them (79%) had at least one special need;[12] 80% of these had alcohol or drug abuse disorders as one of their diagnoses.

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[8] Based on turn-away rates from 1999-2002 One Night Shelter Counts.
[9] JOIN street count, April 22, 2002
[10] Housing and Community Development Commission Weeklong Needs and Gaps Survey, Feb. 25-March 3, 2002
[11] The Booking Frequency Pilot Project Report, Multnomah County's Sheriff's Office, January 2002
[12] Multnomah County Community Justice Department's Transitional Services Unit (TSU) enrollment records

A sub-population of people with severe and persistent mental illness is responsible for a disproportionate number of incarcerations. In 2000, for example, 3,800 individuals with identified mental health problems were booked into Multnomah County jails a total of 5,700 times. Nearly one-third were diagnosed with a serious mental disorder.[13]

HALF OF OREGON'S HOMELESS LIVE HERE: The statewide March 27, 2002 One Night Shelter Count shows that a disproportionate number of Oregon's homeless persons seek emergency services in Multnomah County. While 19% of the state's adult population reside in Multnomah County (666,350 of 3.4 million), 51% of Oregon's homeless single adults sought shelter in Multnomah County.

Of all the adults seeking shelter in Oregon who were homeless due to chemical dependency, mental illness, and/or medical problems, over half sought shelter in Multnomah County.[14] Of 3,813 homeless adults enrolled in state substance abuse treatment services during the 2001-02 fiscal year, Multnomah County served 2,143 (56%).[15]

HOMELESS FAMILIES

It is difficult to obtain comprehensive data on homeless families. Again, we know more about families that seek shelter through the homeless families system than about families that live doubled-up, or in cars, or camp in our local parks. According to the November 2002 One Night Shelter Count, 38.6% of the homeless family population that sought shelter statewide was in Multnomah County.

The homeless family system does not currently collect data on special needs. In one study sponsored by the Robert Wood Johnson Foundation, 41% of adults in homeless families self-declared that they were suffering from alcohol or drug dependencies or addictions, or had used hard drugs during the past year. In an annual progress report filed by one local homeless family agency, out of 144 families, 4 presented with mental illness, 3 self-reported for substance abuse, and 5 had a physical disability. However, these numbers may be misleading, since homeless families coming from substance abuse treatment are directed primarily to other agencies.

There is a clear need to develop better data on homeless families with special needs, to inform policy and program development.

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[13] From 1995 to 2001, the number of individuals with mental health problems in Multnomah County jails increased from 1,500 to 3,400, with a peak of 3,800 during 2000. Nearly one-third of the 3800 were diagnosed with a serious mental disorder. *See Mentally Ill Treatment*, by Bill Midkiff, Health Services Administrator, Multnomah County Health Department, Corrections Health Division, November 2002.

[14] March 27, 2002 One Night Shelter Count, Oregon Office of Housing and Community Services

[15] Oregon Department of Human Services, Office of Mental Health and Addictive Services

HOMELESS YOUTH

It is difficult to obtain a comprehensive data picture of homeless youth with special needs. Of the population of homeless youth, only a fraction apply for services and go through the initial screening process. This is what we know: In calendar year 2002, 465 youth presented for screening into the homeless youth continuum of services. At this time, youth reported information about their medications, on-going health problems, and desire for services. Twenty-five percent of them reported that they had an on-going health problem at the time of screening, and 30% requested services for health care. Only 5% requested drug and alcohol treatment.

Homeless program staff completed 299 actual assessments in 2002. At this time, the youth have an opportunity to give information about their mental health and substance abuse disability history. Nearly one-third reported that they had previously attempted suicide. More than half had received counseling in the past. Nineteen percent had received psychiatric counseling, and 16% had received residential treatment of some kind. Eight percent indicated that they would like to receive mental health services/counseling at the time of the assessment, and were referred.

We cannot ascertain at this time what percentage of homeless youth have either physical or developmental disabilities. This information is not specifically requested under current practice, although the caseworker could enter the data in the comments filed.

There is a clear need to develop better data on homeless youth with special needs, to inform policy and program development.

SUMMARY OF NEED – ADULTS 18 - 64

We have developed a summary of the need and unmet need for permanent housing for people with special needs, compiling data from many sources with the intent to be as comprehensive as possible, while avoiding duplication where feasible. This section attempts to quantify the number of permanent housing units required to meet the needs of people who:

- **have special needs**, defined as: a severe and persistent mental illness, a substance abuse disability, a developmental disability, a serious physical disability, or any combination of these conditions resulting in a serious functional impairment; and
- **are age 18-64**; and
- **are extremely low income**, defined as 0 to 20% of Median Family Income[16]; and
- **do not have permanent housing** (i.e. are homeless, sleeping on someone's couch or in their car, in jail, or in transitional housing with no place to go); and

[16] See footnote No. 3.

- **are likely to need some kind of supportive services** and/or enhanced housing management to succeed in community-based housing.

TABLE 1. SUMMARY OF NEED AND UNMET NEED FOR PERMANENT SUPPORTIVE HOUSING

Selected Special Need Populations Age 18-64	Estimate of Need For Special Needs Permanent Housing	Current Permanent Unlicensed Housing[17]	Unmet Need for Permanent Housing
Severe & Persistent Mental Illness	1,683	464	1,219[18]
Substance Abuse Disability	3,086	572	2,514[19]
Developmental Disability	520	20	500[20]
Serious Physical/ Functional Disability (includes AIDS/HIV)	2,540	209	2,331[21]
Multiple Disabilities[22]	1,375	49	1,326[23]
Totals	**9,204**	**1,314[24]**	**7,890**

In 2002, 9,204 people age 18 to 64, with extremely low-incomes and special needs, required a combination of permanent Housing + Services. Currently 1,314 units of such housing are available, leaving an unmet need for 7,890 additional units.

- **Annual:** Numbers are annual, e.g. 1,219 people with a severe and persistent mental illness did not have permanent housing for part or all of last year.

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[17] Reflects current unlicensed housing only.
[18] Number derived from combination of OMHAS CMPS Report FY 01-02 identifying 1,019 MH clients who were homeless at time of service enrollment, plus March 2002 One Night Shelter Report identifying 200 with Mental Illness.
[19] Number derived from a combination of the OMHAS FY 01-02 Report identifying 2,143 clients who were homeless at time of service enrollment, plus 371 persons from the March 2002 One Night Shelter Report.
[20] Number derived from data from data from 3 Agencies: MCDDS, ARC of Multnomah County, and ILR.
[21] Number includes 682 persons from Portland EMA AIDS/HIV Housing Plan plus 1,649 persons from Multnomah County Housing Needs Report.
[22] The category, Multiple Disabilities, are people who were reported in this category as having includes a combination of conditions resulting in a functional impairment, including: developmental, mental, physical, chemical, and cognitive.
[23] Number derived from Multnomah County 2001 Housing Needs Report and includes any combination of conditions including physical, developmental, mental, cognitive, and chemical
[24] Of these, 946 units support people with special needs who have been homeless or are at-risk of homelessness

- **Unlicensed:** The inventory of housing in this table is all unlicensed housing for specific populations, with varying degrees of linkage to services. While some people without permanent housing may qualify for licensed housing (e.g. foster homes, group homes, or residential care facilities, which serve people requiring a greater intensity of services), we believe most do not.

- **Current Permanent Housing:** This is the current inventory of permanent housing which is affordable to those with extremely low incomes, identifiable for a specific disability group, and linked to services.

- **Housing + Services:** Most people reflected in this table will need housing linked with some kind of enhanced property management or supportive services to succeed in maintaining permanent housing.

- **System Contact:** The table represents those who had contact with the system in some way – who sought services or shelter, and/or who were found during the one-night shelter/street counts that attempted to locate all homeless people.

- **Homelessness:** The focus is on people with special needs who need but do not have permanent housing, which is not the same as being homeless: some are only at risk of being homeless. Only homeless people who also have special needs are included.

- **Families:** No firm data is available on how many single adults, couples, or families are included; indicators support estimating about 10% of those in each category represent people living in families, and 90% singles or couples.

- **Gap:** The current unmet need is for 7,890 units of special needs housing. This gap results in a large population that is constantly homeless (such as the 3,500 people with special needs who experienced chronic homelessness last year), or who are at risk of homelessness (such as the 4,390 people with special needs who cycled into homeless at some time last year). The gap in housing may be met by licensed or unlicensed units.

- **Multiple Disabilities:** The numbers probably under-represent the number of people with multiple diagnoses, due to different methods of collecting data, different definitions of disabilities, limitations of self-reporting, and masking by more overt symptoms. However, an increase in multiple disabilities would likely result in a decrease in single diagnosis categories.

- **Duplication:** There may be some duplication in the table, as it is not currently possible to sort by client name or identifier among the various service systems' databases. We do not believe the duplication is large.

- **Undercount:** We believe, however, that this data significantly undercounts the need for permanent housing for people with special

needs, because many have not made contact with any system for shelter or services.

Unaccompanied Minors with Special Needs

We found no reliable data on the number of unaccompanied minors with special needs. There is a clear need to develop data on unaccompanied minors with special needs, to inform policy and program development.

Seniors over age 65 with Mental Illness or Substance Abuse Disorder

Older adults age 65+ with a primary diagnosis of mental illness, or with a combination of mental illness and other conditions resulting in a functional impairment, have similar needs for housing coordinated with services as the 18-64 population. The most critical need is for low-income seniors who have both a physical disability and mental illness.[25] According to Multnomah County Aging and Disability Service's Housing Placement Specialist, the most frequent reason case managers sought assistance for locating an Adult Foster Home or Residential Care Home was to serve these seniors, whose medical needs and/or mental illness had exhausted family and mainstream housing providers. During the three-year period from 1996-1999, ADS worked with 633 clients who fit this profile.

The second most critical need is for low-income seniors with only a primary mental health diagnosis. They are under-served by the mental health system and, if they do not have a physical impairment, they are not eligible for Medicaid-funded services.

Increasing Need: Budget cuts this fiscal year and anticipated in the next biennium will likely increase the numbers of individuals and families who will lose stable housing due to cuts in their services and/or income supports. This will increase the number of people experiencing homelessness. For example:

- 1,090 adults with disabilities who had not yet qualified for federal Social Security Income (SSI) or Social Security Disability (SSD) benefits lost their income, due to the elimination of the state-funded General Assistance (GA) program on January 31, 2003. Of these, 125 recipients were already homeless.
- 1,100 ADS long-term care clients, who primarily live at home, lost care services provided under a Medicaid waiver.

In Multnomah County, voters do not want services cut. Some of the support for Measure 26-48, the temporary local income tax passed in May 2003, was from voters who wanted to restore a portion of the safety net for low-income people. Likewise, legislators are considering changes to the State budget to partially

[25] There is consensus among the ADS Public Guardian Office, the ADS Adult Protective Service Office, social workers and the senior community service network that seniors with very low incomes, mental illness and medical needs are most in need of Housing + Services. There are few housing/service options that can handle both.

restore some previous service cuts. The following cuts may be partially or temporarily reversed:

- Eligibility for the Oregon Health Plan has been reduced to mandatory groups. Low-income people who could previously qualify for a range of medical, mental health, and addiction treatment services under OHP may now only qualify for prescription medications, subject to co-pays and premiums.[26]
- Oregon has eliminated the Medically Needy program, resulting in loss of mental health treatment, medical transportation, alcohol and drug treatment, and prescriptions for 1,955 ADS clients.
- 4,000 previously eligible Multnomah County mental health consumers became ineligible for mental health services after State mental health program reductions and OHP cuts.
- Between 460-750 Multnomah County residents lost coverage to pay for methadone due to OHP cuts.

Effect of Poverty

Many of the housing challenges faced by people with special needs are directly related to income. Although some people with special needs earn a sufficient wage to purchase housing and health care, those with severe disabilities are often unable to earn enough to provide for their basic needs. Lack of ability to earn a good income, and thus reliance on low wages or public benefit levels, severely limits or eliminates housing choice.

The U.S. Department of Housing and Urban Development (HUD) issues the Area Median Income for Multnomah County on an annual basis. *See* Appendix .No more than 30% of income should be spent on rent. Recipients of SSI have income supplemented up to $552/month, or 14% of the Area Median Income for a single person household, and should spend no more than $165 on rent and utilities. The average recipient of SSD has an income of $800/month, or 19% of Area Median Income, and should spend no more than $240 on rent and utilities. However, fair market rent in Multnomah County in 2003 for a studio apartment is $508 per month; a one-bedroom apartment is $625; and a two-bedroom is $771.

In Multnomah County's housing market, low income has extremely harsh consequences. The Consolidated Plan for Multnomah County, prepared by HCDC to meet HUD requirements, has documented a significant loss of housing affordable to low-income people within the County over the past 12 years. Increasing market rents and loss of restricted-rent housing projects have similarly resulted in greater levels of homelessness for people with special needs locally and throughout the nation.

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[26] 2,100 ADS clients had OHP services significantly reduced or eliminated.

In the late 1990s, the City of Portland created the Housing Investment Fund to develop subsidized units, producing a record 4,000 units over 5 years. However, no concerted effort was made to link persons with special needs to these units. Looking at this situation, the City Club of Portland has recently recommended priority funding for housing for people with special needs, and a massive program of rent assistance so that people with special needs can rent on the open market.[27]

THE HARDEST-TO-HOUSE

Another set of challenges relates to people whose level of disability or combination of disabilities puts them into the "hardest to house" category. The hardest-to-house tend to exhibit problematic behaviors, have poor rental histories marked by multiple evictions, and often have criminal records. People with psychiatric disabilities, especially those with a co-occurring addiction disorder or another additional disability, are often in this group of hard-to-house people.[28]

Even when rental subsidies are available, people who are hard-to-house will find it difficult to secure housing.

The Challenge of Housing the Hardest to House

The "hard to house" population becomes the "chronically homeless," living on the streets, in shelters or transitional housing, cycling through jails, hospitals, and nursing homes, and using resources disproportionate to their numbers. Some of the recommendations in this report target this population specifically, with the belief that better serving this group will increase the cost-effectiveness of our human service, housing and corrections systems.

The Housing Authority of Portland reports that its Section 8 voucher program has a 17% turn-back rate. This means that 17% of people with a voucher guaranteeing that the federal government will pay the difference between 30% of their income and a reasonable rent cannot find a landlord willing to rent to them. HAP's analysis shows that many of those who turn back their vouchers fall in this hard-to-house category.

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[27] *See* the City Club of Portland Report: *Affordable Housing in Portland*, February 2002. See the report at http://www.pdxcityclub.org/afhous.pdf

[28] Research done by the Multnomah County Mental Health Design Team, created in 2000, supports this. They noted the difficulties of housing and serving persons with a psychiatric disability who also have an additional issue, such as: being under 25; having substance abuse issues; having a developmental disability; having involvement in the criminal justice system; or being physically compromised.

SUPPORTIVE SERVICE NEEDS

The most vulnerable people with special needs often require supportive services to succeed in housing. The variety of needed services - from medication management to housekeeping assistance to food security to money management – calls for a variety of housing and service models.[29]

> **DEFINITION: SUPPORTIVE SERVICES** – the range of supports needed for people to be successful in housing.

The SNC has developed the term **HOUSING + SERVICES** to mean the combination of housing and the appropriate level of services to meet the individual's needs.[30] When a family member has a disability, services may extend to the needs of other family members, including arranging for childcare, and providing transportation to school and medical appointments for the children in the household.

> **DEFINITION: HOUSING + SERVICES** – Permanent housing that incorporates supportive services into housing operations, and/or coordinates with outside service providers for supportive services to meet the resident's needs.

The continuum of Housing + Services types ranges from a licensed care facility with 24-hour care provided on-site, to a standard affordable apartment with client-initiated services provided off-site. There are currently a variety of options available, albeit in limited quantities. Future work should include evaluation of these models for suitability, cost-effectiveness, and adaptability to changing funding levels.

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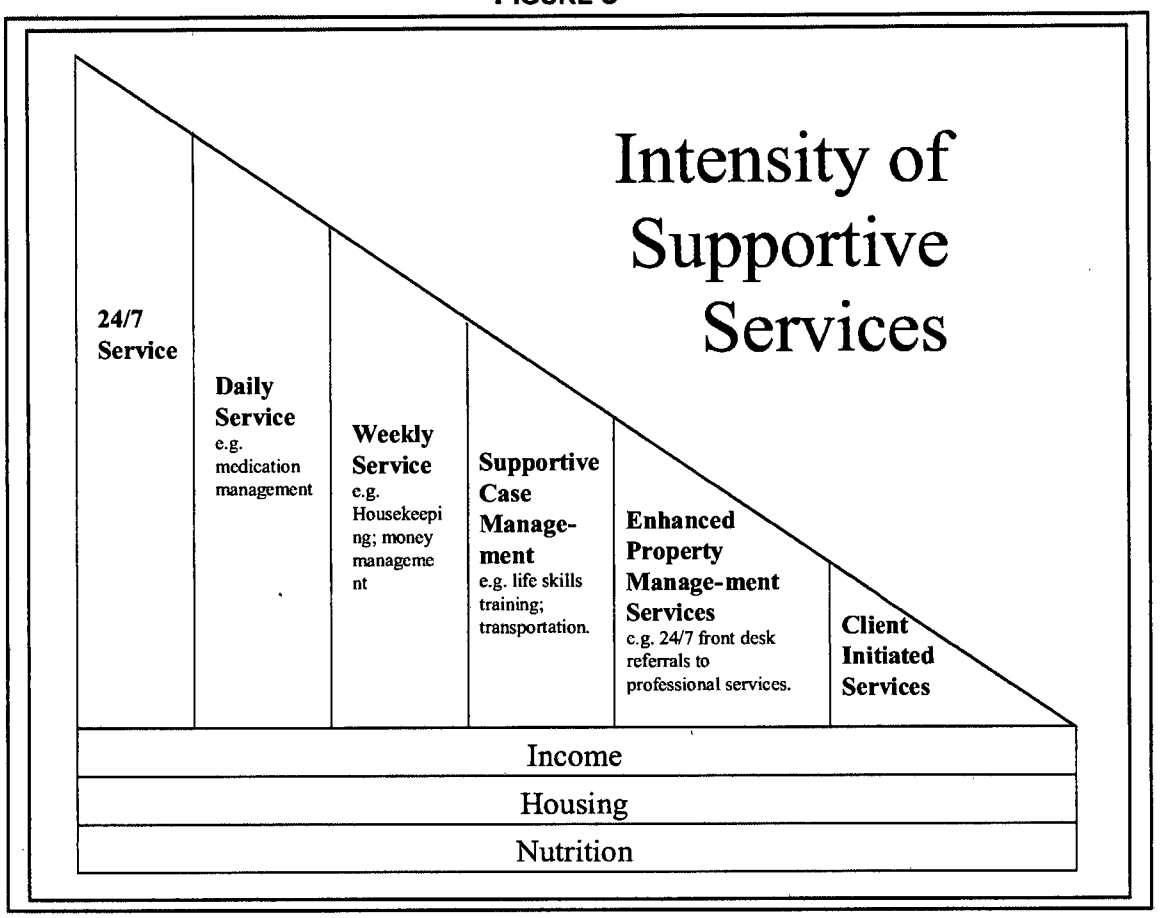
[29] Professional medical and dental treatment is an important issue that falls beyond the scope of the Special Needs Committee and this Report.

[30] We use Housing + Services instead of the more commonly used "supportive housing," because we found that "supportive housing" has some very specific definitions in certain contexts, resulting in confusion.

The table below describes the spectrum of intensity of supportive services. Many of these services could be provided on-site or off-site. The housing provider could provide them, or other providers could coordinate their services with the housing. Generally, more intense services are more expensive. However, even the most intense services are less expensive than homelessness, incarceration, or hospitalization.

FIGURE 5



New and innovative Housing + Service models may be needed to match service capacity to housing, especially given Oregon's current cutbacks in service delivery.

VISION & GOALS

VISION FOR THE FUTURE

Although significant barriers stand in the way, we believe that it is possible to develop and maintain an adequate supply of special needs housing and coordinated services.

> **VISION FOR THE FUTURE:**
>
> In Multnomah County, people with special needs have decent stable affordable housing for themselves and their families, along with the support and services they need for a good quality of life.

REORIENTING TOWARDS HOUSING + SERVICES

Experience shows that housing coordinated with services is a critical element to the success of people with special needs. Recent research shows that homeless people with disabilities who moved to permanent supportive housing experienced marked reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated. [31]

In Multnomah County, we can significantly reduce homelessness and inappropriate institutionalization of low-income people with special needs if we **reorient** our social service and housing systems to do three things[32]:

1. Coordinate housing + services to maximize success of people with special needs in permanent housing.
2. Create enough housing for people with special needs, including housing linked to services and housing for the hard-to-house.
3. Improve access to housing + services, including outreach to the hard-to-house.

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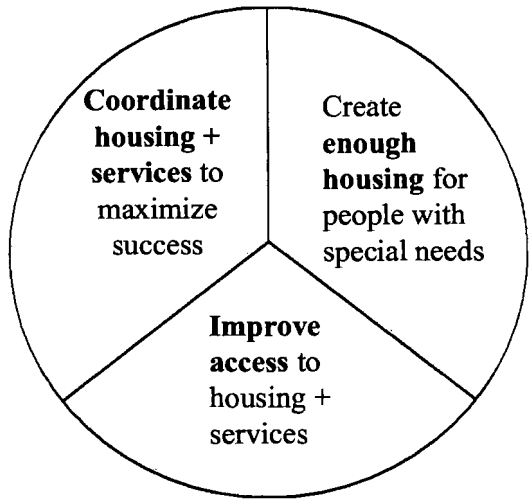
[31] Research by Corporation for Supportive Housing, in January 2003 issue of their publication, *Opening Doors*. In 2001, the University of Pennsylvania's Center for Mental Health Policy and Services Research compared 4,500 homeless people with severe mental illness who moved into supportive housing, with a control group who were not offered permanent housing. They found that those who moved into supportive housing experienced marked reductions in shelter use, hospitalizations , and time incarcerated. Prior to living in permanent supportive housing, the people in the study used an average of $40,449 per person per year in such services; after supportive housing, there was an average reduction in service use of $16,282.

[32] These recommendations are consistent with those made by the Multnomah County Mental Health Design Team and the Multnomah County Health Department, Corrections Health Division Administrator.

These three necessary actions have become our primary goals, and are used to organize our recommended strategies, tasks and outcomes.

FIGURE 6



Adequate funding is obviously an issue for both housing and services. But we also believe that when the systems are reoriented towards these goals, resources will be used more effectively, outcomes in housing stability will be improved, and the strain on shelters, jails, and hospitals, will be reduced.

GOALS

1. <u>Coordinate housing + services</u> to maximize success of people with special needs in permanent housing.

Service systems are generally based on a person-centered model: the client is either eligible or not eligible for services at different times; services may be reduced or eliminated based on federal, state, or local budget levels; or the client could experience a crisis that may or may not be referred to or responded to by service systems. Cutbacks or reconfigurations of the service systems can destabilize clients.

The affordable housing system, on the other hand, is asset based. The housing project itself must be managed to remain healthy – *i.e.* residents must be safe, staff must feel safe, rent must be collected to ensure financial solvency, and the physical premises must be maintained. Clients who experience "unmanaged" crises often create stress for staff and other residents, and are often unable to make rent payments. Eviction is frequently the result.

Large cutbacks or reconfigurations in social services systems can destabilize entire housing projects by significantly altering or eliminating subsidies and services that have allowed tenants with special needs to succeed in housing. The effects of large-scale reconfigurations may be felt for years. Housing

providers, after experiencing unreliability in social services, can become unwilling to continue to make units available to people with special needs.

Social services from each system (mental health, substance abuse, developmental disabilities, corrections, and aging and disability services) need to be reliable and coordinated with housing availability if we are to be successful in providing more special needs housing opportunities. This is a policy issue that should be discussed and resolved at the highest levels.

2. Create <u>enough housing</u> for people with special needs, including housing linked to services and housing for the hard-to-house.

Housing Supply

The Consolidated Plan for Multnomah County, prepared by HCDC to meet HUD requirements, documents that there is an inadequate supply of housing affordable to people earning less than 30% of the area median income.[33] This market fact has created a bottleneck, preventing people from moving out of shelters and transitional housing into permanent housing.

Limited public funding has been the main engine of special needs housing development. Legislative efforts to create a sustainable funding source, such as a real estate transfer tax, should be supported vigorously, but may not succeed. Accordingly, the proportion of public funds allocated to special needs housing must be increased.

Rent subsidy programs, coordinated with appropriate services, can help match some special needs households with the private housing market. Short-term, as well as long-term, rent subsidy programs should be expanded.

We must also increase the number of willing housing providers. One tool is the Fresh Start program.[34] Fresh Start helps overcome barriers to housing by creating a partnership between case managers, landlords/property managers and tenants. Landlords/property managers agree to rent to people who would not qualify under standard screening criteria, in return for commitment by the tenant's case manager to provide ongoing support to the tenant. By bringing the

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[33] HUD regulations state that housing is "affordable" if rent plus utilities do not exceed 30% of the household's gross income. An individual receiving SSI of $552 per month can afford a rent of $166. Fair market rent for a studio apartment in the Portland metropolitan service area is $508 per month. Thus, a renter with SSI income, who is unable to secure a Section 8 certificate or other subsidized housing, can expect to pay over 90% of his or her income on housing.

[34] Fresh Start was developed in 1998 by a coalition of property management, legal and social service providers to meet the needs of the downtown singles population. Between March 1998 and August 2000, 210 units were rented to people using Fresh Start referrals. 77% of these tenants (167) went on to become successful renters. The one social service agency that made 70 percent of the referrals had a 79 percent success rate. Recently, the Bureau of Housing and Community Development (BHCD) has decided to bring the Fresh Start program in-house to ensure quality control and monitoring.

landlord/property manager, case manager and tenant together to resolve rental problems as they arise, Fresh Start helps prevent evictions and has had success in breaking the cycle of homelessness for 77% of participants.

We must also develop a public consensus that results in neighborhoods that are welcoming to housing for people with special needs. This may require assurance to neighbors that adequate, long-term services will be provided to support the new residents' special needs.

Housing Funding Priorities

The committee developed criteria to be used in evaluating and prioritizing projects to assist special needs populations.

Projects that meet all three criteria and show linkage with services should receive the highest priority.

CRITERIA FOR FUNDING
SPECIAL NEEDS HOUSING PROPOSALS

1. Serves people with incomes at or below 30% of area median income, with an emphasis on those with incomes below 20% AMI.
2. Serves those at risk of becoming homeless or otherwise institutionalized inappropriately.
3. Serves those with the greatest degree of disability.

Private Sector Investment

There is a lack of private sector understanding of the funding programs for special needs housing, especially with the multiple sources and delivery points, and inconsistent program requirements. The unpredictable stream of funding for these programs, and the lack of a seamless delivery mechanism, adds to confusion. The current budget situation amplifies risks for private lenders on such projects, and jeopardizes future investment. Some degree of certainty is critical to attract private sector resources to produce much needed housing for people with special needs.

Housing + Service Funding Opportunities

Services that allow a person with special needs to be successful in housing typically cannot be funded by affordable housing development funds[35].

[35] There is a statutory prohibition against using tax increment funds for services. Community Development Block Grant funds may be used for services, but are subject to a "public services" cap of 15%.

Therefore funding that can be used for services must be aggressively sought. For example, some believe that federal Medicaid matching funds could be increased, to provide services coordinated with housing.

A barrier to this goal is that each service system offers a different menu of services to its eligible individuals. This is especially problematic when individuals have multiple disabilities or service needs not readily served by the menu offered.

There are also large gaps in service availability, excluding many people who need assistance. Others receive some but not all of the help needed. Federal Medicaid regulations for each program, and corresponding Oregon Medicaid Waivers (the plans approved by federal officials that govern how Medicaid programs are provided), are focused on each population separately, also contributing to gaps in coverage. Although Oregon has some of the most significant waivers in the nation, there are limited State resources for "match," forcing difficult decisions about whom to serve and what services to provide.

Frequently, there are barriers to using funds in ways that would maximize our ability to provide and support housing. The SNC believes there is opportunity to better leverage our limited state and local financial resources, and believes we should actively work with the state to seek better coordination of state policy, and improved Medicaid Waivers. We also believe there is the ability, even under existing regulations, to do more to support people in housing.

3. <u>Improve access</u> to housing + services, including outreach to the hard-to-house.

While access would naturally improve for many people if increased amounts of housing and services are available, other major barriers to access would remain.

Providers of both supportive services and housing frequently fail to refer to each other. Social service providers may not understand housing alternatives or actively link their clients to needed housing. Landlords and property managers generally do not see their role as linking tenants to needed services, and both public and private housing providers need education about available services. Policy and funding priorities should encourage housing and service providers to work together to ensure that individuals with special needs are offered both housing and services, as needed.

However, some people with special needs do not seek permanent housing, fail to access or are rejected from social services, or are otherwise hard-to-house. Persistent outreach is needed to maintain contact with hard-to-house people, and individualized plans should assist them to accept and succeed in permanent housing. While the intensive level of supportive services needed for this population is expensive, we believe the investment will be more than recovered with savings from police, corrections, shelter, and hospitalizations.

RECOMMENDED ACTION STEPS FOR 2003-2005

After developing our vision and long-term goals, the Committee created long-term strategies, which would move us toward these goals. See Appendix G. We then assessed these strategies in light of current circumstances, including budget cut backs. We recommend the following action steps for the 2003-05 period.

1. **Increase financial resources for social services related to housing.** Find new ways to leverage County and other financial resources to expand services associated with supportive housing, and implement additional ways to coordinate housing and service funding streams. *(Relates to Goal 1. Coordinate Housing + Services)*
    a) Find new ways to match housing operations resources with Medicaid.
    b) Explore creating a County General Assistance program using funds currently used for rent assistance, housing subsidies, etc. Seek reimbursement from the Social Security Administration when the client is deemed eligible for SSI or SSDI.
    c) Maximize use of Federally Qualified Health Center status to provide psychiatric services, case management, etc., to support housing stability, thus obtaining more federal matching funds.
    d) Maximize other federal resources such as USDA food programs, social service and criminal justice block grants, McKinney, Community Development Block Grant (CDBG), and workforce support programs.
2. **Increase the proportion of housing funds allocated to housing for people with special needs.** *(Relates to Goal 2. Enough Housing)*
    a) All involved jurisdictions (City of Portland, Portland Development Commission, City of Gresham, State of Oregon, HUD, the Housing Authority of Portland and Multnomah County) should make development and preservation of supportive housing a high priority for use of publicly-funded housing development resources.
    b) A significant portion of Urban Renewal District revenues should be dedicated to housing for people with special needs.
3. **Strengthen the partnership between the human service system and the social housing system.** Strengthen both systems through shared priorities and increased cooperation. *(Relates to Goal 1. Coordinate Housing + Services)*
    a) Expand and develop the ongoing group composed of human services management personnel and social housing leadership; focus on maximizing the success of people with special needs

within housing environments, e.g. provide updates, cross-educate, plan new service and housing opportunities, and coordinate responses to new issues.

b) Service systems and housing providers should work together to protect housing assets that serve special needs populations from destabilization resulting from cutbacks and reconfigurations in social service systems.

c) Expand programs that provide incentives for non-profit and for-profit landlords to house people with special needs. Fully implement the Fresh Start program.

d) Use capital and rent subsidies to buy down rents of units currently affordable to households at or above 50% MFI, reprogramming admission criteria to target the "hardest-to-house."

e) Create a cross-training program for housing management personnel who deal with special needs residents, and for case managers to learn about housing opportunities and challenges.

4. **Continue the City/County/HAP partnership** that has created new understandings, policy directions and systems changes in the direction of maintaining and creating new special needs housing. Include the City of Gresham. *(Relates to Goal 2. Enough Housing)*

   a) Provide for HCDC oversight of implementation of these recommendations. Adopt outcome indicators and measure progress towards our **Housing + Services** goals.

   b) Create an "express lane" in the development pipeline for special needs housing projects (especially those targeted to homeless) by coordinating resources into joint RFPs, and packaging development dollars and service commitments.

   c) Create and staff a high level interagency body of funders with authority to integrate funding streams and create and maintain the "express lane" for special needs housing projects.

   d) Continue the City-County Pilot Special Needs Housing Set Aside for at least another three years while the "express lane" in the pipeline is developed.

   e) Underwrite new housing projects (or re-underwrite old ones) that serve special needs tenants to provide for Enhanced Property Management, which provides extra support ON SITE at housing projects serving people with special needs. This model has been developed successfully in Seattle, WA.

5. **Develop services and housing targeted to the "hardest-to-house."** *(Relates to Goal 1. Coordinate Housing + Services, Goal 2. Enough Housing, and Goal 3. Improve Access)*

a) Develop specialized activities targeted specifically to chronically homeless people with disabilities. Expand the Assertive Community Treatment (ACT) team model. The ACT team model engages chronically homeless individuals, houses them, and arranges for mainstream health, mental health, addictions, employment and other services after a person is initially housed. ACT teams effect a resolution of the problems that cause homelessness.

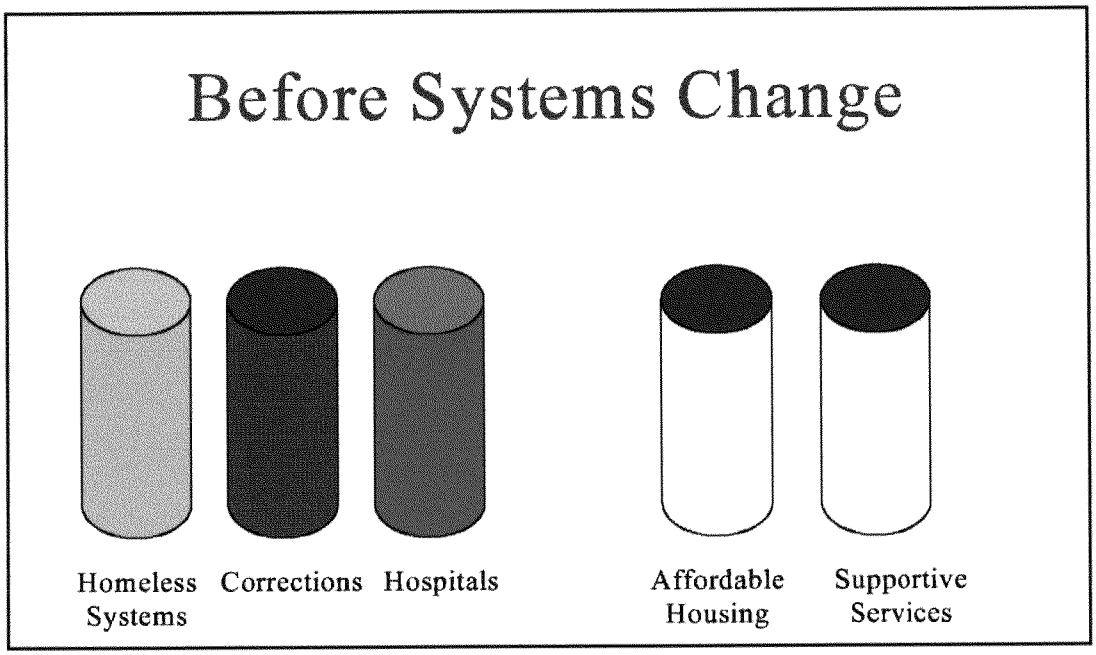
b) Review the myriad of rent assistance programs operated by the City of Portland, Multnomah County, HAP and others, and create a system that is streamlined, efficient and accessible to homeless and special needs populations.

6. **Create new resources dedicated to special needs housing.** *(Relates to Goal 2. Enough Housing)*
   a) Support the creation of a Real Estate Transfer Tax for affordable housing; a local bond issue for affordable housing development; and establishment of a National Housing Trust Fund.
   b) Establish goals within any new housing funds to be spent for people with special needs;
   c) Increase the proportion of housing funds, from all public and private sources, used for housing for people with special needs.
   d) Short and long-term rent subsidy programs should be expanded.
   e) Develop strategies to attract private lending capital.

RESULTS

We believe that, if we implement the Action Steps above in the next two years, and embrace the long-term strategies in Appendix D, we will be creating the conditions for permanent system change. We will know if we have succeeded, because both our housing and service systems will be different. The systems will be more integrated, and some funding will shift to support a Housing + Services strategy. As a result, fewer people with special needs will cycle through shelters, jails, hospitals and the street, and people with special needs will no longer be over-represented in the homeless system. Figures 7 and 8 illustrate the "before" and "after" of system change.

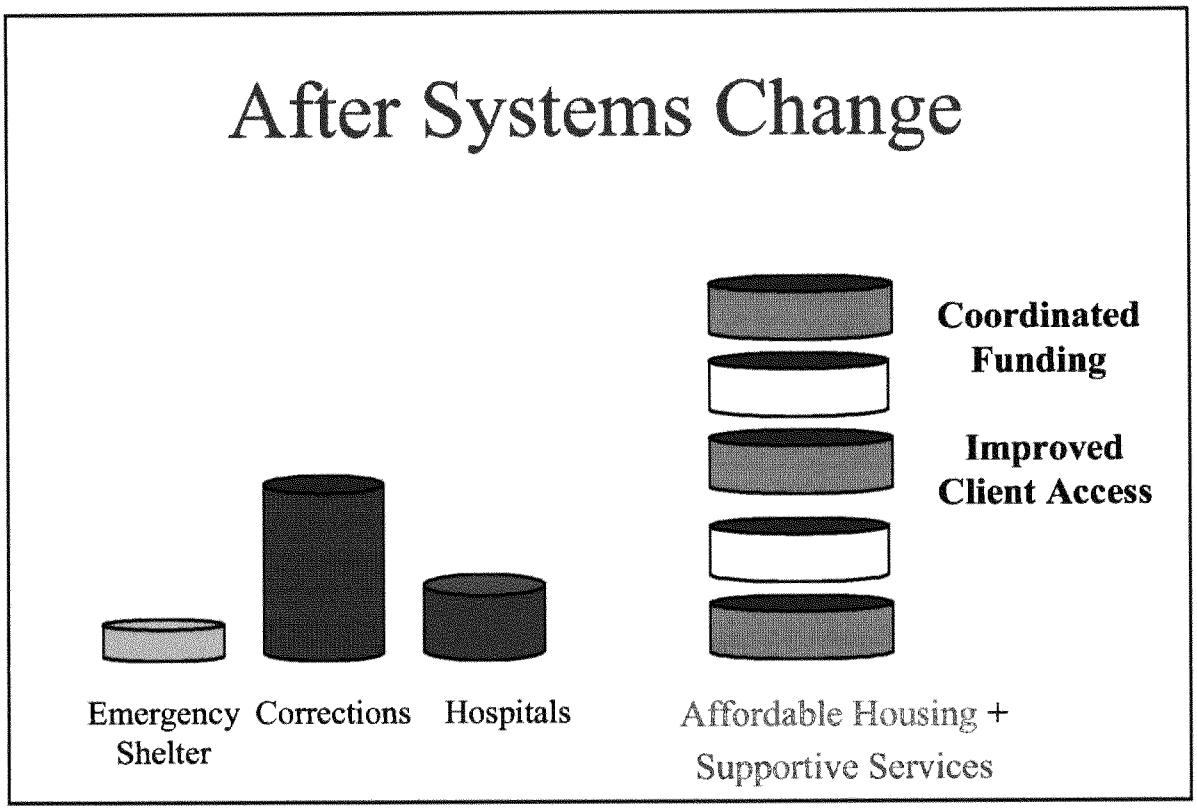
FIGURE 7



Currently, the homeless, corrections, hospital, affordable housing, and supportive service systems are structured in cylinders of separated services. Within each of these silos may be multiple separate agencies or funding streams, each with its own rules and eligibility criteria. Staff in all these cylinders know that there are too many people with special needs cycling through the homeless system, jails, and hospitals, and that the affordable housing and supportive service systems have not responded adequately, but the separate systems have not effected the necessary change to prevent this.

In the system we envision, people with special needs will not be over-represented in our homeless, hospital or corrections systems.

FIGURE 8



The homeless system will be smaller, and will be limited to emergency shelter. Hospital beds will be used for medical and mental health crises only. The affordable housing and supportive service systems will be coordinated at the personal level, the residential project level, the funding level, and the systems level resulting in improved client access, staff cross-training, a larger volume of special needs housing development, and increased housing retention rates. More people with special needs will be successfully housed, and thus have the opportunity to enjoy a good quality of life.

RESPECTFULLY SUBMITTED ON JULY 2, 2003.

THE HOUSING AND COMMUNITY DEVELOPMENT COMMISSION

Bill Van Vliet, Co-Chair
Catherine Such, Co-Chair

Janet Byrd
Paul Dagle
Linda Kaeser
Diane Meisenhelter[37]
Roger Meyer
Kevin Montgomery-Smith
Louis A. Ornelas
Roserria Roberts
Terri Silvis
Joe Wykowski

HCDC Staff
Beth Kaye

County Staff
Linda Grimes
Gail Wilson

BHCD Staff
Molly Rogers
Ruth Benson

THE SPECIAL NEEDS COMMITTEE[36]

Linda Kaeser, Chair

John Ball
Neal Beroz
Mary Carroll
Rosanne Costanzo
Serena Cruz
Peter Davidson, MD
Tracy Davies
Susan Dietsche
Betty Dominguez
Joyce Dougherty
Rachael Duke
Jamaal Folsom
Leslie Ford
Joanne Fuller
Bernie Giusto
Leah Halstead
Richard Harris
Jim Hlava
Carol Islam
Liv Jenssen
Christine Kirk
Anthony Lincoln
Heather Lyons
Seth Lyon
Diane Luther
Martha McLennan
Roger Meyer
Andy Miller
Susan Montgomery
Tim Moore
Terri Naito
Rachel Post
Paul Parker
Tonya Parker
Virginia Seitz
Vicki Skryha
Andy Smith
Cathy Spofford
Kim Tierney
Andreé Tremoulét
H.C. Tupper
Bill Van Vliet
Steve Weiss
Sherry Willmschen
Keren Brown Wilson
Nancy Wilton
Jim Wrigley

[36] Over the course of the year, participation by some of the committee's most thoughtful and experienced members was lost due to budget cuts, restructurings, and reassignments. The report benefited greatly from their contributions: Jim McConnell, Jacob Mestman, Howard Klink, May Simeone, Dan Noelle, Bethany Wertz, and Peter Wilcox. The committee also benefited from the perspective of Jim Winkler, who resigned when his term on HCDC elapsed.
[37] Ms. Meisenhelter's term on HCDC expired June 30, 2003.

APPENDICES

PRESENTATION TO
Multnomah County
Board of Commissioners

HIGHLIGHTS OF
THE SPECIAL NEEDS COMMITTEE
REPORT

September 2003

Key Finding:

Individuals who are disabled and poor are at increased risk of becoming homeless, hospitalized, and/or incarcerated.

Focus Populations

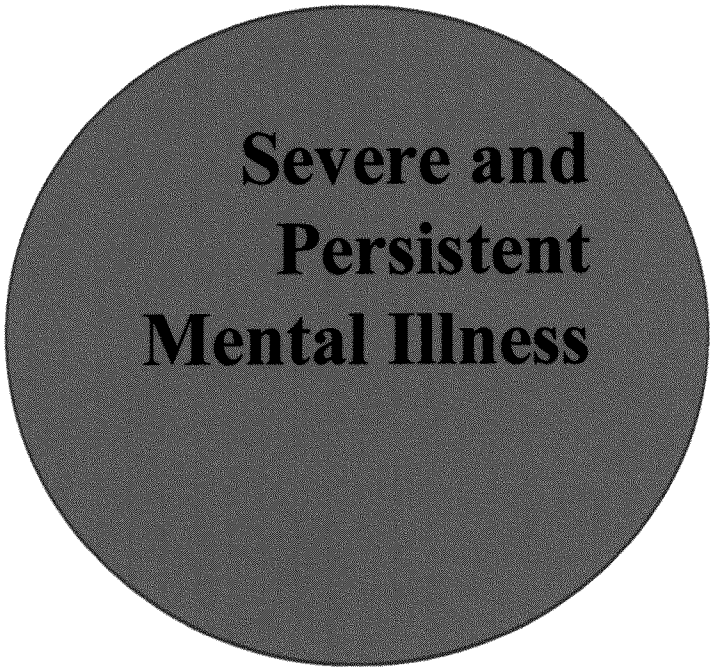
Focus Populations	Special Needs
Unaccompanied Minors	☑ Severe and Persistent Mental Illness ☑ Substance Abuse Disability ☑ Developmental Disability ☑ Serious Physical Disability ☑ Multiple Disabilities: two or more of the above
Extremely Low-Income Adults Age 18-64	☑ Severe and Persistent Mental Illness ☑ Substance Abuse Disability ☑ Developmental Disability ☑ Serious Physical Disability ☑ Multiple Disabilities: two or more of the above
Extremely Low-Income Seniors Age 65+	☑ Severe and Persistent Mental Illness ☑ Substance Abuse Disability ❑ Developmental Disability ❑ Serious Physical Disabilit ☑ Multiple Disabilities: two or more of the above

What is Permanent Housing?

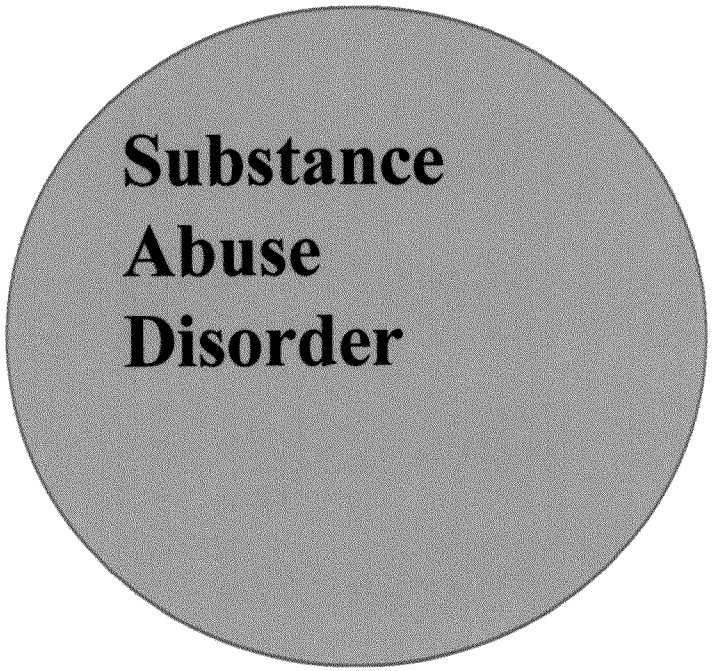
A place to live where you can remain indefinitely.

Severe and Persistent Mental Illness

- Definition: Severe Mental Illness resulting in a functional disability
- In Multnomah County, at least 1,219 persons aged 18-64 needed permanent housing in 2002



Substance Abuse Disability



- Definition: Chronic alcohol and/or drug abuse resulting in a functional disability
- In Multnomah County, at least 2,514 persons aged 18-64 needed permanent housing in 2002

Developmental Disabilities

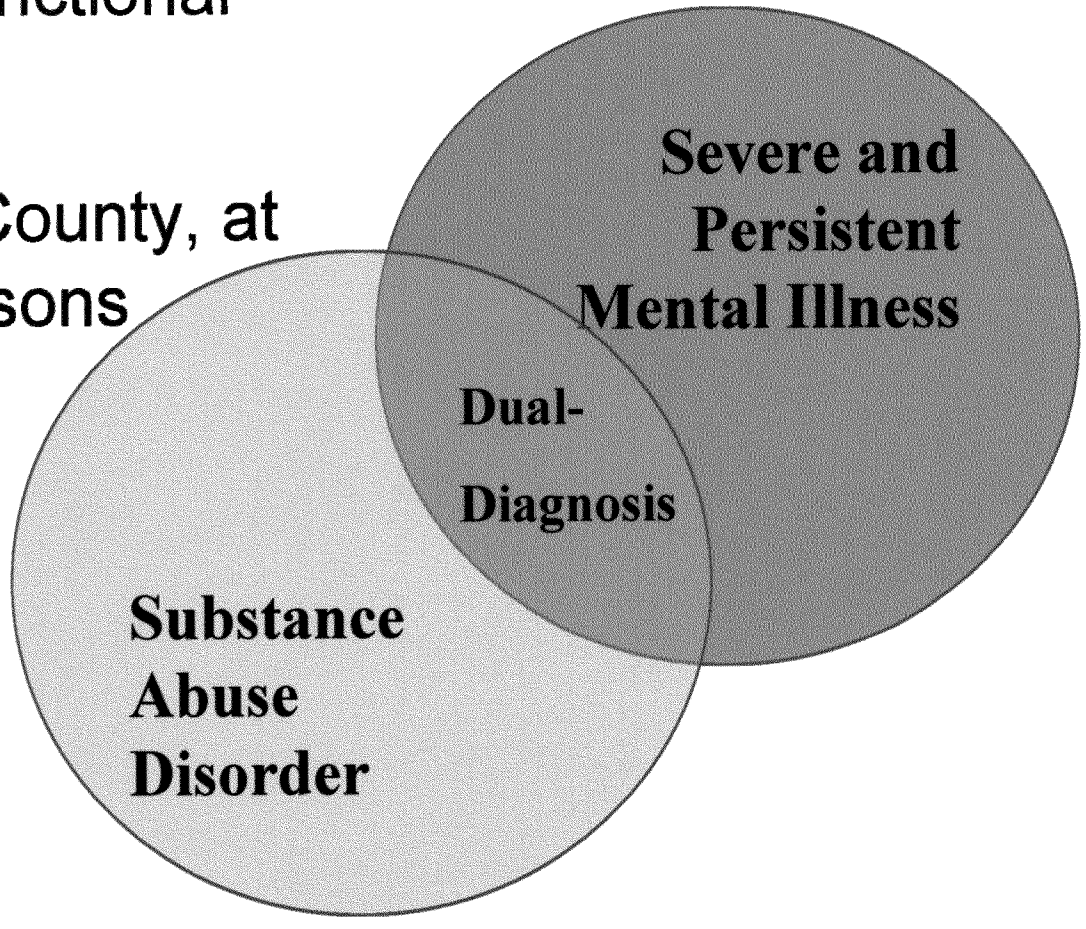
- Definition: Functional disability resulting from IQ of 69 or below, autism spectrum disorder, cerebral palsy, etc.
- In Multnomah County, at least 500 persons aged 18-64 needed permanent housing in 2002

Physical Disabilities

- Definition: Any physical disability resulting in a functional disability, including HIV/AIDS
- In Multnomah County, at least 2,331 persons aged 18-64 needed permanent housing in 2002

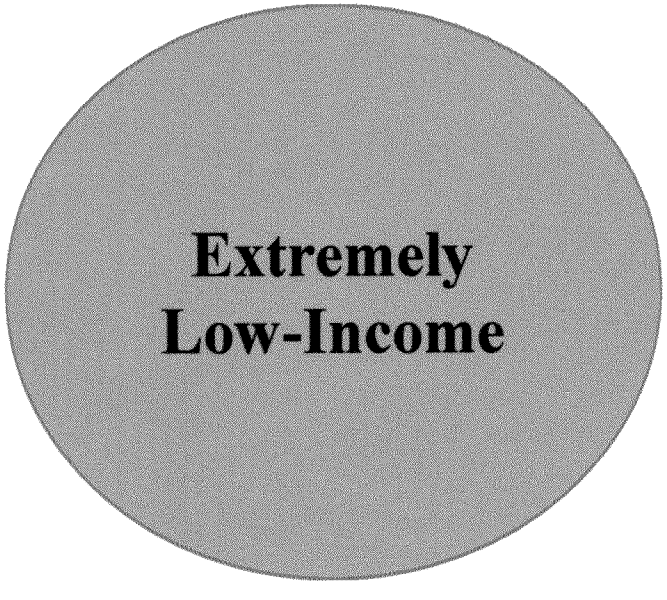
Multiple Diagnosis

- Definition: Any combination of disabilities resulting in a functional disability
- In Multnomah County, at least 1,326 persons aged 18-64 needed permanent housing in 2002

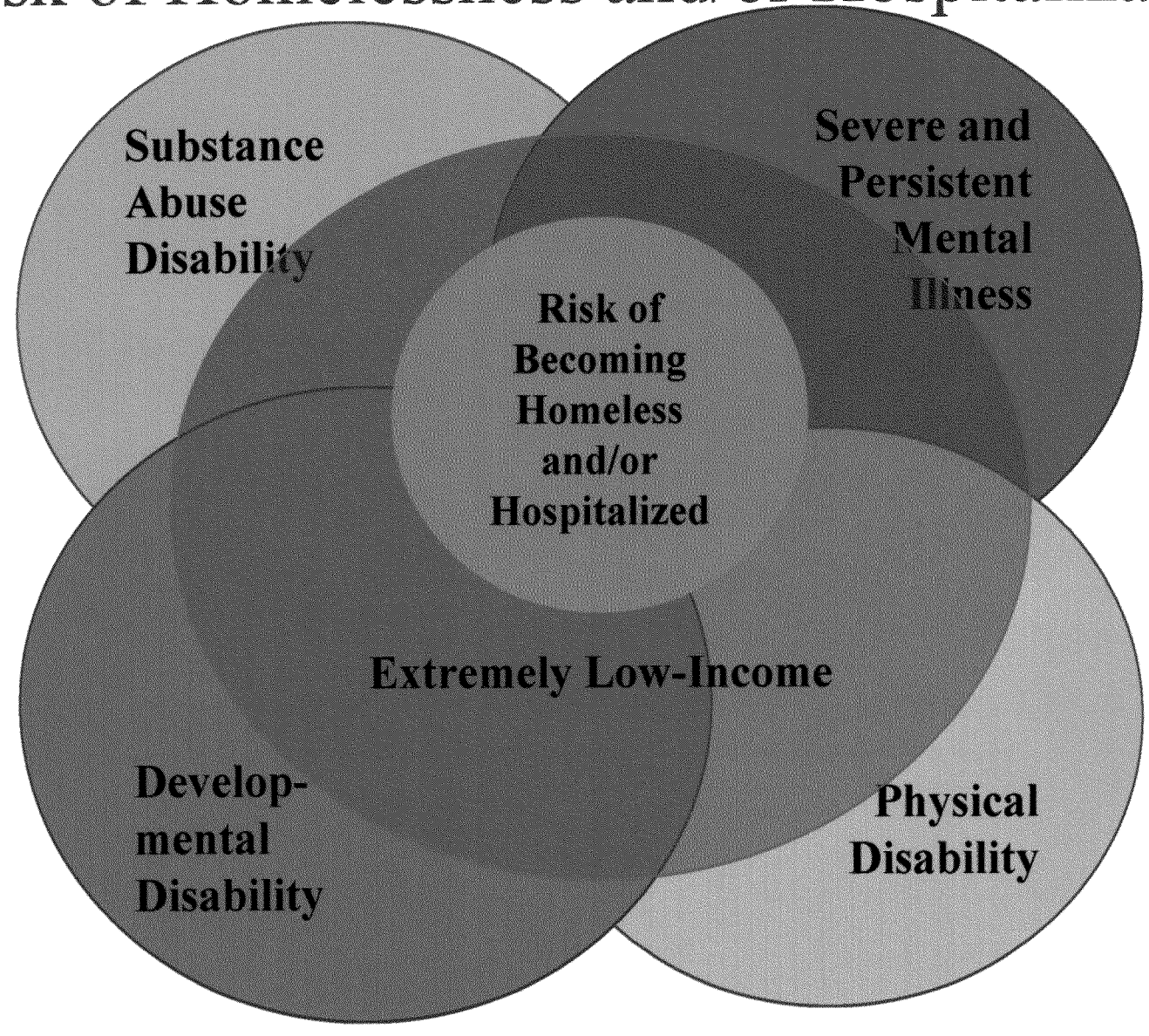


Disabilities and Poverty

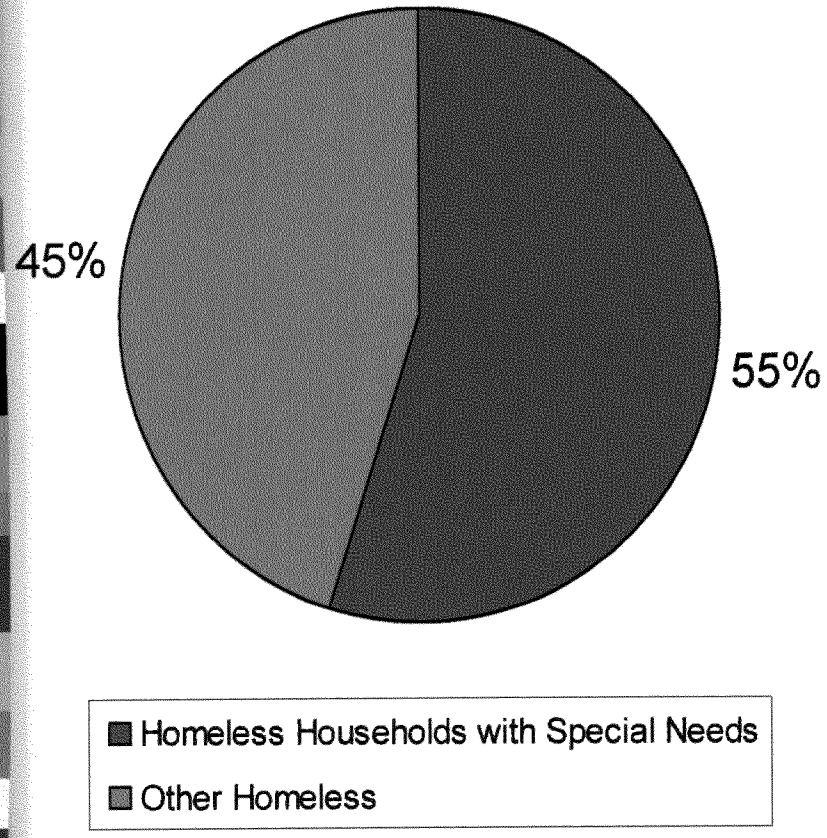
- Definition of Extremely Low-Income:
- Household income below $13,800 for a single person; $15,800 for a couple; and $19,750 for a household of 4
- SSI benefit is $6,624 for household of 1
- SSDI supplements income to average of $9,600 for household of 1

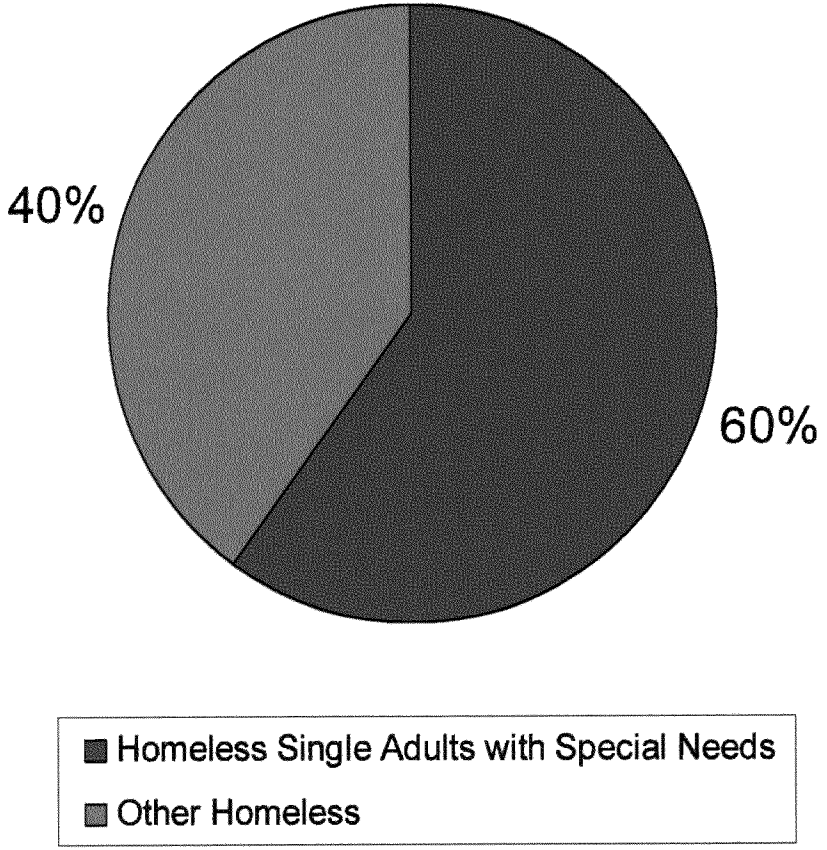


Relationship Between Disability, Poverty, and Risk of Homelessness and/or Hospitalization



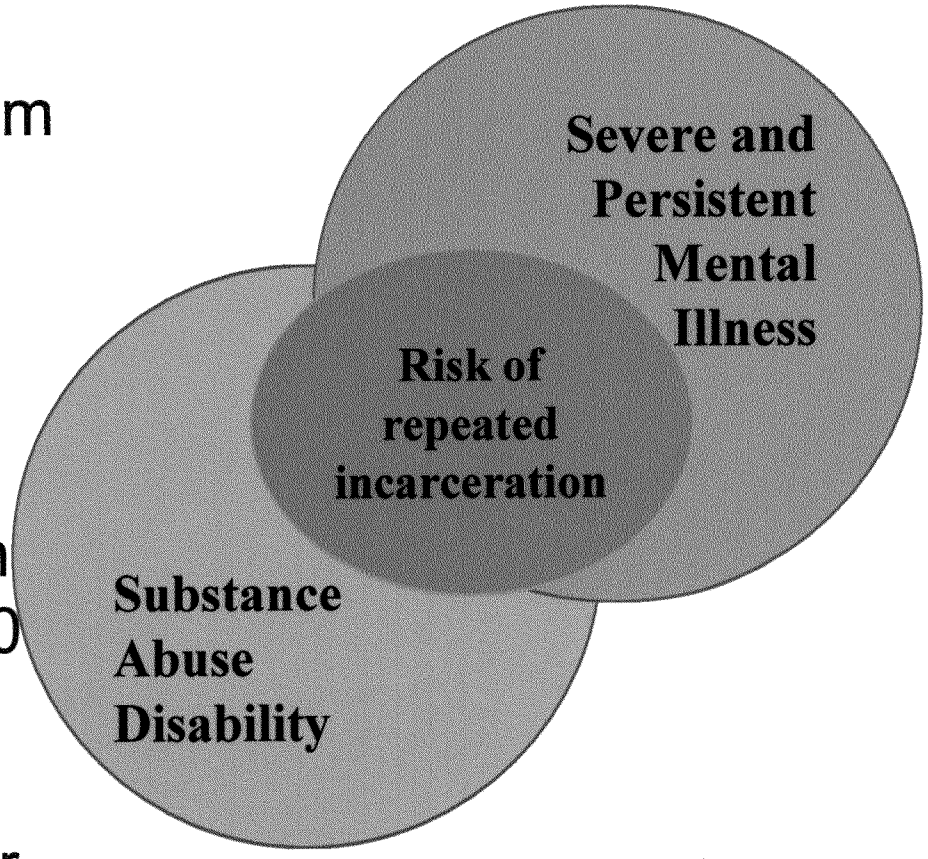
Proportion of People Seeking Shelter in Multnomah County Who Had Special Needs on March 27, 2002



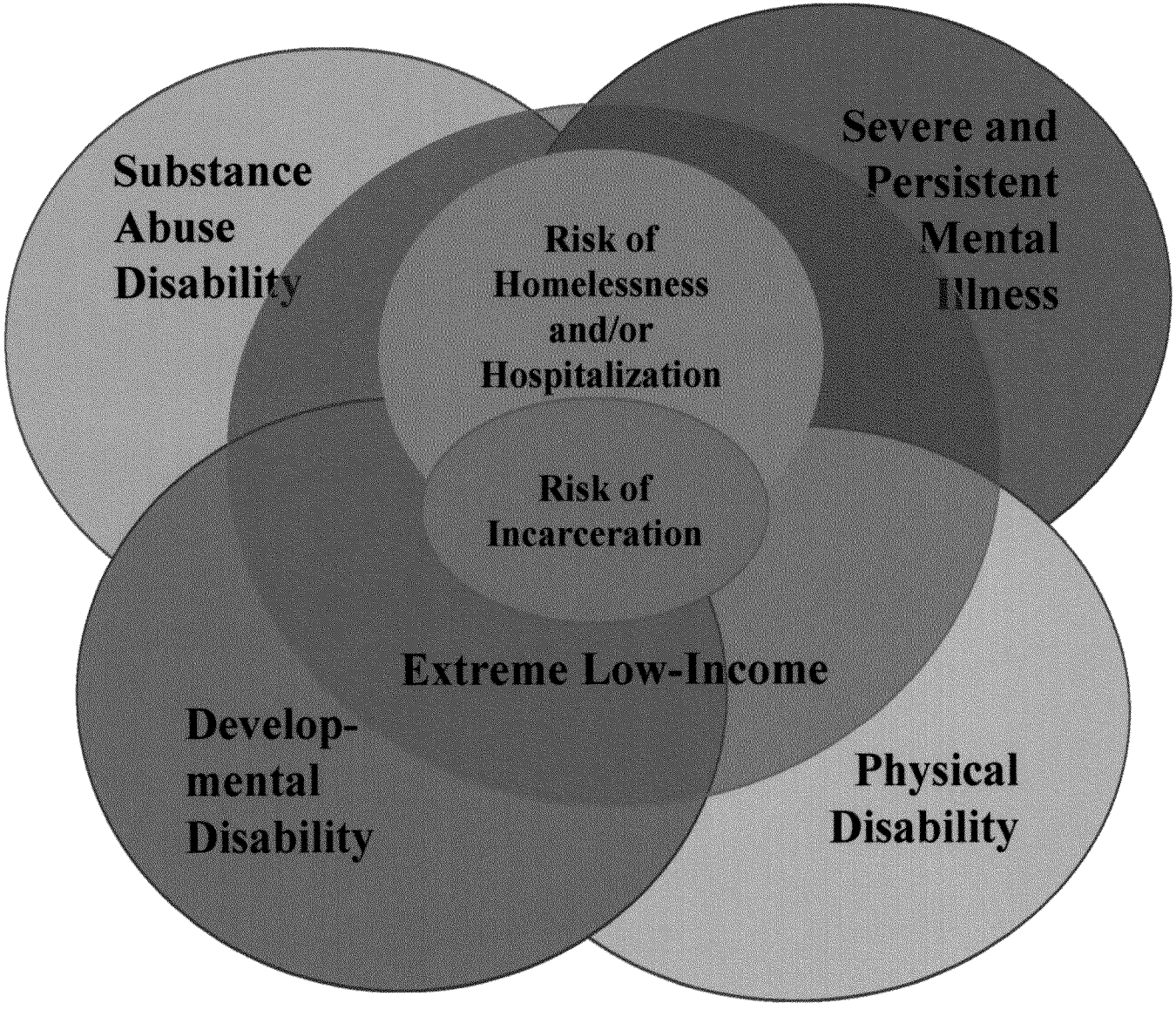


Community Justice Clients

- From 1995 to 2001, the number of individuals with mental health problems increased from 1,500 to 3,400, with a peak of 3,800 in 2000
- CY 2000: There were 3,800 individuals with identified mental health problems booked 5,700 times; nearly one-third were diagnosed with serious mental disorder



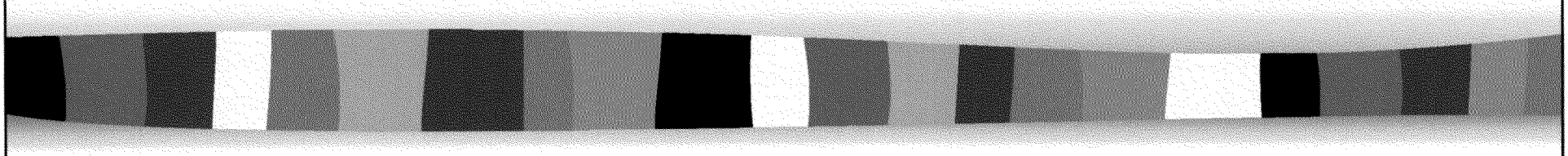
Relationship Between Disability, Poverty and Risk of Homelessness, Hospitalization and/or Incarceration



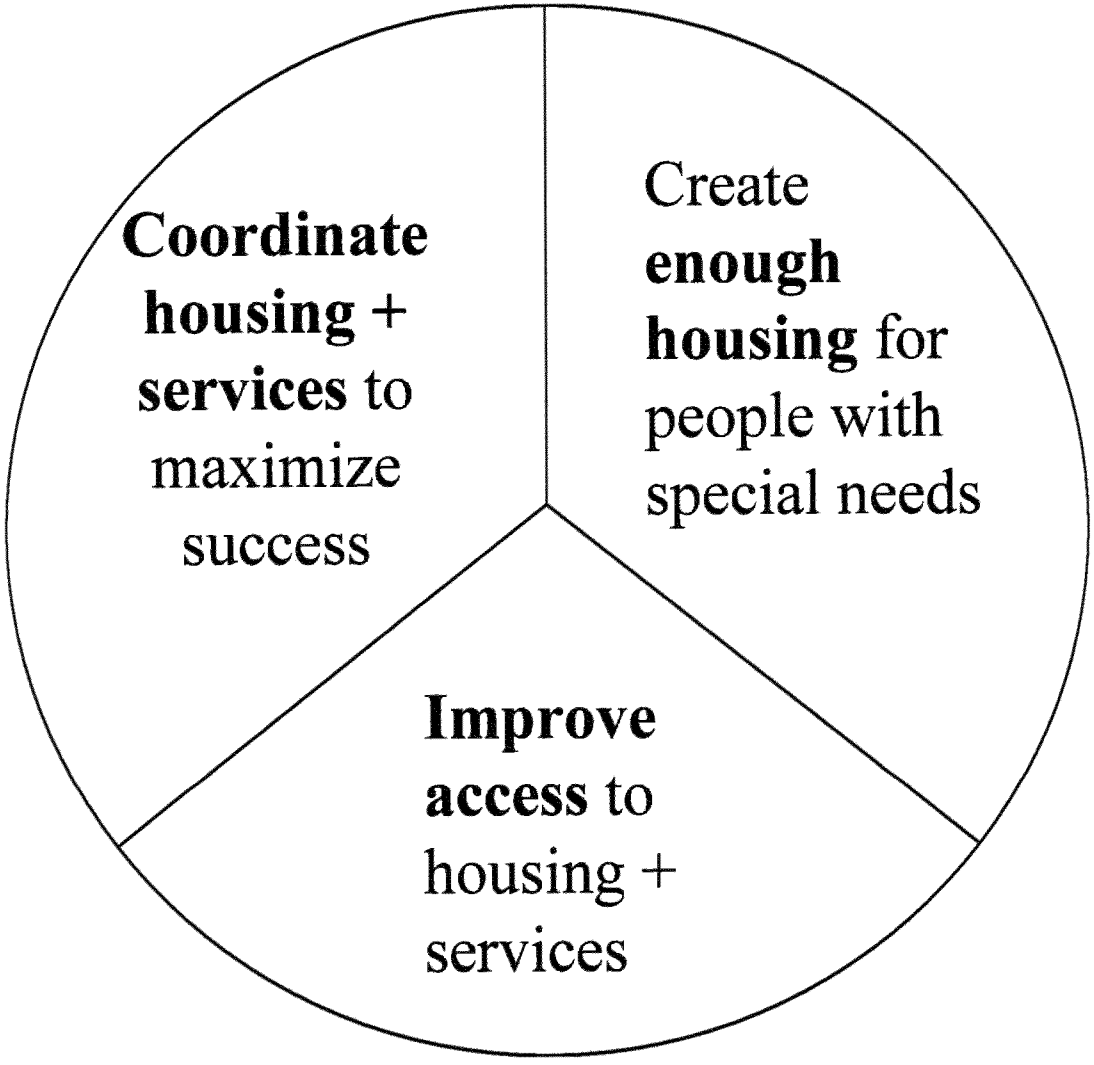
Summary of Need and Unmet Need

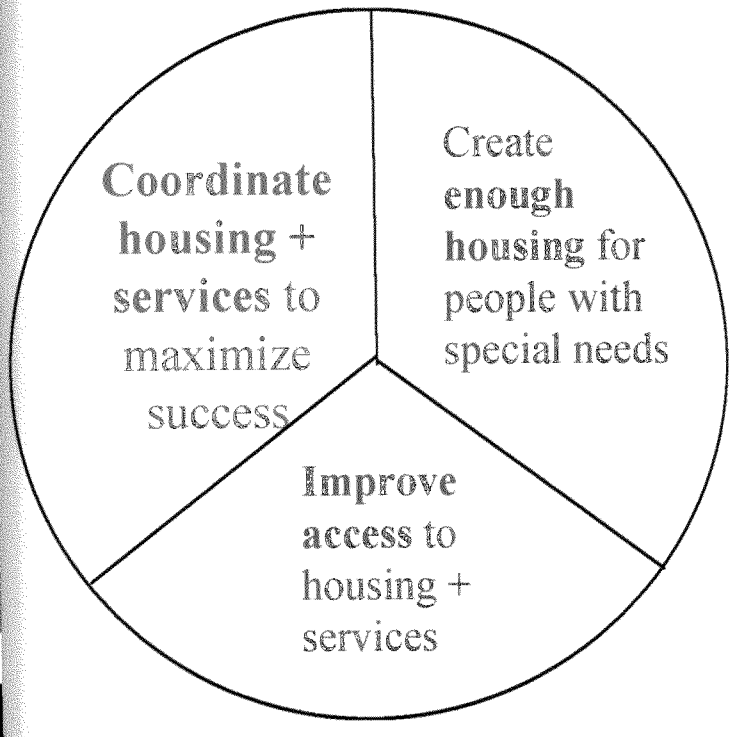
Selected Special Need Populations Age 18-64	Estimate of Need For Special Needs Permanent Housing	Current Permanent Unlicensed Housing	Unmet Need for Permanent Housing
Severe & Persistent Mental Illness	1,683	464	1,219
Substance Abuse Disability	3,086	572	2,514
Developmental Disability	520	20	500
Serious Physical/ Functional Disability (includes AIDS/HIV)	2,540	209	2,331
Multiple Disabilities	1,375	49	1,326
Totals	**9,204**	**1,314**	**7,890**

RECOMMENDATIONS



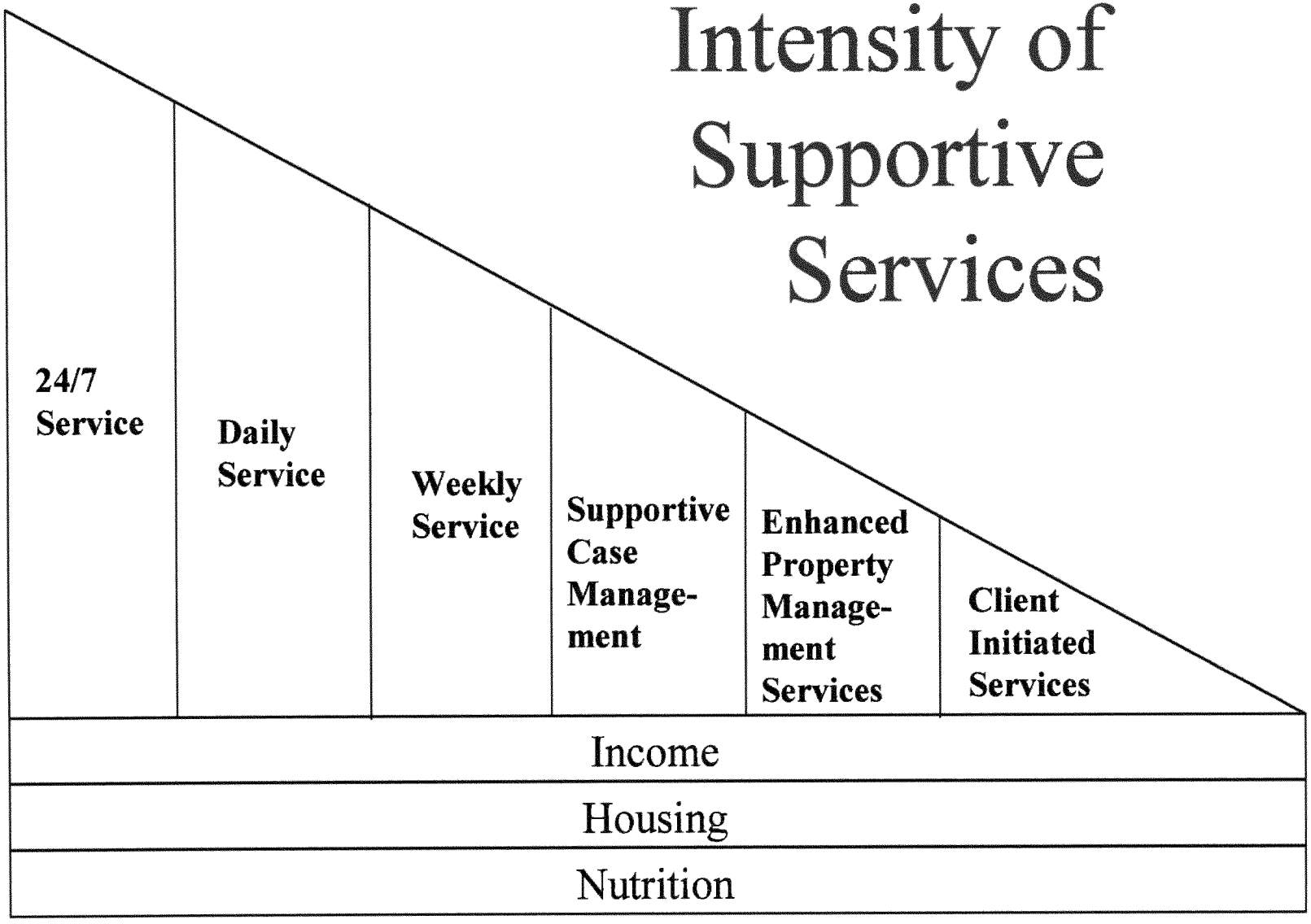
Three-Pronged Approach

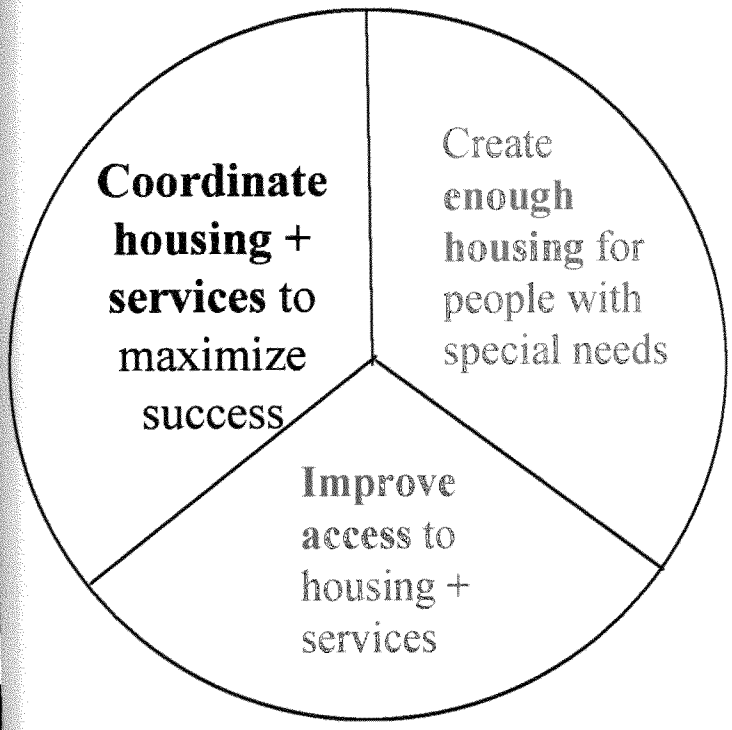




- Realign service systems to help people with special needs succeed in housing
- Focus mainstream services on hardest-to-house to end homelessness
- Cross-training of housing managers and case managers

Intensity of Supportive Services

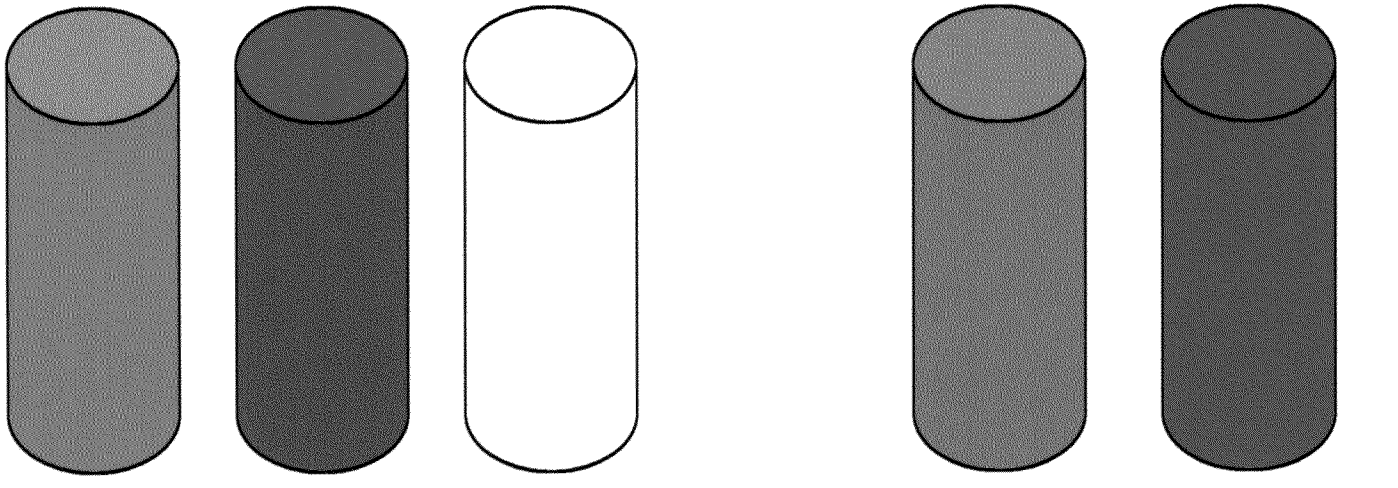




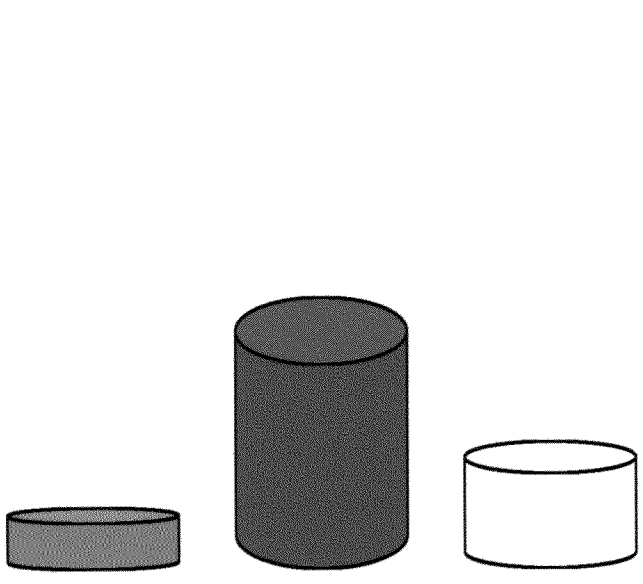
- Increase proportion of housing resources allocated to people with special needs
  - Development Dollars
  - Rent Assistance
- Create "express lane" in development pipeline for projects that package housing $$ and service commitments
- Leverage public and private resources

- Comprehensive and culturally competent service plan addressing housing + services + food security
  - Early planning for discharge from hospitals and jails

Before Systems Change



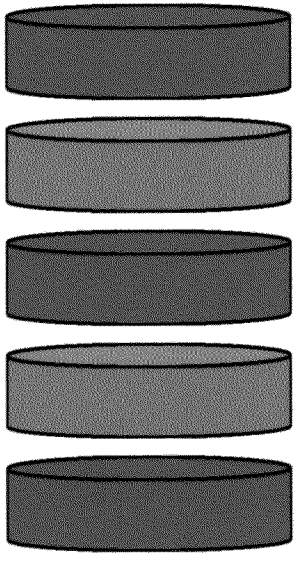
After Systems Change



Emergency Shelter

Corrections

Hospitals



Coordinated Funding

Improved Client Access

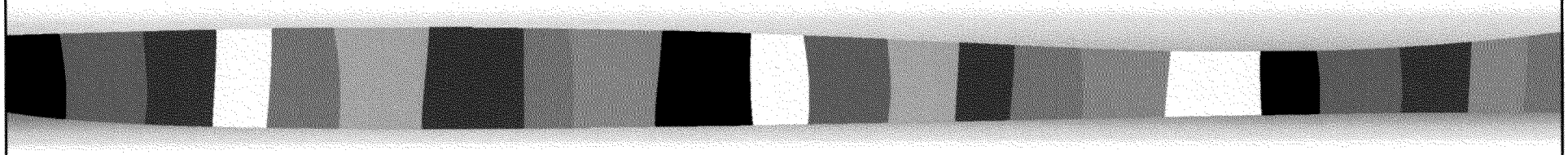
Cross Training

Affordable Housing

+

Supportive Services

Questions and Comments



BOGSTAD Deborah L

From: LUTHER Diane M
Sent: Wednesday, September 24, 2003 2:38 PM
To: 'Linda Kaeser'; Bob Durston (bdurston@ci.portland.or.us); 'SHERIFF'; 'Rachael Duke'; 'Andrew Wilch'; 'vicki.skryha@state.or.us'; PATE Patricia; DAVIDSON Peter J; SHORTALL Mary E; SHIRLEY Lillian M; LIDAY Steve G; Leslie Ford (leslie@cascadiabhc.org); 'Richard Harris'; 'McLennan, Martha'; Dee Walsh (dwalsh@REACHCDC.org); 'Susan Stoltenberg'; 'Steve Weiss'; Roger Meyer; JENSSEN Liv E; Andy Miller (amiller@ci.portland.or.us); LINN Diane M
Cc: 'Kaye, Beth'; TURNER Kathy G; BOGSTAD Deborah L; WALKER Derald R; SWIFT Richard F; TIERNEY Kim H; 'Halstead, Leah'; SMITH Andy J; Neal Beroz; COSTANZO Rosanne; 'Rose Mary Ojeda'; CARROLL Mary P; Jean DeMaster (jdemaster@humansolutions.org); Susan Dietsche (rsdietsche@aol.com); Betty Dominguez (betty.dominguez@hcs.state.or.us); Jim McConnell (E-mail); LYON Seth A; Lyons, Heather; 'tremoulet@ci.gresham.or.us'; WILLMSCHEN Sherry; WILTON Nancy L; Jim Wrigley (jwrigley@oradvocacy.org); 'Rogers, Molly'; MCGEE Tanya Colie; BELL Iris D; FULLER Joanne; MOORE Byron R
Subject: Special Needs Committee Presentation

Below is the plan for the Special Needs Committee presentation to the Board of Multnomah County Commissioners.

All Special Needs Committee members are invited to come to the presenation and enjoy our reception afterwards. If you'd like to speak, and you are not listed below, feel free to say a few words during the Public Testimony.

Special Needs Committee Presentation
Thursday, October 2
10:30 am to Noon
Followed by reception to celebrate completion of Report

Some of the individuals listed below are still to be confirmed. Please let me know as soon as possible - I'll email a final version before the hearing.

The resolution that the Board will be contemplating is attached. If you need a copy of the Committee Report, please let me or Beth Kaye know (Beth has the hard copies).

We are asking a variety of people to testify because we want to illustrate the wide extent of players/partners it will take to really make progress in special needs housing. Each of you has your own perspective on the system and your own take on the report and the resolution. You should feel free to express whatever opinions you hold, but I am hoping that each of you will endorse the basic outcomes of those documents and urge the Board to put its influence behind implementing the recommendations. Thanks everyone - please email any questions you may have.

Diane Luther
Housing Director
Multnomah County
503 988-4463

Special Needs Committee Presentation to BCC – October 2
90 Minutes

	Minutes	
1. Introduction/Set Context – Diane Luther	**5**	
2. Power Point /Report Summary - Linda Kaeser, Beth Kaye	**15**	
3. Invited Testimony		
1. Bob Durston - City Commissioner Sten's Office		**5**
2. Sheriff Giusto	**5**	
3. Rachel Duke - Housing Authority of Portland	**5**	
4. Andy Wilch - Portland Development Commission	**5**	
5. Vicki Skryha - State Office of Mental Health and Addictions Services	**5**	
6. Patricia Pate - Dept. of County Human Services		**2**
7. Peter Davidson - Mental Health and Addictions Services	**2**	
8. Mary Shortall - Aging and Disabled Services	**2**	
9. Lillian Shirley - County Health Department	**2**	
10. Steve Liday - Department of Community Justice	**2**	
11. Leslie Ford - Cascadia Behavioral Health	**2**	
12. Richard Harris - Central City Concern		**2**
13. Martha McLennan - Northwest Housing Alternatives		**2**
14. Dee Walsh - REACH Community Development Corp.		**2**
15. Susan Stoltenberg - Portland Impact	**2**	
16. Steve Weiss - Advocate/Committee Member	**2**	
17. Roger Meyer - Advocate/Committee Member	**2**	

4. Public Testimony

5. Adopt Resolution

6. Reception

RES_AcceptingSN CReport.doc (51...

BEFORE THE BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

RESOLUTION NO. _____

Accepting the Report of the Special Needs Committee of the Housing and Community Development Commission, and Implementing the Recommendations Therein

The Multnomah County Board of Commissioners Finds:

a. Through parallel resolutions, Multnomah County, the City of Portland and the Housing Authority of Portland (the Partners) created and staffed the Special Needs Committee (SNC) of the Housing and Community Development Commission (HCDC) to assess the need for special needs housing in Multnomah County and make recommendations to stimulate its development.

b. On July 2, 2003, HCDC adopted the SNC's report with recommendations intended to result in development of more housing coordinated with services for special needs populations. For purposes of this resolution, the term "special needs populations" means those with disabilities, including severe and persistent mental illnesses, substance abuse disabilities, developmental disabilities, physical disabilities and multiple disabilities. Although most members of this population live alone, some are accompanied by family members and need larger housing units and family-oriented services.

c. Many persons with special needs served by Multnomah County and its contract agencies are unable to succeed because of lack of stable, affordable housing. Barriers to housing for these populations can include lack of income, lack of services that support housing success, criminal records, and unusual behaviors. As a result, people with special needs are disproportionately served by jails, hospitals, shelters, health clinics and other publicly and community-funded resources. Research shows that providing supportive housing to people with special needs is more cost effective and humane than continuing to use these scarce public resources. It is in the County's interest that significant new housing resources for special needs populations be created and preserved.

d. The SNC report describes a gap of 7890 units of Permanent Supportive Housing for people age 18-64, resulting in a chronically homeless population of about 3500 people with special needs in Multnomah County.

e. Filling the gap of 7890 units of permanent supportive housing resources should be a very high priority for available housing and services funds during the next few years. The community should set a target of meeting 50% of this housing need during the next five years. The need can be met by constructing new housing units, acquiring existing buildings for conversion to housing, refinancing

existing units to accommodate lower resident incomes, provision of permanent rent subsidies, and other means.

f. In order to fill the gap, Federal, State and local funds, including rent subsidy resources and tax increment funds generated by urban renewal districts, must be committed to developing more special needs housing.

g. The County and its Partners need to coordinate services with housing so that people with special needs can access and succeed in housing.

h. The efforts of the Special Needs Committee and its members have already resulted in new awareness, relationships and initiatives that are moving ahead to develop supportive housing. Those initiatives include obtaining a large grant from the Corporation for Supportive Housing for systems change to develop 400 new units of supportive housing for chronically homeless people with disabling health conditions; and the first-ever issuance of a coordinated Request For Proposals for special needs housing projects using Project Based Section 8 vouchers administered by the Housing Authority of Portland linked with City-controlled federal housing funds.

The Multnomah County Board of Commissioners Resolves:

1. The Board accepts and approves the Report of the Special Needs Committee of HCDC; and appreciates the work of all members of the Committee, in particular its Chair, Linda Kaeser.

2. The Board urges the City of Portland, the Portland Development Commission, the Housing Authority of Portland, the State of Oregon, and the City of Gresham to give the highest priority for housing funds to permanent housing for special needs populations until the gap is filled.

3. The County and its departments will join with Partners, including the City of Portland, the Housing Authority of Portland, the Portland Development Commission, nonprofit community housing and social service providers, the State of Oregon, and others to coordinate services with housing and implement the recommendations contained in the Report to create new permanent supportive housing units.

4. The County will implement certain recommendations in the SNC Report, including

   - finding new ways to expand Medicaid resources in order to create new housing-related services;

   - using Federally Qualified Health Center status to provide services to special needs populations that support housing success;

- strengthening partnerships between its services systems and the social housing industry through improving communications, creating training programs, participating in private market access programs, and incorporating housing relationships into social and human service program designs and plans; and
- developing, with its Partners, significant specialized new housing and service opportunities for the "hardest-to-house," i.e. chronically homeless people with special needs.

5. The County recognizes that implementing the recommendations in the Special Needs Committee report will be a critical element in the Portland area's efforts to end homelessness.

6. The County will participate in a review of existing rent assistance programs operated by the County and by others, to create a system that is streamlined, efficient and accessible to homeless and special needs populations.

7. The County will actively support strategies and tools to create new capital, operating and services resources for affordable housing, and will seek commitments at every opportunity to include supportive housing for special needs populations in any new housing resources that become available.

8. The Board requests that the Special Needs Committee oversee implementation of recommendations contained in the Report.

ADOPTED this 2nd day of October 2003.

BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

_____
Diane M. Linn, Chair

REVIEWED:

AGNES SOWLE, COUNTY ATTORNEY
FOR MULTNOMAH COUNTY, OREGON

By _____
Agnes Sowle, County Attorney

BEFORE THE BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

RESOLUTION NO. _____

Accepting the Report of the Special Needs Committee of the Housing and Community Development Commission, and Implementing the Recommendations Therein

The Multnomah County Board of Commissioners Finds:

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c. Many persons with special needs served by Multnomah County and its contract agencies are unable to succeed because of lack of stable, affordable housing. Barriers to housing for these populations can include lack of income, lack of services that support housing success, criminal records, and unusual behaviors. As a result, people with special needs are disproportionately served by jails, hospitals, shelters, health clinics and other publicly and community-funded resources. Research shows that providing supportive housing to people with special needs is more cost effective and humane than continuing to use these scarce public resources. It is in the County's interest that significant new housing resources for special needs populations be created and preserved.

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e. Filling the gap of 7890 units of permanent supportive housing resources should be a very high priority for available housing and services funds during the next few years. The community should set a target of meeting 50% of this housing need during the next five years. The need can be met by constructing new housing units, acquiring existing buildings for conversion to housing, refinancing

existing units to accommodate lower resident incomes, provision of permanent rent subsidies, and other means.

f. In order to fill the gap, Federal, State and local funds, including rent subsidy resources and tax increment funds generated by urban renewal districts, must be committed to developing more special needs housing. ***The County does not intend to decrease current funding in existing poverty programs to fund this effort.***

g. The County and its Partners need to coordinate services with housing so that people with special needs can access and succeed in housing.

h. The efforts of the Special Needs Committee and its members have already resulted in new awareness, relationships and initiatives that are moving ahead to develop supportive housing. Those initiatives include obtaining a large grant from the Corporation for Supportive Housing for systems change to develop 400 new units of supportive housing for chronically homeless people with disabling health conditions; and the first-ever issuance of a coordinated Request For Proposals for special needs housing projects using Project Based Section 8 vouchers administered by the Housing Authority of Portland linked with City-controlled federal housing funds.

The Multnomah County Board of Commissioners Resolves:

1. The Board accepts and approves the Report of the Special Needs Committee of HCDC; and appreciates the work of all members of the Committee, in particular its Chair, Linda Kaeser.

2. The Board urges the City of Portland, the Portland Development Commission, the Housing Authority of Portland, the State of Oregon, and the City of Gresham to give the highest priority for housing funds to permanent housing for special needs populations until the gap is filled.

3. The County and its departments will join with Partners, including the City of Portland, the Housing Authority of Portland, the Portland Development Commission, nonprofit community housing and social service providers, the State of Oregon, and others to coordinate services with housing and implement the recommendations contained in the Report to create new permanent supportive housing units.

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    - finding new ways to expand Medicaid resources in order to create new housing-related services;

- using Federally Qualified Health Center status to provide services to special needs populations that support housing success;

- strengthening partnerships between its services systems and the social housing industry through improving communications, creating training programs, participating in private market access programs, and incorporating housing relationships into social and human service program designs and plans; and
- developing, with its Partners, significant specialized new housing and service opportunities for the "hardest-to-house," i.e. chronically homeless people with special needs.

5. The County recognizes that implementing the recommendations in the Special Needs Committee report will be a critical element in the Portland area's efforts to end homelessness.

6. The County will participate in a review of existing rent assistance programs operated by the County and by others, to create a system that is streamlined, efficient and accessible to homeless and special needs populations.

7. The County will actively support strategies and tools to create new capital, operating and services resources for affordable housing, and will seek commitments at every opportunity to include supportive housing for special needs populations in any new housing resources that become available.

8. The Board requests that the Special Needs Committee oversee implementation of recommendations contained in the Report, ***including how to identify special needs families and improve their access to services and housing***.

ADOPTED this 2nd day of October 2003.

BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

_____
Diane M. Linn, Chair

REVIEWED:

AGNES SOWLE, COUNTY ATTORNEY
FOR MULTNOMAH COUNTY, OREGON

By_____
Agnes Sowle, County Attorney

BOGSTAD Deborah L

From: LUTHER Diane M
Sent: Tuesday, September 30, 2003 11:21 AM
To: 'Bob Durston'; SHERIFF Deputy; 'vicki.skryha@state.or.us'; PATE Patricia; DAVIDSON Peter J; SHORTALL Mary E; SHIRLEY Lillian M; LIDAY Steve G; 'Leslie Ford'; JENSSEN Liv E; 'Andy Miller'; LINN Diane M; TURNER Kathy G; BOGSTAD Deborah L; WALKER Derald R; SWIFT Richard F; TIERNEY Kim H; SMITH Andy J; Neal Beroz; COSTANZO Rosanne; 'Jean DeMaster'; 'Susan Dietsche'; 'Betty Dominguez'; Jim McConnell (E-mail); LYON Seth A; Lyons, Heather; 'tremoulet@ci.gresham.or.us'; WILLMSCHEN Sherry; WILTON Nancy L; 'Jim Wrigley'; MCGEE Tanya Colie; BELL Iris D; FULLER Joanne; MOORE Byron R; KAPLAN Daniel B; Linda Kaeser (E-mail); 'Rachael Duke'; Andrew Wilch (wilcha@portlanddev.org); 'Richard Harris'; 'McLennan, Martha'; 'Rogers, Molly'; 'Susan Stoltenberg'; 'Kaye, Beth'; 'Roger N. Meyer'; 'Steve Weiss'; 'Halstead, Leah'
Cc: COMITO Charlotte A; MARTIN Chuck T; CARROLL Mary P; ROMERO Shelli D
Subject: SNC Presentation - Final

PLEASE NOTE change in time. We have been pushed back to 10:50. I suggest being there by 10:30 in case the agenda runs early. We will try to be done by Noon, but it will depend on the amount of public testimony.

Below is what I believe to be the final list of presenters and times. Thanks everybondy!

Special Needs Committee Presentation to BCC – October 2
Multnomah County Board Room
75 Minutes w/o public testimony

	Minutes	
1. Introduction/Set Context – Diane Luther	**5**	
2. Power Point /Report Summary - Linda Kaeser, Beth Kaye	**15**	
3. Invited Testimony		
1. Bob Durston - City Commissioner Sten's Office		**5**
2. Sheriff Giusto	**5**	
3. Rachel Duke - Housing Authority of Portland	**5**	
4. Andy Wilch - Portland Development Commission	**5**	
5. Vicki Skryha - State Office of Mental Health and Addictions Services	**5**	
6. Patricia Pate - Dept. of County Human Services		**5**
7. Peter Davidson - Mental Health and Addictions Services	**2**	
8. Lillian Shirley - County Health Department	**2**	
9. Steve Liday - Department of Community Justice	**2**	
10. Leslie Ford - Cascadia Behavioral Health	**2**	
11. Richard Harris - Central City Concern		**2**
12. Martha McLennan - Northwest Housing Alternatives		**2**
13. Susan Stoltenberg - Portland Impact	**2**	
14. Steve Weiss - Advocate/Committee Member	**2**	
15. Roger Meyer - Advocate/Committee Member	**2**	

4. Public Testimony

5. Adopt Resolution

6. Reception

NON-DEPARTMENTAL - 10:50 AM

R-8 Special Needs Committee Report and Consideration of a RESOLUTION Accepting the Report of the Special Needs Committee of the Housing and Community Development Commission, and Implementing the Recommendations Therein. Presented by Diane Luther, Linda Kaeser, Beth Kaye and Invited Guests. 90 MINUTES REQUESTED.

COMMISSIONER _____ MOVES
COMMISSIONER _____ SECONDS
APPROVAL OF R-8

DIANE LUTHER INTRODUCTIONS, SET CONTEXT PRESENTATION/EXPLANATION AND REQUEST FOR AMENDMENTS TO THE RESOLUTION FINDING F., ADDING THE FOLLOWING SENTENCE AFTER THE FIRST SENTENCE: "THE COUNTY DOES NOT INTEND TO DECREASE CURRENT FUNDING IN EXISTING POVERTY PROGRAMS TO FUND THIS EFFORT." AND ADDING LANGUAGE TO THE END OF RESOLVE 8 SO IT READS: "THE BOARD REQUESTS THAT THE SPECIAL NEEDS COMMITTEE OVERSEE IMPLEMENTATION OF RECOMMENDATIONS CONTAINED IN THE REPORT, INCLUDING HOW TO IDENTIFY SPECIAL NEEDS FAMILIES AND IMPROVE THEIR ACCESS TO SERVICES AND HOUSING."

COMMISSIONER _____ MOVES
COMMISSIONER _____ SECONDS
APPROVAL OF AMENDMENT TO F., ADDING THE FOLLOWING SENTENCE AFTER THE FIRST SENTENCE: "THE COUNTY DOES NOT INTEND TO DECREASE CURRENT FUNDING IN EXISTING POVERTY PROGRAMS TO FUND THIS EFFORT." AND ADDING LANGUAGE TO THE END OF RESOLVE 8 SO IT READS: "THE BOARD REQUESTS THAT THE SPECIAL NEEDS COMMITTEE OVERSEE IMPLEMENTATION OF RECOMMENDATIONS CONTAINED IN THE REPORT, INCLUDING HOW TO IDENTIFY

SPECIAL NEEDS FAMILIES AND IMPROVE THEIR ACCESS TO SERVICES AND HOUSING."

ALL IN FAVOR, VOTE AYE, OPPOSED____?

THE MOTION FAILS
OR
THE AMENDMENTS ARE APPROVED

LINDA KAESER AND BETH KAYE POWERPOINT AND REPORT SUMMARY PRESENTATION, EXPLANATION, RESPONSE TO QUESTIONS

INVITED TESTIMONY:

1. Bob Durston - City Commissioner Sten's Office	**5**
2. Sheriff Bernie Giusto	**5**
3. Rachel Duke - Housing Authority of Portland	**5**
4. Andy Wilch - Portland Development Commission	**5**
5. Vicki Skryha - State Office of Mental Health and Addictions Services	**5**
6. Patricia Pate - Dept. of County Human Services	**5**
7. Peter Davidson - Mental Health and Addictions Services	**2**
8. Lillian Shirley - County Health Department	**2**
9. Steve Liday - Department of Community Justice	**2**
10. Leslie Ford - Cascadia Behavioral Health	**2**
11. Richard Harris - Central City Concern	**2**
12. Martha McLennan - Northwest Housing Alternatives	**2**
13. Susan Stoltenberg - Portland Impact	**2**
14. Steve Weiss - Advocate/Committee Member	**2**
15. Roger Meyer - Advocate/Committee Member	**2**

OPPORTUNITY FOR PUBLIC TESTIMONY

OPPORTUNITY FOR BOARD COMMENTS

ALL IN FAVOR, VOTE AYE, OPPOSED____?

THE MOTION FAILS
OR
THE RESOLUTION IS ADOPTED, AS AMENDED

Special Needs Committee Presentation to BCC – October 2
60 Minutes plus Public Testimony

	Minutes
1. Introduction/Set Context – Diane Luther	5
2. Power Point /Report Summary - Linda Kaeser, Beth Kaye	15
3. Invited Testimony	
1. Bob Durston - City Commissioner Sten's Office	3
2. Sheriff Giusto	3
3. Rachel Duke - Housing Authority of Portland	3
4. Andy Wilch - Portland Development Commission	3
5. Vicki Skryha - State Office of Mental Health and Addictions Services	3
6. Patricia Pate - Dept. of County Human Services	3
7. Peter Davidson - Mental Health and Addictions Services	2
8. Lillian Shirley - County Health Department	2
9. Steve Liday - Department of Community Justice	2
10. Leslie Ford - Cascadia Behavioral Health	2
11. Richard Harris - Central City Concern	2
12. Martha McLennan - Northwest Housing Alternatives	2
13. Susan Stoltenberg - Portland Impact	2
14. Steve Weiss - Advocate/Committee Member	2
15. Roger Meyer - Advocate/Committee Member	2
4. Public Testimony	
5. Adopt Resolution	
6. Reception	

MULTNOMAH COUNTY OREGON

DEPARTMENT OF COUNTY HUMAN SERVICES
Patricia K. Pate, Director
421 SW 6TH Ave, Suite 700
Portland, Oregon 97204
(503) 988-3691
FAX: (503) 988-3379

Memorandum

To: Deborah Bogstad

From: Patsy Mousher

CC:

Date: 9/29/2003

Re: BCC Handouts for R-8

Attached are the Handouts from Dr. Peter Davidson for item R-8 Special Needs Committee. Please contact me if you have any questions.

Thank you for your assistance.

ORIGINAL ARTICLE

Cost-effectiveness of Supported Housing for Homeless Persons With Mental Illness

Robert Rosenheck, MD; Wesley Kasprow, PhD; Linda Frisman, PhD; Wen Liu-Mares, PhD

Background: Supported housing, integrating clinical and housing services, is a widely advocated intervention for homeless people with mental illness. In 1992, the US Department of Housing and Urban Development (HUD) and the US Department of Veterans Affairs (VA) established the HUD-VA Supported Housing (HUD-VASH) program.

Methods: Homeless veterans with psychiatric and/or substance abuse disorders or both (N=460) were randomly assigned to 1 of 3 groups: (1) HUD-VASH, with Section 8 vouchers (rent subsidies) and intensive case management (n=182); (2) case management only, without special access to Section 8 vouchers (n=90); and (3) standard VA care (n=188) Primary outcomes were days housed and days homeless. Secondary outcomes were mental health status, community adjustment, and costs from 4 perspectives.

Results: During a 3-year follow-up, HUD-VASH veterans had 16% more days housed than the case management–only group and 25% more days housed than the standard care group ($P<.001$ for both). The case management–only group had only 7% more days housed than the standard care group ($P=.29$). The HUD-VASH group also experienced 35% and 36% fewer days homeless than each of the control groups ($P<.005$ for both). There were no significant differences on any measures of psychiatric or substance abuse status or community adjustment, although HUD-VASH clients had larger social networks. From the societal perspective, HUD-VASH was $6200 (15%) more costly than standard care. Incremental cost-effectiveness ratios suggest that HUD-VASH cost $45 more than standard care for each additional day housed (95% confidence interval, $-19 to $108).

Conclusions: Supported housing for homeless people with mental illness results in superior housing outcomes than intensive case management alone or standard care and modestly increases societal costs.

Arch Gen Psychiatry. 2003;60:940-951

From the Veterans Affairs Northeast Program Evaluation Center, West Haven, Conn (Drs Rosenheck, Kasprow, and Liu-Mares); the Departments of Psychiatry (Drs Rosenheck, Kasprow, and Frisman) and Epidemiology and Public Health (Dr Rosenheck), Yale University School of Medicine, New Haven, Conn; the Connecticut Department of Mental Health and Addiction Services, Hartford (Dr Frisman); and the Department of Psychology, University of Connecticut, Storrs (Dr Frisman).

DELIVERY OF effective services to homeless people with serious psychiatric or addictive disorders or both has been difficult, in part, because of their need for assistance from diverse agencies and the difficulty of integrating services at the interorganizational level.[1] A recent 18-site demonstration project[2] found that extensive and well-funded efforts to promote integration of service delivery across dozens of agencies by implementing global, systemwide integration strategies did not result in improved access to services or better client outcomes. In contrast, a more focused, agency-specific approach, in which pairs of agencies map out specific ways of coordinating their efforts, increased access of homeless veterans to social security benefits[3] and improved their quality of life.[4]

Clinical services for this population have included (1) community outreach,[5] (2) case management,[6-8] and (3) housing assistance involving either time-limited halfway house treatment[9,10] or longer-term mainstream community housing with support.[11,12] Recently, experimental studies[6-14] have demonstrated superior outcomes for diverse interventions, typically described as supported housing programs in which case management and housing resources are combined, with benefits more often demonstrated for housing outcomes than for clinical status.[15] Although no paradigmatic standards for this approach have emerged, it received a strong endorsement from the congressionally appointed Bipartisan Millennial Housing Commission.[16(p49)]

An important unanswered question is whether setting aside housing resources is either necessary or sufficient for facilitating exit from homelessness in this population. On the one hand, provision of intensive clinical services may result in receipt of sufficient access to health care, income support, or rehabilitation ser-

vices to facilitate exit from homelessness without formal linkage to housing subsidies. On the other hand, even when given priority access to housing subsidies, people with serious behavioral disorders may not be able to take advantage of them.

Only one experimental study[12,17] has attempted to disentangle the effect of housing subsidies and intensive case management for this population. That study used a 2 × 2 study design, crossing rent subsidies with intensive case management, and reported that clients who received rent subsidies were more likely to be independently housed after 18 months but that intensive case management was not associated with greater improvement than standard case management in any outcome domain. However, these findings are ambiguous because (1) receipt of housing subsidies did not reduce nights of homelessness and (2) the intensive case management intervention as actually delivered was not dissimilar from the standard care intervention. Access to housing subsidies did not reduce homelessness.

Supported housing services can be costly.[18] However, a recent study[19] that assessed the costs for clients placed in the New York–New York (NY/NY) supported housing initiative and a matched control group found substantially greater reductions in hospital use among NY/NY clients than controls, offsetting almost the entire $19 000 annual program cost. In the absence of random assignment, however, it is possible that these savings reflected unmeasured (and unmatched) client characteristics rather than placement in NY/NY housing.

To evaluate the cost-effectiveness of an agency-specific approach to the integration of clinical and housing services, we conducted an experimental evaluation of a joint program of the US Department of Housing and Urban Development (HUD) and the US Department of Veterans Affairs (VA)—the HUD-VA Supported Housing (HUD-VASH) program—in which HUD Section 8 housing vouchers were paired with intensive case management services provided by VA clinicians.

In a 3-year prospective experimental study, we compared outcomes and societal costs among clients randomly assigned to (1) HUD-VASH, (2) intensive case management without special access to Section 8 vouchers, or (3) standard VA homeless services.[17] We hypothesized that case management combined with housing subsidies in HUD-VASH would result in better housing, mental health, and social adjustment outcomes than either control condition and that intensive case management, in turn, would result in better outcomes than standard care. We further hypothesized that HUD-VASH would generate sufficient savings in hospital, halfway house, criminal justice, and emergency shelter costs to offset the additional costs of intensive case management services but that case management alone would be almost as expensive as HUD-VASH but less effective.

METHODS

THE HUD-VASH PROGRAM

Through an interagency agreement, HUD allocated funds for approximately 1000 housing vouchers for a program providing housing and case management assistance for literally homeless veterans with psychiatric or substance abuse problems or both.[20] Participants were offered priority access to Section 8 housing vouchers administered by local housing authorities. These vouchers authorize payment of a standardized local fair-market rent (established by HUD using surveys of local rents) less 30% of the individual beneficiary's income.

Professional staff of the VA's Health Care for Homeless Veterans (HCHV) program,[21] to which each experimental HUD-VASH program was linked, identified potential candidates for the program. To participate in the study, each veteran had to agree to a treatment plan involving further participation in case management and other specified services if randomized to either HUD-VASH or case management only. However, once assigned, retention of the voucher was not contingent on participation in treatment.

The case managers linked clients with the local housing authority and facilitated administrative access and use of the voucher. Case managers also eased the transition to independent living by helping clients (1) locate an apartment, (2) negotiate the lease (through face-to-face landlord meetings if the client wished), and (3) furnish and move into their new apartment. The case management model used in HUD-VASH was modified from the Assertive Community Treatment (ACT) model[22] and encouraged at least weekly face-to-face contact, community-based service delivery, and more intensive involvement in crisis situations. Case managers, most of whom were experienced social workers and nurses, were also encouraged to provide substance abuse and employment counseling and to facilitate linkage with other VA services. Teams in this study consisted of 3 case managers and an allocation of 50 vouchers, allowing maximal caseloads of 25:1, including 25 case management–only clients. Training and monitoring were conducted with written materials and through conference calls, case reviews, and evaluation forms. There were no on-site monitoring visits.

STUDY DESIGN AND DATA COLLECTION

Eligibility was determined from administrative intake forms documenting housing and clinical status at the time of the initial outreach assessment by the HCHV program.[21] After providing written informed consent and completing baseline assessments, 460 veterans were randomly assigned through a telephone call to the central evaluation staff, who identified the next assignment from a deck of cards specific to each site. Veterans were assigned to (1) HUD-VASH (case management plus vouchers) (n = 182), (2) case management only (n = 90), or (3) standard care (n = 188), which consisted of short-term broker case management as provided by HCHV program outreach workers. The randomization was weighted so that half as many veterans were assigned to case management alone as to the other 2 groups. In the case management–only condition, case managers were to provide the same intensity of services as in the HUD-VASH condition and were encouraged to use whatever housing resources could be obtained for their clients. Neither veterans nor staff could be masked to group assignment.

Baseline and follow-up assessment interviews every 3 months were conducted by trained evaluation assistants. The VASH clinicians used (1) structured forms to document their efforts to assist their clients in obtaining their vouchers and apartments and (2) quarterly structured summaries of case management services.

PARTICIPANTS

The study took place at VA medical centers in San Francisco, Calif (n = 107); San Diego, Calif (n = 91); New Orleans, La

(n=165); and Cleveland, Ohio (n=97). Veterans were eligible if they were literally homeless at the time of outreach assessment (ie, living in a homeless shelter or on the streets), had been homeless for 1 month or longer, and had received a diagnosis of a major psychiatric disorder (schizophrenia, bipolar disorder, major affective disorder, or posttraumatic stress disorder) or an alcohol or drug abuse disorder or both.

All veterans provided written informed consent to participate in the study, and the protocol was approved by the human investigations committee at each medical center. Veterans received $20 after each interview.

Recruitment for the study took place between June 1, 1992, and December 31, 1995. During this time, 3489 veterans contacted through outreach at the 4 sites met minimal eligibility criteria, and 460 (13.2%) gave written informed consent to participate in the study. The major reason most veterans did not participate was limited program capacity.

Comprehensive intake data from all HCHV program participants allow detailed comparison of participants and nonparticipants. Compared with other eligible veterans, those who joined the study were slightly younger (42.0 vs 42.8 years, $t=2.2_{637}$; $P<.03$), were more likely to be female (4.2% vs 1.8%, $\chi^2_1=11.3$; $P<.001$), were more likely to be African American (64% vs 57%, $\chi^2_1=7.1$; $P<.008$), and had slightly fewer nights of literal homelessness in the 60 days before intake (26.1 vs 27.1 nights, $t=2.8$; $P<.01$), but they had a greater likelihood of past hospitalization for drug abuse (49.8% vs 39.5%, $\chi^2_1=17.3$; $P<.001$). They were more likely to have been admitted to the residential treatment component of the HCHV program (29.1% vs 10.9%, $\chi^2_1=119.7$; $P<.001$). Participants thus showed evidence of more severe illness on some measures and greater involvement in treatment.

MEASURES

Demographic and Clinical Characteristics

Data were obtained on current sociodemographic characteristics, duration of the current episode of homelessness, and housing status during the 90 days before each interview. We recorded the number of days in the previous 90 that the client spent in each of 11 different types of housing. The primary outcome measures were the number of days housed in the previous 90 (ie, sleeping in an apartment, room, or house of one's own or of a family member or friend) and the number of days homeless in the previous 90 (ie, sleeping in an emergency shelter; a substandard, single-room occupancy hotel; or outdoors, on the sidewalk, or in a park, abandoned building, automobile, truck, or boat).

Psychiatric, alcohol, and drug problems were assessed using specific items and composite scores from the Addiction Severity Index.[23] Psychological distress was measured using the Brief Symptom Index.[24] Diagnoses were based on the working clinical diagnoses of the case management teams. Quality of life was evaluated using selected subscales from the Lehman Quality of Life Interview.[25]

Among those who were housed, the quality of their residence was further assessed using one scale that addressed positive characteristics of the residence (eg, safety, proximity to shopping, affordability, adequate size, and privacy) and another that measured housing problems (eg, pests, broken windows, neighborhood crime, and plumbing problems).[26]

Social support was measured by the number of people in 9 different categories to whom the veteran reported feeling close, an index of the total frequency of contacts with these people, and the average number of types of people who would help with a loan, with transportation, or in an emotional crisis.[27,28]

Treatment Process

Five kinds of indicators were used to compare services provided to each treatment group during the study. First, computerized VA workload data were used to measure contacts with the HUD-VASH or HCHV programs. Second, the nature of the therapeutic alliance was measured by a 5-item rating scale completed separately by the clinician (Cronbach $\alpha=.85$) and the veteran (Cronbach $\alpha=.86$) using a modified version of the Working Alliance Inventory.[29,30] Veterans' assessments of their alliance with their case managers were self-administered in private and mailed in a separate envelope. Third, data were obtained on the use of Section 8 housing vouchers in all 3 groups and on the initial housing search for those assigned to the HUD-VASH group using a structured activities questionnaire. Fourth, data from the quarterly case manager summaries were used to compare case management services provided to each group. Finally, we measured use of regular VA mental health outpatient services (ie, beyond those from HUD-VASH or HCHV program staff).

ASSESSMENT OF HEALTH CARE COSTS

The VA health care costs were estimated by multiplying the number of units of service consumed by each patient by the estimated unit cost of each type of service using VA cost data from fiscal year 1996 and methods developed previously.[31] Unit costs of the HUD-VASH case management were estimated separately using more detailed data on program expenditures and services delivered during a sample year (1996) when the program was fully operational.[32]

Service Utilization

The VA health service utilization data were derived from the VA's comprehensive national workload data systems: the Patient Treatment File for inpatient care, the Outpatient Care File for outpatient care, and program monitoring data on the delivery of residential treatment through VA contracts with community agencies.

VA Unit Costs

Unit costs for VA inpatient, residential care, and outpatient treatment were estimated on the basis of data from the VA's Cost Distribution Report, which is a facility-by-facility accounting record that identifies total expenditures and unit costs associated with VA inpatient and outpatient health care services nationwide.[31]

Non-VA Health Costs

Utilization of non-VA services was documented through quarterly patient interviews, during which was recorded the use of non-VA medical and mental health inpatient, residential, and nursing home care; non-VA medical-surgical outpatient care; and non-VA mental health outpatient care. Non-VA unit costs were estimated from several sources, including analysis of costs in the 1998 MarketScan (The Medstat Group, Ann Arbor, Mich) data set[33] and published studies[34,35] that identify unit costs in large non-VA health care systems.

NON–HEALTH CARE COSTS

Non–health care costs were also evaluated and used to estimate costs from the perspective of governmental agencies or taxpayers and of society as a whole (total resource consumption). Interview data documented the number of days spent in shel-

ter beds or in jail or prison, cash transfer payments (eg, VA benefits, Supplemental Security Income, and Social Security disability), earnings, and the cost of the Section 8 vouchers. Although cash transfer payments (including housing subsidies) were included in the evaluation of costs from the perspective of governmental agencies, only the administrative cost of these payments was included in societal cost estimates.[36] Productivity (employment earnings) was also included in the societal cost estimate, as a negative cost.

Per diem estimates of the cost of shelter and jail days were based on published literature.[19] The administrative cost of the Section 8 vouchers were estimated by multiplying the number of months each veteran received a Section 8 subsidy during 3-year follow-up by HUD's estimated monthly administrative cost for the Section 8 program at each locality.[37] The value of housing subsidies received by program participants was calculated by subtracting 30% of monthly income from reported monthly rent among clients who identified themselves as Section 8 beneficiaries. This figure was only included in the cost estimate from the perspective of the government.

ANALYSIS

First, we evaluated the effectiveness of the randomization by comparing baseline characteristics of clients randomly assigned to each of the 3 groups. Next, we compared housing procurement processes and delivery of case management services across the 3 groups to determine whether the intended differences in access to housing subsidies and case management were achieved.

Third, housing and clinical outcomes across the groups were compared. The follow-up periods selected for analysis were baseline and 6, 12, 18, 24, and 36 months, and all interviews conducted during each interval were included. Because we planned to compare the groups during 5 intervals after the baseline assessment, we used a repeated-measures with mixed-effects analytic strategy. This method was chosen to allow use of all available data from each participant during each follow-up interval. Using hierarchical linear modeling, we modeled random effects for each participant to adjust standard errors for the nonindependence of observations within participants.[38] The repeated-measures mixed-effects model approach was chosen because it allows (1) comparison of each experimental group (HUD-VASH and case management only) with the standard care group at each specific point and (2) comparison of groups averaged across all points (ie, area under the curve). These analyses were conducted using PROC MIXED of SAS version 8.0 (SAS Institute Inc, Cary, NC), with $\alpha < .05$.

Differential Follow-up Rates

Comparison across groups showed significant differences in follow-up rates within each assessment period from the 6-month assessment ($\chi^2_2 = 10.3$; $P < .006$) through the 3-year assessment ($\chi^2_2 = 55.1$; $P < .001$), with higher follow-up rates in the voucher plus case management group (146 [80%], 153 [84%], 142 [78%], 140 [77%], and 127 participants [70%] at 6 months and 1, 1.5, 2, and 3 years, respectively) than in the case management–only group (59 [66%], 62 [69%], 66 [73%], 55 [61%], and 43 participants [48%]); follow-up rates were even lower in the standard care group (126 [67%], 113 [60%], 111 [59%], 92 [49%], and 75 participants [40%]). Two strategies were used to address the potential bias from data loss. First, patients actually followed up at each point were compared on baseline characteristics, and measures for which significant differences were identified were included as covariates in subsequent analyses.

Second, marginal structural modeling was used to inversely weight observations from patients on the basis of their likelihood of being followed up.[39,40] In this approach, survival analysis is first used to model the likelihood that each observation for each participant will be available for analysis. The predicted probabilities are then used to inversely weight each observation so that available observations from clients with characteristics similar to those who were not followed up are given a greater weight. Since the results did not differ substantially across these analytic strategies, we present data from the analysis that adjusted for baseline measures that were significantly different among interviewed groups at any point and dichotomous dummy codes representing 3 of the 4 sites.

Cost-effectiveness

Incremental cost-effectiveness ratios were used to compare the cost-effectiveness of each of the experimental conditions with standard care[41] from each of 4 cost perspectives: the VA, the total health care system (VA and non-VA), the government (or taxpayers), and society as a whole. The incremental cost-effectiveness ratio is the ratio of the difference between groups in costs to the difference in effectiveness. The 95% confidence interval (CI) of the combined incremental cost-effectiveness ratio was computed using the methods described by O'Brien et al.[42] In addition, cost-effectiveness acceptability curves were constructed using recently published methods[43] for analyzing net benefits[44] in which the probability that benefits equal costs is plotted across a range of possible shadow prices for a day of independent housing.

These analyses require complete data for all participants during 3-year follow-up. Although complete data were available for VA health costs, some data were missing on housing outcomes and non-VA resource use. We used multiple regression models to impute missing data. First, a series of models were estimated in which housing outcomes or service use were the dependent variables and measures of baseline clinical status and dichotomous dummy-coded variables representing treatment group and time interval were the independent variables. These models were then used to generate estimated values of these dependent variables for each client at each point, which were used to impute missing data.

To examine longitudinal time trends in costs, we conducted a series of analyses of variance comparing VA health care costs among groups at 6-month intervals from the year before randomization to 3 years after. We used VA costs for longitudinal analysis because no data are missing and they account for 77% of all health costs (range, 73%-82% across groups).

RESULTS

BASELINE CHARACTERISTICS

There were no significant differences among groups on any sociodemographic, clinical, or community-adjustment measures at baseline (data available from the authors on request). The sample was diagnostically heterogeneous: 9.7% had serious psychiatric diagnoses, 50.4% had alcohol or drug disorders, and 35.2% had dual diagnoses, and 4.7% has other psychiatric disorders.

PROGRAM PARTICIPATION

Comparison of workload data showed greater participation rates and greater numbers of visits among participants in the HUD-VASH group than in the case management–only group and in the case management–only group than in the standard care group across all years (**Table 1**).

Table 1. Comparison of Treatment Process Across Groups

Treatment Process	Group 1 HUD-VASH (n = 182)	Group 2 CM Only (n = 90)	Group 3 Standard Care (n = 188)	F/χ^2	*df*	*P* Value	Paired Comparison (*P*<.05)*
VASH Program contact							
Any clinical contacts, %‡							
Year 1	95.6	95.6	85.6	19.36	2	<.001†	
Year 2	85.6	80.0	67.0	18.85	2	<.001†	
Year 3	80.8	71.1	49.5	55.96	2	<.001†	
Contacts, No.§							
Year 1	34.2	22.0	6.8	71.07	2,418	<.001†	1>2>3
Year 2	22.1	16.2	5.2	47.33	2,356	<.001†	1>2>3
Year 3	16.3	13.9	6.4	12.65	2,301	<.001†	1,2>3
Duration of involvement, y‖	2.4	2.08	0.69	145.88	2,395	<.001†	1>2>3
Therapeutic alliance¶							
Clinician rating							
Year 1	4.29	3.92	3.99	13.59	2,1244	<.001†	1>2,3
Year 2	4.06	3.79	3.93	3.57	2,698	.03†	1>2
Year 3	4.25	3.75	3.87	12.42	2,715	<.001†	1>2
Client rating							
Year 1	4.71	4.43	4.28	10.74	2,991	<.001†	1>2,3
Year 2	4.73	4.52	4.52	1.71	2,470	.18	
Year 3	4.21	4.35	4.60	0.37	2,346	.69	
Initial HUD-VASH housing search							
Obtained Section 8 voucher, %	78.6	5.6	1.6	288.65	2	<.001†	
Months to obtain voucher#	3.03	12.03	20.87	39.12	2	<.001†	
Client and CM met with landlord, %**	71.6	NA	NA	NA	NA	NA	
Number of apartments visited by client**	4.20	NA	NA	NA	NA	NA	
CM helped furnish apartment, %**	54.1	NA	NA	NA	NA	NA	
Case management activities (first year)††							
Days from randomization to community entry	80.1	78.1	68.2	0.76	2,406	0.46	
Helped find employment, %	16.9	6.9	15.2	17.9	2	<.001†	
Helped access income, %	17.2	12.9	19.4	4.3	2	.11	
Helped locate apartment, %	25.4	21.1	8.9	24.4	2	<.001†	
Helped obtain or keep housing, %	53.5	48.4	31.4	30.1	2	<.001†	
Helped negotiate with landlord, %	33.7	17.2	5.2	79.6	2	<.001†	
Helped move into apartment, %	11.7	6.6	3.1	16.7	2	<.001†	
Helped furnish apartment, %	26.4	20.8	5.2	40.3	2	<.001†	
Provided rehabilitation services, %	52.4	52.3	43.3	5.5	2	.06	
Provided substance abuse services, %	51.9	52.3	38.1	12.6	2	<.002†	
Provided psychotherapy, %	27.7	23.7	19.6	6.007	2	<.05†	
VA mental health visits (non-VASH or HCHV), No. ‡‡							
Year 1	68.5	51.3	65.1	1.72	2,458	.18	
Year 2	43.4	26.6	22.6	5.71	2,458	.004†	1>2,3
Year 3	29.7	23.2	17.5	2.73	2,458	.06	

Abbreviations: CM, case management; HUD-VASH, US Department of Housing and Urban Development–US Department of Veterans Affairs Supported Housing; HCHV, Health Care for Homeless Veterans; NA, not applicable.

*Paired comparisons are calculated for continuous variables only.

†Statistically significant.

‡Contact with specialized VA homeless programs (HUD-VASH or HCHV) (based on computerized administrative workload data).

§Average number of contacts among those with any contacts.

‖Years from randomization to last contact documented on case manager clinical summary up to 3 years after randomization.

¶Average score on 5 items, scored on a scale from 0 to 6.

#Median number of months from randomization to obtaining voucher among those who obtained a voucher.

**Sample limited to clients who found housing using the allocated voucher: n = 143 (group 1).

††Based on quarterly case management reports completed during the first year (most reports followed the initial housing search and reflect subsequent case management activity): n = 768 (group 1), 303, (group 2), and 191 (group 3).

‡‡Other outpatient VA psychiatric or substance abuse services (based on computerized administrative workload data).

Clinician- and veteran-rated therapeutic alliance scores in the HUD-VASH group were significantly higher than those in the other 2 groups during the first year of treatment (Table 1).

More than three fourths of veterans assigned to the voucher condition received vouchers (78.6%) compared with only 5.6% of the case management–only group and 1.6% of the standard care group (Table 1). As planned, HUD-VASH case managers were actively involved in the housing search, meeting with prospective landlords for 72% of clients and helping furnish apartments for 54%. During the first year of case management, HUD-VASH clients received more specialized services than the other groups, especially in the housing domain. These data provide evidence that the treatment conditions differed in the expected ways, although the case management–

Table 2. Outcome Measures Across All Points During 3-Year Follow-up: HUD-VASH Program*

Variable	Group 1 HUD-VASH (n = 182)	Group 2 CM Only (n = 90)	Group 3 Standard Care (n = 188)	Significance of Differences†					
				t Test (1 vs 2)	*P* Value	*t* Test (1 vs 3)	*P* Value	*t* Test (2 vs 3)	*P* Value
Housing									
Days housed (in past 90 d)	59.39	50.81	47.60	2.90	<.004‡	4.88	<.001‡	1.06	.29
Days homeless (in past 90 d)	13.05	20.33	20.45	2.87	.004‡	3.56	<.001‡	0.05	.96
Days in institutions (in past 90 d)	17.25	18.51	21.64	0.58	.56	2.46	.01‡	1.40	.16
Subjective QOL: housing	4.48	4.02	4.12	4.40	<.001‡	4.27	<.001‡	0.90	.37
Housing problems	0.34	0.46	0.45	2.99	.003‡	3.48	<.001‡	0.12	.91
Housing quality	0.66	0.63	0.61	1.52	.13	2.53	.01‡	0.54	.59
Clinical status									
Drank to intoxication, d	1.46	1.95	1.71	1.17	.24	0.73	.46	0.55	.58
Worked past 30 days, d	6.96	6.82	6.71	0.17	.87	0.36	.71	0.13	.89
Alcohol index score (ASI)	0.12	0.151	0.121	1.90	.06	0.34	.73	1.59	.11
Drug index score (ASI)	0.061	0.065	0.063	0.44	.66	0.21	.83	0.26	.79
Psychiatric index score (ASI)	0.25	0.26	0.24	0.69	.49	0.34	.73	0.95	.34
Psychological distress score (BSI)	1.20	1.29	1.16	0.96	.34	0.47	.64	1.33	.18
Medical index score (ASI)	0.26	0.28	0.27	0.47	.63	0.39	.69	0.15	.88
Community adjustment									
Employment index score (ASI)	0.191	0.187	0.187	0.17	.86	0.20	.84	0.01	.99
Legal index score (ASI)	0.061	0.063	0.087	0.14	.89	1.92	.06	1.36	.17
Total income, $	656	684	717	0.59	.55	1.56	.12	0.67	.50
Expenditures on substance abuse, $	75	96	77	1.01	.31	0.10	.92	0.89	.37
Social network size, No.	11.6	9.3	10.1	2.52	.01‡	2.02	.04‡	0.88	.38
Social contacts, No.	39.1	30.4	36.5	2.50	.01‡	0.91	.36	1.74	.08
Social support, No.	7.85	6.54	7.11	2.65	.008‡	1.83	.07	1.15	.25
Subjective QOL: overall score	4.31	3.92	4.18	2.64	.009‡	1.09	.28	1.73	.08
Subjective QOL: family score	4.49	4.16	4.25	2.28	.02‡	2.02	.04‡	0.62	.53
Subjective QOL: finances score	3.26	2.93	3.12	2.50	.01‡	1.31	.19	1.41	.16
Subjective QOL: health score	4.50	4.18	4.36	2.87	.004‡	1.54	.12	1.60	.11
Subjective QOL: social relations score	4.31	4.04	4.20	2.42	.02‡	1.25	.21	1.38	.17
Arrests: major crimes, No.	0.23	0.20	0.23	0.79	.43	0.10	.92	0.82	.41
Arrests: minor crimes, No.	0.22	0.21	0.22	0.46	.64	0.22	.82	0.27	.79

Abbreviations: ASI, Addiction Severity Index; BSI, Brief Symptom Index; CM, case management; HUD-VASH, US Department of Housing and Urban Developments–US Department of Veterans Affairs Supported Housing; QOL, quality of life.

*Data are given as means.

†Significance of differences in least-square means in repeated-measures mixed-effects models using PROC MIXED of SAS version 8.0 (SAS Institute, Inc, Cary, NC).

‡Statistically significant.

only group received somewhat less intensive services than the HUD-VASH group.

All 3 groups showed substantial use of VA mental health services, declining progressively within each group from year 1 to year 3 (Table 1). Service use was substantially higher in the HUD-VASH group than in the other 2 groups in the second year.

OUTCOMES

Averaging across all 3 years, repeated-measures mixed-effects analysis shows that veterans assigned to the HUD-VASH group had 25% more days in an apartment, room, or house than the standard care group (59.4 vs 47.6 days) (t=4.88; P<.001) and 16.9% more days housed than the case management–only group (59.4 vs 50.8 days) (t=2.90; P<.004) (**Table 2**). Differences were significant across time for the first 2 years but attenuated in year 3 (**Figure 1**). The case management–only group had only 7% more days housed than the standard care group (t=1.06; P=.29) (Table 2).

Veterans assigned to the HUD-VASH group had 36.2% fewer days homeless than the standard treatment group (13.1 vs 20.5 days) (t=3.56; P<.001) and 35.8% fewer days homeless than the case management–only group (13.1 vs 20.3 days) (t=2.87; P=.004). There was no significant difference between the case management–only group and the standard care group (t=0.05; P=.96) (Table 2). Differences in days homeless were significant across time for the first 2 years and then attenuated in years 2 and 3 (**Figure 2**).

Consistent with these objective findings, veterans in the HUD-VASH group reported greater subjective satisfaction with housing than either of the other groups and, among those who were housed, experienced fewer housing problems (Table 2). Those who were housed also experienced higher housing quality (ie, more desirable features) than the standard care group but not than the case management–only group.

Veterans assigned to the HUD-VASH group had larger social networks overall (numbers of people they felt close to) and were more satisfied with their family relationships than either of the other groups (Table 2). There were no significant differences on other clinical or community-adjustment measures in either the cumulative analysis (Table 2) or at any specific point.

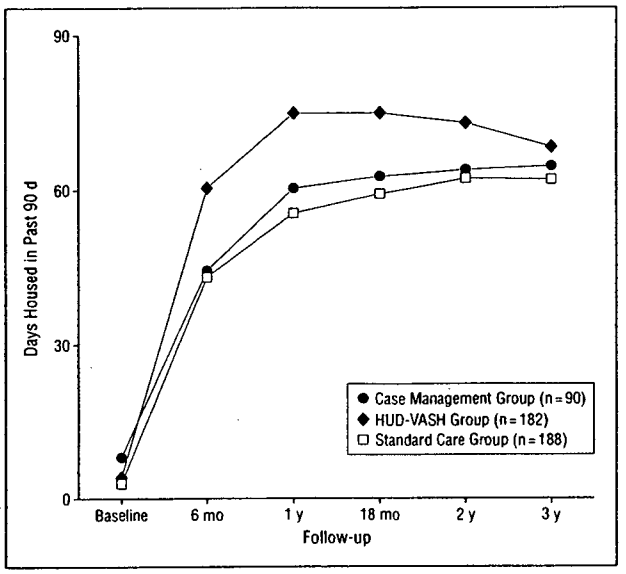

Figure 1. Outcomes in the US Department of Housing and Urban Development and US Department of Veterans Affairs Supported Housing (HUD-VASH) program: mean number of days housed in the past 90 days (N=460). Paired comparisons are based on repeated-measures mixed-effects models. $P<.05$, HUD-VASH group > case management only group and HUD-VASH group > standard care group between 6 months and 2 years.

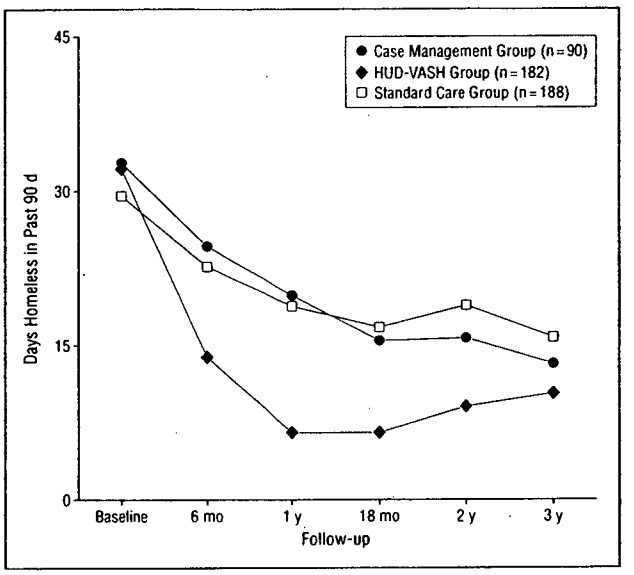

Figure 2. Outcomes in the US Department of Housing and Urban Development and US Department of Veterans Affairs Supported Housing (HUD-VASH) program: mean number of days homeless in the past 90 days (N=460). Paired comparisons are based on repeated-measures mixed-effects models. $P<.05$, HUD-VASH group < case management only group between 6 and 18 months and HUD-VASH group < standard care group between 6 months and 2 years.

SUBGROUP ANALYSES

Outcome analyses were repeated among subgroups of veterans (1) with severe mental illness, (2) dually diagnosed as having psychiatric and substance abuse disorders, (3) with substance abuse disorders, (4) who had been homeless for longer than 1 year at the time of program entry, (5) who were members of racial or ethnocultural minority groups, and (6) with high and low levels of social support at program entry. Results were not different from the analyses of the entire sample or in a set of analyses that excluded "crossovers," that is, veterans in the voucher plus case management group who did not receive a voucher, veterans in the other groups who did receive a voucher, and veterans in the case management–only group who did not participate in case management for at least 6 months. The HUD-VASH was consistently associated with improved housing outcomes but no other outcomes.

COSTS

Total 3-year VA health costs for HUD-VASH clients were $8009 (28%) greater than those for the standard care group (**Table 3**), and costs for the case management–only group were $6580 (23%) greater (results of cost analyses are discussed as differences and percentage differences between the means presented in the tables).

The difference between the HUD-VASH group and the standard care group was almost entirely attributable to the $4905 (774%) greater homeless program costs (ie, HUD-VASH case management) and $2454 (32%) greater outpatient mental health costs.

Longitudinal analysis showed substantial declines in VA costs for all 3 groups after randomization (**Figure 3** and **Figure 4**). There were no significant differences among groups in either total VA health costs (data not shown) or VA inpatient and residential treatment costs (Figure 3) at any specific points. The HUD-VASH clients, however, had significantly higher VA outpatient costs (including HUD-VASH costs) than both of the other groups during the first year (Figure 4). Between 18 months and 3 years, the HUD-VASH and case management–only groups had greater outpatient costs than the standard care group (Figure 4).

Three-year non-VA health costs were estimated to be $1047 (10%) lower for HUD-VASH clients than for standard care clients and $3468 (32%) less for case management–only clients (**Table 4**).

Combining VA and non-VA health cost data, we estimate that from the perspective of the health care system as a whole, costs for HUD-VASH clients were $6962 (18%) greater than costs for standard care clients (Table 4).

Although not included in societal cost estimates,[36] the value of Section 8 vouchers averaged $6775 for veterans in HUD-VASH who received them. These costs, along with shelter, incarceration, and other transfer payments, were included in the governmental cost estimates, which showed HUD-VASH to be $10 295 (17.8%) more expensive than standard care from this perspective (Table 4).

Total non–health care costs in the HUD-VASH group were only $762 (47%) less than those in the standard care group (see component details in Table 4). Combining health care and non–health care resource consumption to estimate costs from the perspective of society as a whole, HUD-VASH clients consumed $6200 (15%) more resources than standard care clients.

Table 3. VA Treatment Costs Over 3 Years (Analysis of Variance)

Treatment	Group 1 HUD-VASH (n = 182)	Group 2 CM Only (n = 90)	Group 3 Standard Care (n = 188)	$F_{2,459}$	*P* Value	Paired Comparison (*P*<.05)
Outpatient care costs, $						
Mental health care	10 183	7253	7729	3.20	.04*	1>2,3
Medical-surgical care	1544	1784	1522	0.83	.44	
Homeless case management†	5539	3741	634	104.89	<.001	1>2>3
Subtotal	**17 267**	**12 779**	**9886**	16.89	<.001*	1>2,3
Inpatient and residential care costs, $						
Mental health care	12 023	12 045	9318	0.72	.49	
Medical-surgical care	4043	5071	4824	0.16	.85	
Residential care‡	3291	5199	4486	1.62	.20	
Subtotal	**19 257**	**22 315**	**18 628**	0.45	.64	
Total	**36 524**	**35 095**	**28 515**	2.80	.06	1>3

Abbreviations: CM, case management; HUD-VASH, US Department of Housing and Urban Development–US Department of Veterans Affairs Supported Housing.
*Statistically significant.
†Case management contacts with either HUD-VASH or Health Care for Homeless Veterans program staff.
‡Including VA residential and domiciliary care and non-VA care funded through VA contracts.

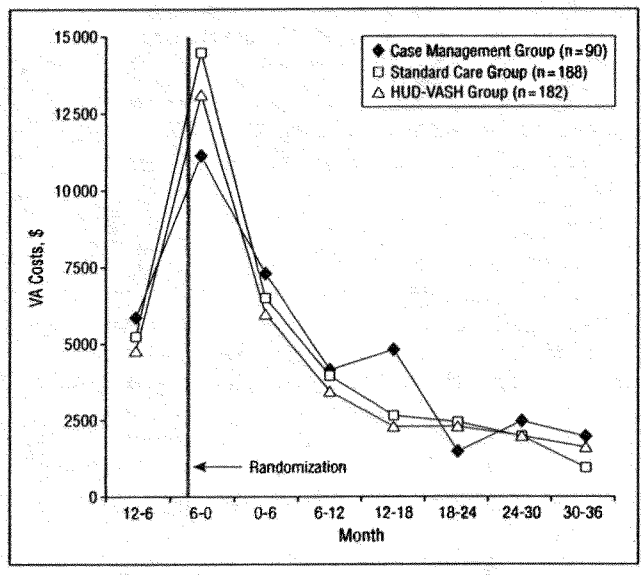

Figure 3. Department of Veterans Affairs (VA) inpatient and residential treatment costs 1 year before and 3 years after randomization (N=460). Analysis of variance showed no significant differences between groups at any point. HUD-VASH indicates US Department of Housing and Urban Development and VA Supported Housing.

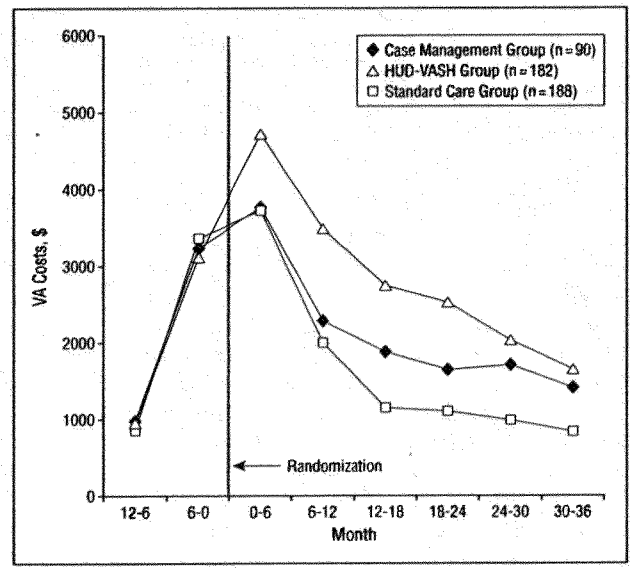

Figure 4. Department of Veterans Affairs (VA) outpatient costs 1 year before and 3 years after randomization (N=460). Outpatient costs for US Department of Housing and Urban Development and VA Supported Housing (HUD-VASH) were significantly higher than for standard care at all points after randomization. *P*<.05, HUD-VASH group > case management–only group and standard care group between 6 and 12 months, HUD-VASH group > case management–only group > standard care group at 12 to 18 months, and HUD-VASH group and case management–only group > standard care group between 24 and 36 months.

COST-EFFECTIVENESS

Incremental cost-effectiveness ratios show that each additional day housed among HUD-VASH clients cost $58 (95% CI, $4-$111) from the perspective of the VA, $50 (95% CI, –$17-$117) from the perspective of the total heath system, $74 (95% CI, $5-$143) from the perspective of governmental agencies, and $45 (95% CI, –$19-$108) from the perspective of society as a whole.

Cost-effectiveness acceptability curves show that from the societal perspective, benefits are likely to outweigh costs with a probability of 56% if a day of housing is valued at $50; 80% if valued at $75; 92% at $100; and 97% above $125 (**Figure 5**). Probabilities of achieving cost-effectiveness were modestly greater from the societal perspective than from the perspective of the health care system or VA and modestly smaller from the governmental perspective. If valued at $125 per day housed, there was a 90% chance of benefits exceeding costs from all perspectives.

COMMENT

The main hypotheses of this study were only partially supported. Assignment to HUD-VASH was associated with improved housing outcomes and greater social contacts but no other benefits, and costs increased. Case management, by itself, yielded no advantage over standard care.

Table 4. Non-VA and Total Societal Cost During 3 Years of Follow-up (Analysis of Variance)

Variable	Group 1 HUD-VASH (n = 182)	Group 2 CM Only (n = 90)	Group 3 Standard Care (n = 188)	F Test*	P Value	Paired Comparison (P<.05)
Non-VA costs, $						
Non-VA health costs						
Mental health	4627	5035	6163	0.95	.39	
Non–mental health	5098	2269	4609	1.25	.29	
Subtotal	**9725**	**7304**	**10 772**	1.08	.34	
Non-health costs						
Shelter	2375	3316	4774	5.31	.01†	1<3
Incarceration	1062	1305	758	0.65	.52	
Administrative costs of transfer payments (excluding voucher)	380	413	389	0.27	.76	
Administrative cost of section 8 vouchers‡	967	40	4	192.40	<.001†	1<2,3
Earned income (productivity)§	(3917)	(3057)	(4296)	2.70	.07	2<3
Subtotal	**867**	**2017**	**1629**	0.51	.60	
Combined VA and non-VA cost, $						
VA health costs (from Table 3)	36 524	35 095	28 515	2.74	.07	
Total health costs (VA and non-VA)	46 249	42 399	39 287	1.40	.25	
Governmental costs‖	68 114	60 977	57 819	2.65	.07	1>3
Total societal cost¶	47 116	44 416	40 916	1.03	.36	
Incremental cost of HUD-VASH (difference between groups)	6200	3500	NA			
Annualized incremental cost	2067	1167	NA			

Abbreviations: CM, case management; HUD-VASH, US Department of Housing and Urban Development–US Department of Veterans Affairs Supported Housing; NA, not applicable; PHA, Public Housing Authority.

*Estimated on the basis of regression model using available interview data on non-VA health and non–health resource use.

†Statistically significant.

‡Based on PHA and HUD administrative costs and duration of possession of voucher.

§Productivity (earned income) increases societal resources and thus is considered a negative cost.

‖Sum of VA and non-VA health costs, plus the cost of homeless shelters, incarceration, and transfer payments.

¶Sum of VA health costs, non-VA health costs, and the cost of homeless shelters, incarceration, and administrative cost of transfer payments, less productivity.

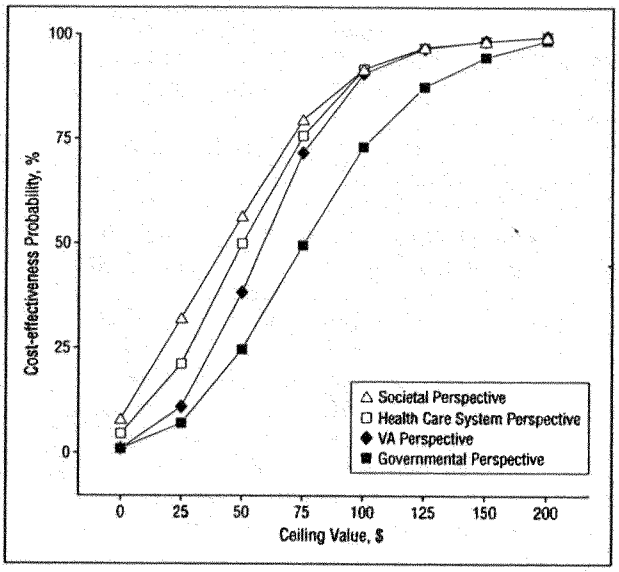

Figure 5. Cost-effectiveness acceptability curves for US Department of Housing and Urban Development and US Department of Veterans Affairs (VA) Supported Housing compared with standard care from 4 cost perspectives (N=460).

COMPARISON WITH OTHER STUDIES

The housing benefits reported for HUD-VASH are more robust than those of the only previous effort to differentiate the impact of housing subsidies and case management. Unlike HUD-VASH, the San Diego Supported Housing Study[12,17] found that assignment to the voucher condition resulted in more days of independent housing but no reduction in homelessness. However, similar to the San Diego study, we found no advantage for case management in the absence of vouchers and no clinical benefits.

Other studies,[6,7,13-15,45] in contrast, have reported gains in housing and some clinical measures with case management interventions based on the ACT model. One possible explanation for these differences is that virtually all the evaluations of ACT in homeless populations have included special access to housing resources and thus may have been more like the HUD-VASH intervention than like the case management–only intervention evaluated herein. In addition, the intended caseloads in the HUD-VASH program and the San Diego program (20-25 cases per case manager) were larger than is typical in ACT programs (10 cases per case manager), and the delivery of services was less intensive. It is also possible that the diagnostic heterogeneity of our sample or receipt of extensive nonprogram services attenuated differences between the 2 case management groups and the standard care group.

Our cost findings are also different from those reported from a nonexperimental study of homeless mentally ill clients placed in the NY/NY supported housing program.[19] Although the NY/NY evaluation compared service use and costs in matched samples, the HUD-VASH evaluation compared costs prospectively between randomly assigned treatment groups. Since the

matching procedure used in the NY/NY evaluation was based entirely on administrative data, it is possible that the matching procedure was imperfect and that clients were selected for NY/NY housing on clinical grounds, for example, because they had made progress toward recovery from acute psychiatric or addictive problems and thus were entering a period in their lives when they would have experienced lower hospital use even without participating in the NY/NY program. Such selection bias is highly unlikely in the HUD-VASH evaluation because treatment groups were identified on the basis of random assignment.

Although net costs in the HUD-VASH program were greater than in the NY/NY program, the increase in annual costs (from $2067 from the societal perspective to $3431 from the governmental perspective) was modest in magnitude and comparable to those of other widely used and demonstrably effective psychiatric treatments such as atypical antipsychotic medications[46] or methadone maintenenace.[47] Further cost-effectiveness analyses suggest that although we do not know the monetary value of a day of housing, if we examine a range of possible values, we find that if a day of housing is valued at $50 the probability of benefits equaling costs is only 25% to 58% across the various cost perspectives, but the probability rises to 90% to 97% at a shadow price of $125 per day housed.

LIMITATIONS

The principal limitation of this study is the substantial and differential follow-up attrition across treatment groups after the first year, with participants in the 2 experimental conditions more likely to be reinterviewed than those in standard care. It is somewhat reassuring that there were few differences at baseline between those who were successfully followed up and those who were not and that results did not change when analyzed using marginal structural models. However, since one would expect that veterans who were doing less well clinically—especially those who had relapsed to substance abuse—would be more likely to be lost to follow-up, the measured outcomes in the standard care group may be biased in the favorable direction. Since such bias would tend to obscure between-group differences, the negative findings for clinical outcomes should be interpreted with some caution.

This program evaluation study was different from a manual-guided psychotherapy trial in that care provided at local sites was neither monitored through site visits or tape-recorded sessions nor guided by quantitative program fidelity standards—which have yet to be developed for this kind of program. However, the implementation approach used in this effectiveness study is of the kind that would occur in a nonresearch dissemination effort, thus increasing its relevance to "real-world" practice. In addition, because the same case managers implemented both experimental conditions, they may have believed that they were offering inferior services to case management–only clients and they (perhaps reinforced by their clients) may have experienced some demoralization. The alternative approach—of assigning different case managers to each of the treatment conditions—was not feasible.

In addition to these limitations of measurement and program implementation, an intrinsic limitation of any cost-effectiveness analysis is that in the absence of a monetary evaluation of the outcomes it is not possible to decide whether the added costs of a program are justified by the benefits. Cost-effectiveness acceptability curves suggest that if a day of housing for a homeless person with mental illness is valued at $125 or more, HUD-VASH is likely to be an efficient investment from all 4 cost perspectives. But it is unclear whether $125 is an appropriate shadow price for a day of housing for this population.

There are a variety of methods for estimating willingness to pay for various states of health or welfare,[48,49] but they are often difficult to administer to people with mental illness, and it has been argued that the preferences of the general (tax-paying) public are more germane to the valuation process than those of the direct beneficiaries.[41] However, the utility associated with basic housing for a person who has been homeless is likely to be far greater than for the public at large, even allowing for the uncertainties associated with interpersonal comparisons of well-being, adding another level of complexity to monetizing the outcomes of this study.[50,51]

Furthermore, in any large-scale dissemination of HUD-VASH, the increased costs associated with the program would be likely to require increased taxation. Taxation incurs deadweight losses that have been estimated at 16% to 30% of revenue.[52,53] Under the assumption of a 20% deadweight loss due to taxation, HUD-VASH client costs would increase to $8265 (15.7%) more than standard care, and the incremental cost-effectiveness ratio would be $59 per day housed (95% CI, -$30-$149). The HUD-VASH program is not an unambiguously cost-effective intervention.

Cost considerations aside, some authorities argue that housing is so fundamental to realizing the worth of liberty and the pursuit of happiness that it must be regarded as a right guaranteed to all citizens.[54-56] Society, in this view, is categorically or constitutionally obligated to ensure access to housing, and costs are irrelevant. This line of inquiry moves us from considerations of efficiency to the just distribution of social resources, and from the domain of health economics to law and philosophy, domains that are beyond the scope of this study but perhaps deserving of greater attention.

Finally, because this study was conducted on a diagnostically heterogeneous population within the VA health care system, the generalizability of the findings to diagnostically homogeneous populations, to women, or to health care systems other than the VA cannot be assumed.

POLICY IMPLICATIONS: VOUCHERS WITHOUT CASE MANAGEMENT

The absence of differences between case management only and standard care in this study and the San Diego study raises the question of whether housing vouchers could be provided to homeless clients without being linked to

intensive case management services. No study or program has offered vouchers to people with serious mental illness without some special program supports,[57] so no answer to this question is available. Some studies suggest that case management services might be effectively delivered on a time-limited basis,[58] as in the critical time intervention,[13] reducing total health care costs while ensuring access to necessary services and supports. However, our data show that as the intensity of case management weakened, in the third year, group differences in outcomes also attenuated, suggesting that service intensity may need to be maintained. Further research is needed on this issue.

To avoid any misunderstanding, it should be emphasized that our findings should not be taken to suggest that case management, in general, does not result in improved health status or community adjustment for homeless people with mental illness. This study compared 2 case management interventions with standard care in a full-service health care system in which homeless veterans had an outreach clinician to link them with a full range of health care services. Housing outcomes, in fact, were impressive even for the standard care group. To evaluate case management in an absolute sense, one would have to compare outcomes for recipients of those services with outcomes for clients who were kept from using any such services at all, which is not a feasible alternative.

Although systemwide efforts to improve client outcomes by fostering services integration across dozens of agencies have been ineffective,[2] the agency-specific approach demonstrated here was successful at integrating clinical and housing services and in improving housing outcomes. This study demonstrates the potential benefit of housing vouchers for this population, although the associated clinical costs are not inconsiderable.

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#16

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
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MEETING DATE: 10-2-03

SUBJECT: Special needs committee

AGENDA NUMBER OR TOPIC: R-8

FOR: ✓ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Michelle Hornbeck

ADDRESS: 9457 N. Bristol #15

CITY/STATE/ZIP: Portland OR 97203

PHONE: DAYS: _____ EVES: _____

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: Homeless needs

WRITTEN TESTIMONY: _____

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#17

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

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MEETING DATE: 10.02.03

SUBJECT: _____

AGENDA NUMBER OR TOPIC: Homeless Special Needs

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: KASSANDRA LANG

ADDRESS: 4620 N Maryland

CITY/STATE/ZIP: Portland OR 97217

PHONE: DAYS: 721-6753 EVES: 901-5705

EMAIL: Kass1ywca-pdx.org FAX: 721-6750

SPECIFIC ISSUE: Housing, Support Services

WRITTEN TESTIMONY: _____

IF YOU WISH TO ADDRESS THE BOARD:

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3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

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#18 & #19

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

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MEETING DATE: 10-2-03

SUBJECT: Special Needs committee

AGENDA NUMBER OR TOPIC:

FOR: V AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Rose O'Day & Daisy O'Day

ADDRESS: 4306 N Williams

CITY/STATE/ZIP: Portland, OR 97217

PHONE: DAYS: (503) 484-8602 EVES:

EMAIL: stinginnettle2002@yahoo.com FAX:

SPECIFIC ISSUE:

WRITTEN TESTIMONY:

IF YOU WISH TO ADDRESS THE BOARD:

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3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

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#20

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
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MEETING DATE: 10/2/03

SUBJECT: Special Needs Report

AGENDA NUMBER OR TOPIC: _____

FOR: X AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: DOREEN WARNER / Human Solutions

ADDRESS: 2900 SE 122nd

CITY/STATE/ZIP: Portland 97236

PHONE: DAYS: _____ EVES: _____

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: _____

WRITTEN TESTIMONY: _____

IF YOU WISH TO ADDRESS THE BOARD:

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2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

BEFORE THE BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

RESOLUTION NO. 03-139

Accepting the Report of the Special Needs Committee of the Housing and Community Development Commission, and Implementing the Recommendations Therein

The Multnomah County Board of Commissioners Finds:

a. Through parallel resolutions, Multnomah County, the City of Portland and the Housing Authority of Portland (the Partners) created and staffed the Special Needs Committee (SNC) of the Housing and Community Development Commission (HCDC) to assess the need for special needs housing in Multnomah County and make recommendations to stimulate its development.

b. On July 2, 2003, HCDC adopted the SNC's report with recommendations intended to result in development of more housing coordinated with services for special needs populations. For purposes of this resolution, the term "special needs populations" means those with disabilities, including severe and persistent mental illnesses, substance abuse disabilities, developmental disabilities, physical disabilities and multiple disabilities. Although most members of this population live alone, some are accompanied by family members and need larger housing units and family-oriented services.

c. Many persons with special needs served by Multnomah County and its contract agencies are unable to succeed because of lack of stable, affordable housing. Barriers to housing for these populations can include lack of income, lack of services that support housing success, criminal records, and unusual behaviors. As a result, people with special needs are disproportionately served by jails, hospitals, shelters, health clinics and other publicly and community-funded resources. Research shows that providing supportive housing to people with special needs is more cost effective and humane than continuing to use these scarce public resources. It is in the County's interest that significant new housing resources for special needs populations be created and preserved.

d. The SNC report describes a gap of 7890 units of Permanent Supportive Housing for people age 18-64, resulting in a chronically homeless population of about 3500 people with special needs in Multnomah County.

e. Filling the gap of 7890 units of permanent supportive housing resources should be a very high priority for available housing and services funds during the next few years. The community should set a target of meeting 50% of this housing need during the next five years. The need can be met by constructing new housing units, acquiring existing buildings for conversion to housing, refinancing

existing units to accommodate lower resident incomes, provision of permanent rent subsidies, and other means.

f. In order to fill the gap, Federal, State and local funds, including rent subsidy resources and tax increment funds generated by urban renewal districts, must be committed to developing more special needs housing. The County does not intend to decrease current funding in existing poverty programs to fund this effort.

g. The County and its Partners need to coordinate services with housing so that people with special needs can access and succeed in housing.

h. The efforts of the Special Needs Committee and its members have already resulted in new awareness, relationships and initiatives that are moving ahead to develop supportive housing. Those initiatives include obtaining a large grant from the Corporation for Supportive Housing for systems change to develop 400 new units of supportive housing for chronically homeless people with disabling health conditions; and the first-ever issuance of a coordinated Request For Proposals for special needs housing projects using Project Based Section 8 vouchers administered by the Housing Authority of Portland linked with City-controlled federal housing funds.

The Multnomah County Board of Commissioners Resolves:

1. The Board accepts and approves the Report of the Special Needs Committee of HCDC; and appreciates the work of all members of the Committee, in particular its Chair, Linda Kaeser.

2. The Board urges the City of Portland, the Portland Development Commission, the Housing Authority of Portland, the State of Oregon, and the City of Gresham to give the highest priority for housing funds to permanent housing for special needs populations until the gap is filled.

3. The County and its departments will join with Partners, including the City of Portland, the Housing Authority of Portland, the Portland Development Commission, nonprofit community housing and social service providers, the State of Oregon, and others to coordinate services with housing and implement the recommendations contained in the Report to create new permanent supportive housing units.

4. The County will implement certain recommendations in the SNC Report, including

   - finding new ways to expand Medicaid resources in order to create new housing-related services;

   - using Federally Qualified Health Center status to provide services to special needs populations that support housing success;

- strengthening partnerships between its services systems and the social housing industry through improving communications, creating training programs, participating in private market access programs, and incorporating housing relationships into social and human service program designs and plans; and

- developing, with its Partners, significant specialized new housing and service opportunities for the "hardest-to-house," i.e. chronically homeless people with special needs.

5. The County recognizes that implementing the recommendations in the Special Needs Committee report will be a critical element in the Portland area's efforts to end homelessness.

6. The County will participate in a review of existing rent assistance programs operated by the County and by others, to create a system that is streamlined, efficient and accessible to homeless and special needs populations.

7. The County will actively support strategies and tools to create new capital, operating and services resources for affordable housing, and will seek commitments at every opportunity to include supportive housing for special needs populations in any new housing resources that become available.

8. The Board requests that the Special Needs Committee oversee implementation of recommendations contained in the Report, including how to identify special needs families and improve their access to services and housing.

ADOPTED this 2nd day of October 2003.

BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

Diane M. Linn, Chair

REVIEWED:

AGNES SOWLE, COUNTY ATTORNEY
FOR MULTNOMAH COUNTY, OREGON

By _____
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Housing and Community Development Commission

SPECIAL NEEDS COMMITTEE REPORT

July 2003

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EXECUTIVE SUMMARY

This is the first report of the Special Needs Committee (SNC), of the Housing and Community Development Commission (HCDC) for Multnomah County.

Our community is experiencing a crisis in special needs housing. People with special needs, some of the most vulnerable members of our community, are unable to find safe, decent housing linked with the appropriate level of service. For lack of suitable supportive housing, too many people with special needs become inpatients at hospitals, are incarcerated, or enter the homeless system. This is neither humane nor financially prudent.

We believe that, if we can provide an adequate supply of supportive housing, we can ease the pressure on the mental health system, the corrections system, and the homeless system, as well as provide people with the homes and services they need and deserve. We can refocus resources in a more compassionate and economically efficient way.

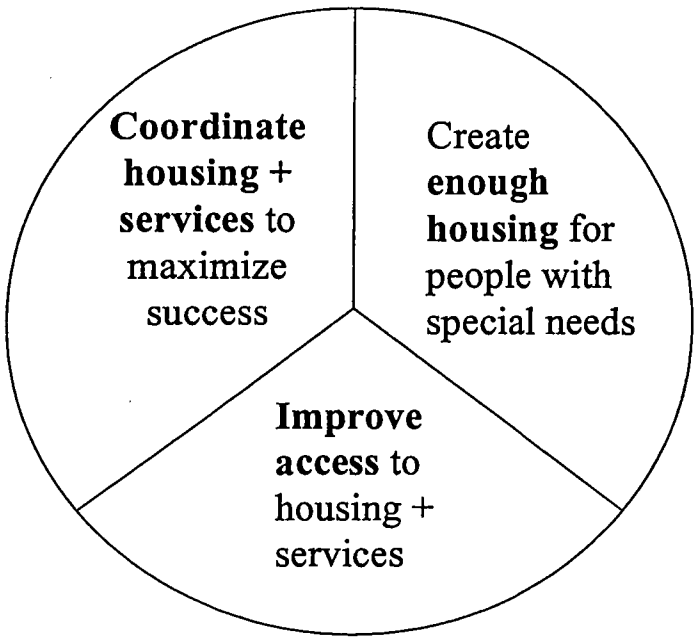
Throughout this report, we have used two important terms:

> **People with Special Needs**: are those with a severe and persistent mental illness, a substance abuse disability, a developmental disability, a serious physical disability, or a combination of these resulting in serious functional impairment. In this report, we focus on people who: meet these special needs criteria, are low income, do not have permanent housing, and will need some type of support to succeed in housing.
>
> **Housing + Services**: means the provision of permanent housing and support services in a linked or coordinated manner, although not necessarily by the same provider.

Over the past year there were almost 8,000 people with special needs in Multnomah County who needed – but did not have – permanent housing for all or part of the year. Of these, 3,500 were chronically homeless. People with special needs are more likely to have repeated episodes of homelessness and to remain homeless for longer periods.

Significant barriers stand in the way of developing and maintaining an adequate supply of special needs housing: lack of housing and service resources; lack of a shared understanding between housing experts and service experts; and lack of public awareness and support for vulnerable people and their housing needs.

The Special Needs Committee recommends an approach to reducing these barriers that requires improvements in three areas:



Public policy that supports **coordinating services with housing** will assist individuals with special needs to succeed in housing, and will encourage housing providers to make units available to people with special needs. Focusing mainstream services on the hardest-to-house can reduce homelessness. Cross training of housing managers and case managers strengthens both the service and housing systems.

We can **create enough housing for people with special needs** over time by increasing the proportion of housing resources – development funds and rent assistance – allocated to people with special needs. We can dedicate an "express lane" in the development pipeline for projects that package housing funds and service commitments. We can leverage more public and private resources.

We can **improve access to housing and services** by providing a comprehensive and culturally competent service plan to each individual, addressing housing, services, and food security needs. We can work with people with special needs who are currently hospitalized or incarcerated to make sure they have a service plan in place prior to discharge.

We believe that achieving success in all three areas will result in Multnomah County becoming a community where people with special needs live in decent, stable and affordable housing that is coupled with the support they need.

PROCESS

In late 2001, the Housing and Community Development Commission[1] (HCDC) assembled a Special Needs Committee (SNC) comprised of people knowledgeable about the current systems and with enough authority to direct and implement changes. The group included senior policy makers, funders, housing providers, service providers, and advocates. A list of members appears on the last page of this Report.

In spring of 2002, the Multnomah County Commission, the Portland City Council, and the Housing Authority of Portland Board of Directors charged the Housing and Community Development Commission's Special Needs Committee, through parallel resolutions (Appendix A), to:

- Assess the need for special needs housing Countywide, including the specific housing needs of individual special needs populations;
- Coordinate housing and service resources to stimulate development of special needs housing;
- Develop hard, realistic, and measurable targets for additional housing for persons with special needs;
- Leverage new resource streams for special needs housing development and operation; and
- Create models for special needs housing development and operation;
- Make policy recommendations to advance the development of special needs housing.

The Special Needs Committee met monthly from January 2002 through June 2003. The first meetings were devoted to an exchange of basic information about the affordable housing world and the discrete service systems for people with severe and persistent mental illness, physical disabilities, developmental disabilities, and/or substance abuse disabilities. The SNC also received information about the challenges faced by people with special needs in the corrections and community justice systems. The result of these discussions is a committee whose members now have a more holistic view of the challenges in special needs housing, and a common language for discussing them.

Tools developed to analyze the current situation include:

- Review of housing need and homelessness data for people with special needs and an inventory of special needs housing. (Appendix B summarized in Table 1, p. 16)

[1] HCDC is a fifteen-member volunteer citizen advisory Commission serving Multnomah County, the City of Portland and the City of Gresham. HCDC is designated as "the primary public forum in which policy development, resource coordination, and civic leadership are provided to address the County's affordable housing problems."

- Matrices of resources for: housing development, emergency housing, housing subsidies, and services.[2]
- An analysis of barriers to special needs housing. (Appendix C)

Based on this foundation, the committee developed:

- The Committee's vision, goals and long-term strategies for special needs housing. (Appendix D)
- Priorities for funding decisions about new housing projects, emphasizing housing for those with: the lowest income; the greatest risk of inappropriate institutionalization in shelters, hospitals, jails, or nursing facilities; and the greatest degree of disability. *See p. 24.*
- Criteria for allocation of project-based Section 8 resources, at the request of the Housing Authority of Portland, based upon SNC priorities but factoring in the risk of displacement. (Appendix E)
- Input on preserving facilities threatened with closure, including the Taft, Hoodview Residential Care Facility, and William-Elaine Residential Care Facility. (These projects also provided good "case studies" of special needs housing challenges, and catalyzed dialogue and increased understanding of the housing/social service relationship.)
- A Long-Range Goal Matrix, setting out the long-range goals and identifying strategies, and outcomes. (Appendix F)

Along with this Report, current initiatives of the SNC and its members include:

- Support of, and participation in, the application for the federal Interagency Council on Homelessness (ICH) grant, the "Collaborative Initiative to Help End Chronic Homelessness." If funded, mental health and addiction treatment, health care, and permanent housing with support services would be provided for 150 people.
- Participating with the Multnomah County Department of Community Justice in developing the "Social Security Income Continuum" project, along with representatives of other federal, state and county agencies. The SSI Continuum will connect disabled prison and jail inmates to entitlements before discharge, enabling them to receive benefits within 30-60 days after release. Access to SSI and Medicaid resources will enable special needs offenders to receive the housing and services they need to live stable, crime-free lives.

[2] The Committee intends to convert these matrixes to web-based resources that can be updated. Copies of the matrixes are available upon request.

- The City of Portland, Portland Development Commission, and the Housing Authority of Portland ("HAP") released a first-ever joint Solicitation of Interest for Special Needs and Affordable Housing Development, Columbia Villa Off-Site Replacement Housing, and a Project-Based Section 8 Pilot Project. This marks a concerted effort by the funders in our community to allocate a variety of scarce housing resources to special needs housing. These projects will inaugurate an "express lane" for special needs housing in the housing development pipeline for projects that package housing development dollars and service funding.
- HCDC has received a $5,000 grant from Eli Lilly and Company for a symposium to explore new ways to bridge housing and services resources to expand the supply of service enriched housing for people with special needs.
- Multnomah County Department of Human Services has agreed to work with affordable housing providers to help special need residents succeed and housing projects to remain stable. If a resident is experiencing a mental health crisis and is at risk of losing housing, the housing provider can use the Call Center to obtain emergency mental health services for the resident.

A major success for our community has resulted from the SNC committee's partnership with Multnomah County, the City of Portland, and other key stakeholders in a successful application to the Corporation for Supportive Housing (CSH) for a "Taking Health Care Home" grant funded by the Robert Wood Johnson Foundation.

This grant will fund systems change directed at ending chronic homelessness. The target population is people who have experienced long-term and episodic homelessness and have disabling health conditions, which is a significant cohort of the special needs population.

After this report has been accepted, the chartering jurisdictions will be asked to adopt a joint memorandum of understanding that will guide implementation of the recommendations in this report.

POPULATION

The Committee has focused on special needs populations who are the most *under-housed:* meaning those who do not have a place to live where they can remain indefinitely. The most under-housed special needs groups are extremely low-income[3] adults between the ages of 18 and 64, and unaccompanied minors. Their low incomes, service needs and problematic behaviors create challenges in obtaining and retaining housing. While most of the people in this group live in households of one, some live in families with minor children or with other household members. Because extremely low-income seniors 65+ are significantly under-served in mental health and addiction services, and have trouble accessing services if their disability is due to mental illness (other than dementia) or substance abuse, they are also included as a focus population.

DEFINITION:

A PERSON WITH SPECIAL NEEDS is an individual with a severe and persistent mental illness, substance abuse disability, developmental disability, serious physical disability, or multiple disabilities.

Focus Populations for the Special Needs Committee

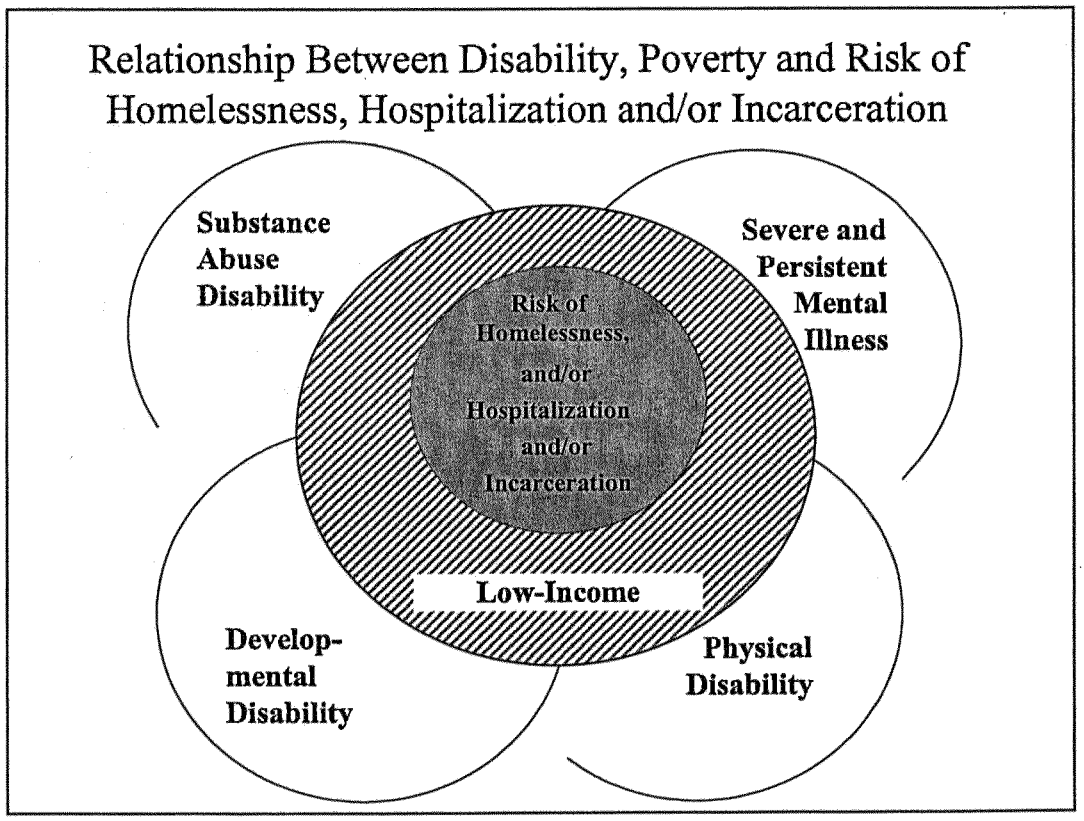
Focus Populations	Special Needs
Unaccompanied Minors	☑ Severe and Persistent Mental Illness ☑ Substance Abuse Disability ☑ Developmental Disability ☑ Serious Physical Disability ☑ Multiple Disabilities: two or more of the above
Extremely Low-Income Adults Age 18-64	☑ Severe and Persistent Mental Illness ☑ Substance Abuse Disability ☑ Developmental Disability ☑ Serious Physical Disability ☑ Multiple Disabilities: two or more of the above
Extremely Low-Income Seniors Age 65+	☑ Severe and Persistent Mental Illness ☑ Substance Abuse Disability ☐ Developmental Disability[4] ☐ Serious Physical Disability[4] ☑ Multiple Disabilities: two or more of the above

[3] HUD defines low-income as a household with income up to 50% of the Median Family Income (MFI). Extremely low-income households have incomes up to 30% MFI. MFI is set by HUD annually for the Portland Metropolitan Statistical Area. *See* Appendix H. For 2003, the MFI is $46,050 for a single person and $ 65,800 for a family of four. The 2003 federal poverty level for a household of one is $8,980 and a household of four is $18,400. This is equivalent to 20% MFI for a single person household and 28% MFI for a household of four. *See* discussion on "Effect of Poverty," p. 19.

[4] Services, often linked with housing, for these populations are funded by Medicaid community-based waivers, through County Developmental Disabilities and Aging & Disability Services.

These focus populations include individuals who often find themselves on the streets, or in the community justice system, homeless shelters, or hospitals. Lack of stable, affordable housing with adequate supports is a major contributor to homelessness and recidivism. An adequate supply of housing coordinated with services would reduce pressure on the jails, shelters, and hospitals of Multnomah County.

FIGURE 2



It is difficult enough to cope with a disability. This figure shows that, when disabilities overlap, or are combined with poverty, the risk of homelessness, hospitalization and/or incarceration increases sharply.

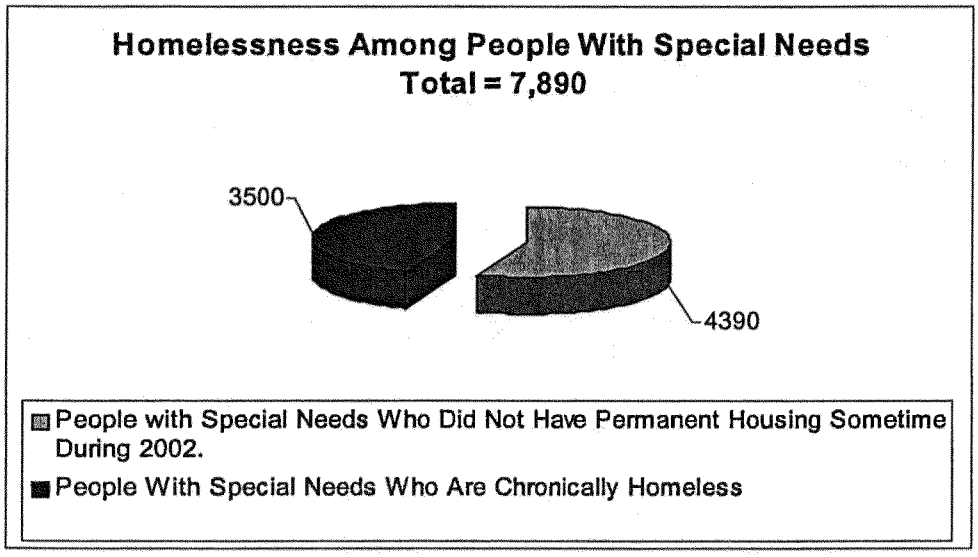
ESTIMATE OF NEED FOR HOUSING LINKED WITH SERVICES

Multnomah County is home to a large number of people with severe and persistent mental illness, physical disabilities, developmental disabilities, and/or substance abuse disabilities, many of whom have multiple disabilities.

The SNC has had difficulty collecting and analyzing data related to these populations. Each housing and service system uses different definitions and maintains different types of data. Additionally, clients often use multiple resources. Although the data below builds on reliable sources and attempts to unduplicate client counts, it lacks the certainty we would prefer. Nevertheless, our research clearly shows the lack of permanent housing and the extent of homelessness for those with special needs.

HOMELESSNESS AND SPECIAL NEEDS: During 2002, 7,890 County residents with special needs did not have permanent housing for part or all of the year, including about 3,500 persons experiencing chronic homelessness.[5] Chronic homelessness means a person has been homeless for more than a year or more than four times in a three-year period.[6]

FIGURE 3



Not only are a large number of people with special needs without stable housing, but people with disabilities are also greatly over-represented among the chronically homeless. They are more likely to have repeated episodes of homelessness and to remain homeless for longer periods.

A survey was taken of those seeking emergency shelter on March 27, 2002. Twenty-nine percent reported that they were eligible for services directed to the psychiatrically disabled, developmentally disabled, substance abusing and dual-diagnosed populations. Fifty-five percent of households of every size, and sixty percent of single adults, indicated a disability as the primary reason for their homelessness (e.g., substance abuse, mental illness, or a medical problem).[7]

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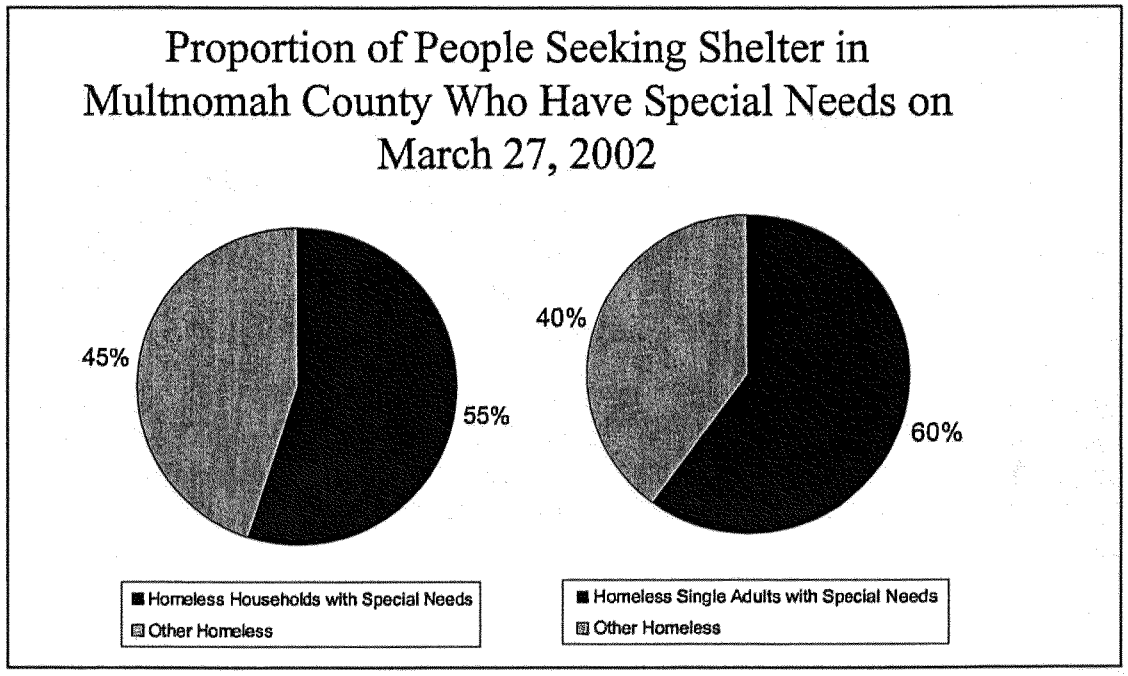
[5] This estimate is a blend of point-in-time and annualized data, as those who experience homelessness multiple times in a year are likely over-represented in point-in-time data.

[6] The federal definition of a Chronically Homeless Person is "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three years. To be considered chronically homeless, persons must have been sleeping in a place not meant for human habitation (*i.e.* streets) and/or in an emergency homeless shelter during that time."

[7] March 27, 2002 One Night Shelter Count, Multnomah County Office of School and Community Partnerships

FIGURE 4



A discouraging picture thus emerges of the shelter system as one of our main resources for housing low-income people with special needs.

LACK OF SHELTER: On any given night, our current homeless system is unable to serve approximately 17 percent of homeless people who seek assistance.[8] A street count found 1,672 unduplicated people sleeping outside on April 22, 2002.[9] One survey of Safe Haven in Portland showed the average length of time people with severe and persistent mental illness were homeless was 49 weeks, while the longest was 36 years.[10]

OFFENDERS WITH SPECIAL NEEDS: A study conducted on a small number of "the most frequently booked" in jails determined that about a fifth of these "frequent flyer" inmates were homeless and repeatedly cycled through jails, hospitals and shelters.[11] Other studies have confirmed that persons with disabilities are disproportionately represented in jails. Of the 1,010 offenders served by the Department of Community Justice Transitional Services Unit (TSU), 802 of them (79%) had at least one special need;[12] 80% of these had alcohol or drug abuse disorders as one of their diagnoses.

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[8] Based on turn-away rates from 1999-2002 One Night Shelter Counts.
[9] JOIN street count, April 22, 2002
[10] Housing and Community Development Commission Weeklong Needs and Gaps Survey, Feb. 25-March 3, 2002
[11] The Booking Frequency Pilot Project Report, Multnomah County's Sheriff's Office, January 2002
[12] Multnomah County Community Justice Department's Transitional Services Unit (TSU) enrollment records

A sub-population of people with severe and persistent mental illness is responsible for a disproportionate number of incarcerations. In 2000, for example, 3,800 individuals with identified mental health problems were booked into Multnomah County jails a total of 5,700 times. Nearly one-third were diagnosed with a serious mental disorder.[13]

HALF OF OREGON'S HOMELESS LIVE HERE: The statewide March 27, 2002 One Night Shelter Count shows that a disproportionate number of Oregon's homeless persons seek emergency services in Multnomah County. While 19% of the state's adult population reside in Multnomah County (666,350 of 3.4 million), 51% of Oregon's homeless single adults sought shelter in Multnomah County.

Of all the adults seeking shelter in Oregon who were homeless due to chemical dependency, mental illness, and/or medical problems, over half sought shelter in Multnomah County.[14] Of 3,813 homeless adults enrolled in state substance abuse treatment services during the 2001-02 fiscal year, Multnomah County served 2,143 (56%).[15]

HOMELESS FAMILIES

It is difficult to obtain comprehensive data on homeless families. Again, we know more about families that seek shelter through the homeless families system than about families that live doubled-up, or in cars, or camp in our local parks. According to the November 2002 One Night Shelter Count, 38.6% of the homeless family population that sought shelter statewide was in Multnomah County.

The homeless family system does not currently collect data on special needs. In one study sponsored by the Robert Wood Johnson Foundation, 41% of adults in homeless families self-declared that they were suffering from alcohol or drug dependencies or addictions, or had used hard drugs during the past year. In an annual progress report filed by one local homeless family agency, out of 144 families, 4 presented with mental illness, 3 self-reported for substance abuse, and 5 had a physical disability. However, these numbers may be misleading, since homeless families coming from substance abuse treatment are directed primarily to other agencies.

There is a clear need to develop better data on homeless families with special needs, to inform policy and program development.

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[13] From 1995 to 2001, the number of individuals with mental health problems in Multnomah County jails increased from 1,500 to 3,400, with a peak of 3,800 during 2000. Nearly one-third of the 3800 were diagnosed with a serious mental disorder. *See Mentally Ill Treatment*, by Bill Midkiff, Health Services Administrator, Multnomah County Health Department, Corrections Health Division, November 2002.

[14] March 27, 2002 One Night Shelter Count, Oregon Office of Housing and Community Services

[15] Oregon Department of Human Services, Office of Mental Health and Addictive Services

HOMELESS YOUTH

It is difficult to obtain a comprehensive data picture of homeless youth with special needs. Of the population of homeless youth, only a fraction apply for services and go through the initial screening process. This is what we know: In calendar year 2002, 465 youth presented for screening into the homeless youth continuum of services. At this time, youth reported information about their medications, on-going health problems, and desire for services. Twenty-five percent of them reported that they had an on-going health problem at the time of screening, and 30% requested services for health care. Only 5% requested drug and alcohol treatment.

Homeless program staff completed 299 actual assessments in 2002. At this time, the youth have an opportunity to give information about their mental health and substance abuse disability history. Nearly one-third reported that they had previously attempted suicide. More than half had received counseling in the past. Nineteen percent had received psychiatric counseling, and 16% had received residential treatment of some kind. Eight percent indicated that they would like to receive mental health services/counseling at the time of the assessment, and were referred.

We cannot ascertain at this time what percentage of homeless youth have either physical or developmental disabilities. This information is not specifically requested under current practice, although the caseworker could enter the data in the comments filed.

There is a clear need to develop better data on homeless youth with special needs, to inform policy and program development.

SUMMARY OF NEED – ADULTS 18 - 64

We have developed a summary of the need and unmet need for permanent housing for people with special needs, compiling data from many sources with the intent to be as comprehensive as possible, while avoiding duplication where feasible. This section attempts to quantify the number of permanent housing units required to meet the needs of people who:

- **have special needs**, defined as: a severe and persistent mental illness, a substance abuse disability, a developmental disability, a serious physical disability, or any combination of these conditions resulting in a serious functional impairment; and
- **are age 18-64**; and
- **are extremely low income**, defined as 0 to 20% of Median Family Income[16]; and
- **do not have permanent housing** (i.e. are homeless, sleeping on someone's couch or in their car, in jail, or in transitional housing with no place to go); and

[16] See footnote No. 3.

- **are likely to need some kind of supportive services** and/or enhanced housing management to succeed in community-based housing.

TABLE 1. SUMMARY OF NEED AND UNMET NEED FOR PERMANENT SUPPORTIVE HOUSING

Selected Special Need Populations Age 18-64	Estimate of Need For Special Needs Permanent Housing	Current Permanent Unlicensed Housing[17]	Unmet Need for Permanent Housing
Severe & Persistent Mental Illness	1,683	464	1,219[18]
Substance Abuse Disability	3,086	572	2,514[19]
Developmental Disability	520	20	500[20]
Serious Physical/ Functional Disability (includes AIDS/HIV)	2,540	209	2,331[21]
Multiple Disabilities[22]	1,375	49	1,326[23]
Totals	**9,204**	**1,314[24]**	**7,890**

In 2002, 9,204 people age 18 to 64, with extremely low-incomes and special needs, required a combination of permanent Housing + Services. Currently 1,314 units of such housing are available, leaving an unmet need for 7,890 additional units.

- **Annual:** Numbers are annual, e.g. 1,219 people with a severe and persistent mental illness did not have permanent housing for part or all of last year.

[17] Reflects current unlicensed housing only.
[18] Number derived from combination of OMHAS CMPS Report FY 01-02 identifying 1,019 MH clients who were homeless at time of service enrollment, plus March 2002 One Night Shelter Report identifying 200 with Mental Illness.
[19] Number derived from a combination of the OMHAS FY 01-02 Report identifying 2,143 clients who were homeless at time of service enrollment, plus 371 persons from the March 2002 One Night Shelter Report.
[20] Number derived from data from data from 3 Agencies: MCDDS, ARC of Multnomah County, and ILR.
[21] Number includes 682 persons from Portland EMA AIDS/HIV Housing Plan plus 1,649 persons from Multnomah County Housing Needs Report.
[22] The category, Multiple Disabilities, are people who were reported in this category as having includes a combination of conditions resulting in a functional impairment, including: developmental, mental, physical, chemical, and cognitive.
[23] Number derived from Multnomah County 2001 Housing Needs Report and includes any combination of conditions including physical, developmental, mental, cognitive, and chemical
[24] Of these, 946 units support people with special needs who have been homeless or are at-risk of homelessness

- **Unlicensed:** The inventory of housing in this table is all unlicensed housing for specific populations, with varying degrees of linkage to services. While some people without permanent housing may qualify for licensed housing (e.g. foster homes, group homes, or residential care facilities, which serve people requiring a greater intensity of services), we believe most do not.

- **Current Permanent Housing:** This is the current inventory of permanent housing which is affordable to those with extremely low incomes, identifiable for a specific disability group, and linked to services.

- **Housing + Services:** Most people reflected in this table will need housing linked with some kind of enhanced property management or supportive services to succeed in maintaining permanent housing.

- **System Contact:** The table represents those who had contact with the system in some way – who sought services or shelter, and/or who were found during the one-night shelter/street counts that attempted to locate all homeless people.

- **Homelessness:** The focus is on people with special needs who need but do not have permanent housing, which is not the same as being homeless: some are only at risk of being homeless. Only homeless people who also have special needs are included.

- **Families:** No firm data is available on how many single adults, couples, or families are included; indicators support estimating about 10% of those in each category represent people living in families, and 90% singles or couples.

- **Gap:** The current unmet need is for 7,890 units of special needs housing. This gap results in a large population that is constantly homeless (such as the 3,500 people with special needs who experienced chronic homelessness last year), or who are at risk of homelessness (such as the 4,390 people with special needs who cycled into homeless at some time last year). The gap in housing may be met by licensed or unlicensed units.

- **Multiple Disabilities:** The numbers probably under-represent the number of people with multiple diagnoses, due to different methods of collecting data, different definitions of disabilities, limitations of self-reporting, and masking by more overt symptoms. However, an increase in multiple disabilities would likely result in a decrease in single diagnosis categories.

- **Duplication:** There may be some duplication in the table, as it is not currently possible to sort by client name or identifier among the various service systems' databases. We do not believe the duplication is large.

- **Undercount:** We believe, however, that this data significantly undercounts the need for permanent housing for people with special

needs, because many have not made contact with any system for shelter or services.

Unaccompanied Minors with Special Needs

We found no reliable data on the number of unaccompanied minors with special needs. There is a clear need to develop data on unaccompanied minors with special needs, to inform policy and program development.

Seniors over age 65 with Mental Illness or Substance Abuse Disorder

Older adults age 65+ with a primary diagnosis of mental illness, or with a combination of mental illness and other conditions resulting in a functional impairment, have similar needs for housing coordinated with services as the 18-64 population. The most critical need is for low-income seniors who have both a physical disability and mental illness.[25] According to Multnomah County Aging and Disability Service's Housing Placement Specialist, the most frequent reason case managers sought assistance for locating an Adult Foster Home or Residential Care Home was to serve these seniors, whose medical needs and/or mental illness had exhausted family and mainstream housing providers. During the three-year period from 1996-1999, ADS worked with 633 clients who fit this profile.

The second most critical need is for low-income seniors with only a primary mental health diagnosis. They are under-served by the mental health system and, if they do not have a physical impairment, they are not eligible for Medicaid-funded services.

Increasing Need: Budget cuts this fiscal year and anticipated in the next biennium will likely increase the numbers of individuals and families who will lose stable housing due to cuts in their services and/or income supports. This will increase the number of people experiencing homelessness. For example:

- 1,090 adults with disabilities who had not yet qualified for federal Social Security Income (SSI) or Social Security Disability (SSD) benefits lost their income, due to the elimination of the state-funded General Assistance (GA) program on January 31, 2003. Of these, 125 recipients were already homeless.
- 1,100 ADS long-term care clients, who primarily live at home, lost care services provided under a Medicaid waiver.

In Multnomah County, voters do not want services cut. Some of the support for Measure 26-48, the temporary local income tax passed in May 2003, was from voters who wanted to restore a portion of the safety net for low-income people. Likewise, legislators are considering changes to the State budget to partially

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[25] There is consensus among the ADS Public Guardian Office, the ADS Adult Protective Service Office, social workers and the senior community service network that seniors with very low incomes, mental illness and medical needs are most in need of Housing + Services. There are few housing/service options that can handle both.

restore some previous service cuts. The following cuts may be partially or temporarily reversed:

- Eligibility for the Oregon Health Plan has been reduced to mandatory groups. Low-income people who could previously qualify for a range of medical, mental health, and addiction treatment services under OHP may now only qualify for prescription medications, subject to co-pays and premiums.[26]
- Oregon has eliminated the Medically Needy program, resulting in loss of mental health treatment, medical transportation, alcohol and drug treatment, and prescriptions for 1,955 ADS clients.
- 4,000 previously eligible Multnomah County mental health consumers became ineligible for mental health services after State mental health program reductions and OHP cuts.
- Between 460-750 Multnomah County residents lost coverage to pay for methadone due to OHP cuts.

Effect of Poverty

Many of the housing challenges faced by people with special needs are directly related to income. Although some people with special needs earn a sufficient wage to purchase housing and health care, those with severe disabilities are often unable to earn enough to provide for their basic needs. Lack of ability to earn a good income, and thus reliance on low wages or public benefit levels, severely limits or eliminates housing choice.

The U.S. Department of Housing and Urban Development (HUD) issues the Area Median Income for Multnomah County on an annual basis. *See* Appendix .No more than 30% of income should be spent on rent. Recipients of SSI have income supplemented up to $552/month, or 14% of the Area Median Income for a single person household, and should spend no more than $165 on rent and utilities. The average recipient of SSD has an income of $800/month, or 19% of Area Median Income, and should spend no more than $240 on rent and utilities. However, fair market rent in Multnomah County in 2003 for a studio apartment is $508 per month; a one-bedroom apartment is $625; and a two-bedroom is $771.

In Multnomah County's housing market, low income has extremely harsh consequences. The Consolidated Plan for Multnomah County, prepared by HCDC to meet HUD requirements, has documented a significant loss of housing affordable to low-income people within the County over the past 12 years. Increasing market rents and loss of restricted-rent housing projects have similarly resulted in greater levels of homelessness for people with special needs locally and throughout the nation.

[26] 2,100 ADS clients had OHP services significantly reduced or eliminated.

In the late 1990s, the City of Portland created the Housing Investment Fund to develop subsidized units, producing a record 4,000 units over 5 years. However, no concerted effort was made to link persons with special needs to these units. Looking at this situation, the City Club of Portland has recently recommended priority funding for housing for people with special needs, and a massive program of rent assistance so that people with special needs can rent on the open market.[27]

THE HARDEST-TO-HOUSE

Another set of challenges relates to people whose level of disability or combination of disabilities puts them into the "hardest to house" category. The hardest-to-house tend to exhibit problematic behaviors, have poor rental histories marked by multiple evictions, and often have criminal records. People with psychiatric disabilities, especially those with a co-occurring addiction disorder or another additional disability, are often in this group of hard-to-house people.[28]

Even when rental subsidies are available, people who are hard-to-house will find it difficult to secure housing.

The Challenge of Housing the Hardest to House

The "hard to house" population becomes the "chronically homeless," living on the streets, in shelters or transitional housing, cycling through jails, hospitals, and nursing homes, and using resources disproportionate to their numbers. Some of the recommendations in this report target this population specifically, with the belief that better serving this group will increase the cost-effectiveness of our human service, housing and corrections systems.

The Housing Authority of Portland reports that its Section 8 voucher program has a 17% turn-back rate. This means that 17% of people with a voucher guaranteeing that the federal government will pay the difference between 30% of their income and a reasonable rent cannot find a landlord willing to rent to them. HAP's analysis shows that many of those who turn back their vouchers fall in this hard-to-house category.

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[27] *See* the City Club of Portland Report: *Affordable Housing in Portland*, February 2002. See the report at http://www.pdxcityclub.org/afhous.pdf

[28] Research done by the Multnomah County Mental Health Design Team, created in 2000, supports this. They noted the difficulties of housing and serving persons with a psychiatric disability who also have an additional issue, such as: being under 25; having substance abuse issues; having a developmental disability; having involvement in the criminal justice system; or being physically compromised.

SUPPORTIVE SERVICE NEEDS

The most vulnerable people with special needs often require supportive services to succeed in housing. The variety of needed services - from medication management to housekeeping assistance to food security to money management – calls for a variety of housing and service models.[29]

DEFINITION: SUPPORTIVE SERVICES – the range of supports needed for people to be successful in housing.

The SNC has developed the term **HOUSING + SERVICES** to mean the combination of housing and the appropriate level of services to meet the individual's needs.[30] When a family member has a disability, services may extend to the needs of other family members, including arranging for childcare, and providing transportation to school and medical appointments for the children in the household.

DEFINITION: HOUSING + SERVICES – Permanent housing that incorporates supportive services into housing operations, and/or coordinates with outside service providers for supportive services to meet the resident's needs.

The continuum of Housing + Services types ranges from a licensed care facility with 24-hour care provided on-site, to a standard affordable apartment with client-initiated services provided off-site. There are currently a variety of options available, albeit in limited quantities. Future work should include evaluation of these models for suitability, cost-effectiveness, and adaptability to changing funding levels.

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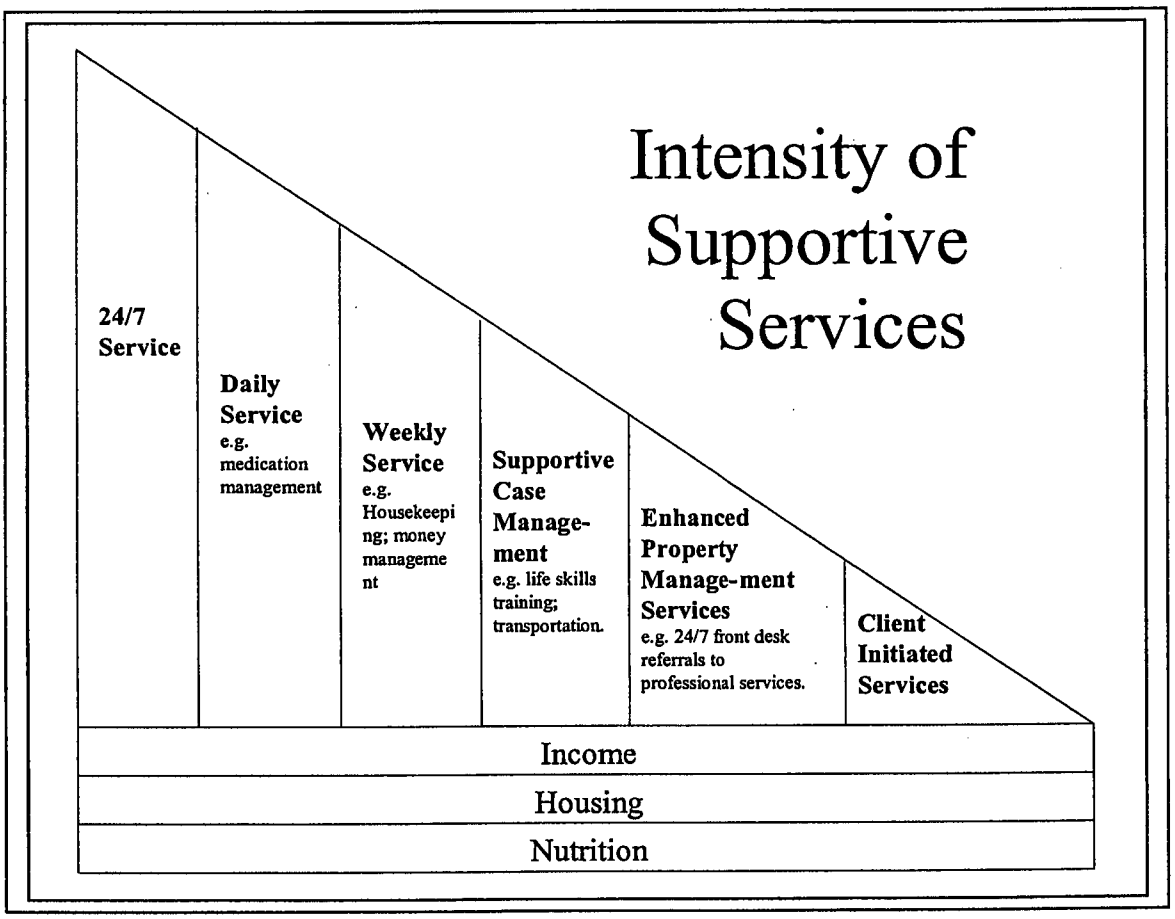
[29] Professional medical and dental treatment is an important issue that falls beyond the scope of the Special Needs Committee and this Report.

[30] We use Housing + Services instead of the more commonly used "supportive housing," because we found that "supportive housing" has some very specific definitions in certain contexts, resulting in confusion.

The table below describes the spectrum of intensity of supportive services. Many of these services could be provided on-site or off-site. The housing provider could provide them, or other providers could coordinate their services with the housing. Generally, more intense services are more expensive. However, even the most intense services are less expensive than homelessness, incarceration, or hospitalization.

FIGURE 5



New and innovative Housing + Service models may be needed to match service capacity to housing, especially given Oregon's current cutbacks in service delivery.

VISION & GOALS

VISION FOR THE FUTURE

Although significant barriers stand in the way, we believe that it is possible to develop and maintain an adequate supply of special needs housing and coordinated services.

> **VISION FOR THE FUTURE:**
>
> In Multnomah County, people with special needs have decent stable affordable housing for themselves and their families, along with the support and services they need for a good quality of life.

REORIENTING TOWARDS HOUSING + SERVICES

Experience shows that housing coordinated with services is a critical element to the success of people with special needs. Recent research shows that homeless people with disabilities who moved to permanent supportive housing experienced marked reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated. [31]

In Multnomah County, we can significantly reduce homelessness and inappropriate institutionalization of low-income people with special needs if we **reorient** our social service and housing systems to do three things[32]:

1. Coordinate housing + services to maximize success of people with special needs in permanent housing.
2. Create enough housing for people with special needs, including housing linked to services and housing for the hard-to-house.
3. Improve access to housing + services, including outreach to the hard-to-house.

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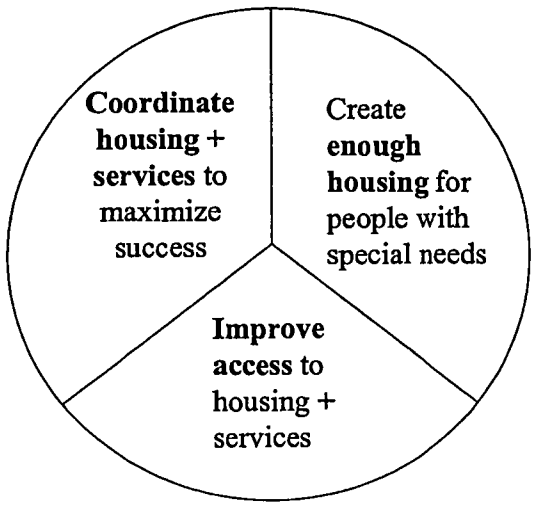
[31] Research by Corporation for Supportive Housing, in January 2003 issue of their publication, *Opening Doors*. In 2001, the University of Pennsylvania's Center for Mental Health Policy and Services Research compared 4,500 homeless people with severe mental illness who moved into supportive housing, with a control group who were not offered permanent housing. They found that those who moved into supportive housing experienced marked reductions in shelter use, hospitalizations , and time incarcerated. Prior to living in permanent supportive housing, the people in the study used an average of $40,449 per person per year in such services; after supportive housing, there was an average reduction in service use of $16,282.

[32] These recommendations are consistent with those made by the Multnomah County Mental Health Design Team and the Multnomah County Health Department, Corrections Health Division Administrator.

These three necessary actions have become our primary goals, and are used to organize our recommended strategies, tasks and outcomes.

FIGURE 6



Adequate funding is obviously an issue for both housing and services. But we also believe that when the systems are reoriented towards these goals, resources will be used more effectively, outcomes in housing stability will be improved, and the strain on shelters, jails, and hospitals, will be reduced.

GOALS

1. <u>Coordinate housing + services</u> to maximize success of people with special needs in permanent housing.

Service systems are generally based on a person-centered model: the client is either eligible or not eligible for services at different times; services may be reduced or eliminated based on federal, state, or local budget levels; or the client could experience a crisis that may or may not be referred to or responded to by service systems. Cutbacks or reconfigurations of the service systems can destabilize clients.

The affordable housing system, on the other hand, is asset based. The housing project itself must be managed to remain healthy – *i.e.* residents must be safe, staff must feel safe, rent must be collected to ensure financial solvency, and the physical premises must be maintained. Clients who experience "unmanaged" crises often create stress for staff and other residents, and are often unable to make rent payments. Eviction is frequently the result.

Large cutbacks or reconfigurations in social services systems can destabilize entire housing projects by significantly altering or eliminating subsidies and services that have allowed tenants with special needs to succeed in housing. The effects of large-scale reconfigurations may be felt for years. Housing

providers, after experiencing unreliability in social services, can become unwilling to continue to make units available to people with special needs.

Social services from each system (mental health, substance abuse, developmental disabilities, corrections, and aging and disability services) need to be reliable and coordinated with housing availability if we are to be successful in providing more special needs housing opportunities. This is a policy issue that should be discussed and resolved at the highest levels.

2. Create enough housing for people with special needs, including housing linked to services and housing for the hard-to-house.

Housing Supply

The Consolidated Plan for Multnomah County, prepared by HCDC to meet HUD requirements, documents that there is an inadequate supply of housing affordable to people earning less than 30% of the area median income.[33] This market fact has created a bottleneck, preventing people from moving out of shelters and transitional housing into permanent housing.

Limited public funding has been the main engine of special needs housing development. Legislative efforts to create a sustainable funding source, such as a real estate transfer tax, should be supported vigorously, but may not succeed. Accordingly, the proportion of public funds allocated to special needs housing must be increased.

Rent subsidy programs, coordinated with appropriate services, can help match some special needs households with the private housing market. Short-term, as well as long-term, rent subsidy programs should be expanded.

We must also increase the number of willing housing providers. One tool is the Fresh Start program.[34] Fresh Start helps overcome barriers to housing by creating a partnership between case managers, landlords/property managers and tenants. Landlords/property managers agree to rent to people who would not qualify under standard screening criteria, in return for commitment by the tenant's case manager to provide ongoing support to the tenant. By bringing the

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[33] HUD regulations state that housing is "affordable" if rent plus utilities do not exceed 30% of the household's gross income. An individual receiving SSI of $552 per month can afford a rent of $166. Fair market rent for a studio apartment in the Portland metropolitan service area is $508 per month. Thus, a renter with SSI income, who is unable to secure a Section 8 certificate or other subsidized housing, can expect to pay over 90% of his or her income on housing.

[34] Fresh Start was developed in 1998 by a coalition of property management, legal and social service providers to meet the needs of the downtown singles population. Between March 1998 and August 2000, 210 units were rented to people using Fresh Start referrals. 77% of these tenants (167) went on to become successful renters. The one social service agency that made 70 percent of the referrals had a 79 percent success rate. Recently, the Bureau of Housing and Community Development (BHCD) has decided to bring the Fresh Start program in-house to ensure quality control and monitoring.

landlord/property manager, case manager and tenant together to resolve rental problems as they arise, Fresh Start helps prevent evictions and has had success in breaking the cycle of homelessness for 77% of participants.

We must also develop a public consensus that results in neighborhoods that are welcoming to housing for people with special needs. This may require assurance to neighbors that adequate, long-term services will be provided to support the new residents' special needs.

Housing Funding Priorities

The committee developed criteria to be used in evaluating and prioritizing projects to assist special needs populations.

Projects that meet all three criteria and show linkage with services should receive the highest priority.

CRITERIA FOR FUNDING
SPECIAL NEEDS HOUSING PROPOSALS

1. Serves people with incomes at or below 30% of area median income, with an emphasis on those with incomes below 20% AMI.
2. Serves those at risk of becoming homeless or otherwise institutionalized inappropriately.
3. Serves those with the greatest degree of disability.

Private Sector Investment

There is a lack of private sector understanding of the funding programs for special needs housing, especially with the multiple sources and delivery points, and inconsistent program requirements. The unpredictable stream of funding for these programs, and the lack of a seamless delivery mechanism, adds to confusion. The current budget situation amplifies risks for private lenders on such projects, and jeopardizes future investment. Some degree of certainty is critical to attract private sector resources to produce much needed housing for people with special needs.

Housing + Service Funding Opportunities

Services that allow a person with special needs to be successful in housing typically cannot be funded by affordable housing development funds[35].

[35] There is a statutory prohibition against using tax increment funds for services. Community Development Block Grant funds may be used for services, but are subject to a "public services" cap of 15%.

Therefore funding that can be used for services must be aggressively sought. For example, some believe that federal Medicaid matching funds could be increased, to provide services coordinated with housing.

A barrier to this goal is that each service system offers a different menu of services to its eligible individuals. This is especially problematic when individuals have multiple disabilities or service needs not readily served by the menu offered.

There are also large gaps in service availability, excluding many people who need assistance. Others receive some but not all of the help needed. Federal Medicaid regulations for each program, and corresponding Oregon Medicaid Waivers (the plans approved by federal officials that govern how Medicaid programs are provided), are focused on each population separately, also contributing to gaps in coverage. Although Oregon has some of the most significant waivers in the nation, there are limited State resources for "match," forcing difficult decisions about whom to serve and what services to provide.

Frequently, there are barriers to using funds in ways that would maximize our ability to provide and support housing. The SNC believes there is opportunity to better leverage our limited state and local financial resources, and believes we should actively work with the state to seek better coordination of state policy, and improved Medicaid Waivers. We also believe there is the ability, even under existing regulations, to do more to support people in housing.

3. <u>Improve access</u> to housing + services, including outreach to the hard-to-house.

While access would naturally improve for many people if increased amounts of housing and services are available, other major barriers to access would remain.

Providers of both supportive services and housing frequently fail to refer to each other. Social service providers may not understand housing alternatives or actively link their clients to needed housing. Landlords and property managers generally do not see their role as linking tenants to needed services, and both public and private housing providers need education about available services. Policy and funding priorities should encourage housing and service providers to work together to ensure that individuals with special needs are offered both housing and services, as needed.

However, some people with special needs do not seek permanent housing, fail to access or are rejected from social services, or are otherwise hard-to-house. Persistent outreach is needed to maintain contact with hard-to-house people, and individualized plans should assist them to accept and succeed in permanent housing. While the intensive level of supportive services needed for this population is expensive, we believe the investment will be more than recovered with savings from police, corrections, shelter, and hospitalizations.

RECOMMENDED ACTION STEPS FOR 2003-2005

After developing our vision and long-term goals, the Committee created long-term strategies, which would move us toward these goals. See Appendix G. We then assessed these strategies in light of current circumstances, including budget cut backs. We recommend the following action steps for the 2003-05 period.

1. **Increase financial resources for social services related to housing.** Find new ways to leverage County and other financial resources to expand services associated with supportive housing, and implement additional ways to coordinate housing and service funding streams. *(Relates to Goal 1. Coordinate Housing + Services)*
    a) Find new ways to match housing operations resources with Medicaid.
    b) Explore creating a County General Assistance program using funds currently used for rent assistance, housing subsidies, etc. Seek reimbursement from the Social Security Administration when the client is deemed eligible for SSI or SSDI.
    c) Maximize use of Federally Qualified Health Center status to provide psychiatric services, case management, etc., to support housing stability, thus obtaining more federal matching funds.
    d) Maximize other federal resources such as USDA food programs, social service and criminal justice block grants, McKinney, Community Development Block Grant (CDBG), and workforce support programs.
2. **Increase the proportion of housing funds allocated to housing for people with special needs.** *(Relates to Goal 2. Enough Housing)*
    a) All involved jurisdictions (City of Portland, Portland Development Commission, City of Gresham, State of Oregon, HUD, the Housing Authority of Portland and Multnomah County) should make development and preservation of supportive housing a high priority for use of publicly-funded housing development resources.
    b) A significant portion of Urban Renewal District revenues should be dedicated to housing for people with special needs.
3. **Strengthen the partnership between the human service system and the social housing system.** Strengthen both systems through shared priorities and increased cooperation. *(Relates to Goal 1. Coordinate Housing + Services)*
    a) Expand and develop the ongoing group composed of human services management personnel and social housing leadership; focus on maximizing the success of people with special needs

within housing environments, e.g. provide updates, cross-educate, plan new service and housing opportunities, and coordinate responses to new issues.

b) Service systems and housing providers should work together to protect housing assets that serve special needs populations from destabilization resulting from cutbacks and reconfigurations in social service systems.

c) Expand programs that provide incentives for non-profit and for-profit landlords to house people with special needs. Fully implement the Fresh Start program.

d) Use capital and rent subsidies to buy down rents of units currently affordable to households at or above 50% MFI, reprogramming admission criteria to target the "hardest-to-house."

e) Create a cross-training program for housing management personnel who deal with special needs residents, and for case managers to learn about housing opportunities and challenges.

4. **Continue the City/County/HAP partnership** that has created new understandings, policy directions and systems changes in the direction of maintaining and creating new special needs housing. Include the City of Gresham. *(Relates to Goal 2. Enough Housing)*

   a) Provide for HCDC oversight of implementation of these recommendations. Adopt outcome indicators and measure progress towards our **Housing + Services** goals.

   b) Create an "express lane" in the development pipeline for special needs housing projects (especially those targeted to homeless) by coordinating resources into joint RFPs, and packaging development dollars and service commitments.

   c) Create and staff a high level interagency body of funders with authority to integrate funding streams and create and maintain the "express lane" for special needs housing projects.

   d) Continue the City-County Pilot Special Needs Housing Set Aside for at least another three years while the "express lane" in the pipeline is developed.

   e) Underwrite new housing projects (or re-underwrite old ones) that serve special needs tenants to provide for Enhanced Property Management, which provides extra support ON SITE at housing projects serving people with special needs. This model has been developed successfully in Seattle, WA.

5. **Develop services and housing targeted to the "hardest-to-house."** *(Relates to Goal 1. Coordinate Housing + Services, Goal 2. Enough Housing, and Goal 3. Improve Access)*

a) Develop specialized activities targeted specifically to chronically homeless people with disabilities. Expand the Assertive Community Treatment (ACT) team model. The ACT team model engages chronically homeless individuals, houses them, and arranges for mainstream health, mental health, addictions, employment and other services after a person is initially housed. ACT teams effect a resolution of the problems that cause homelessness.

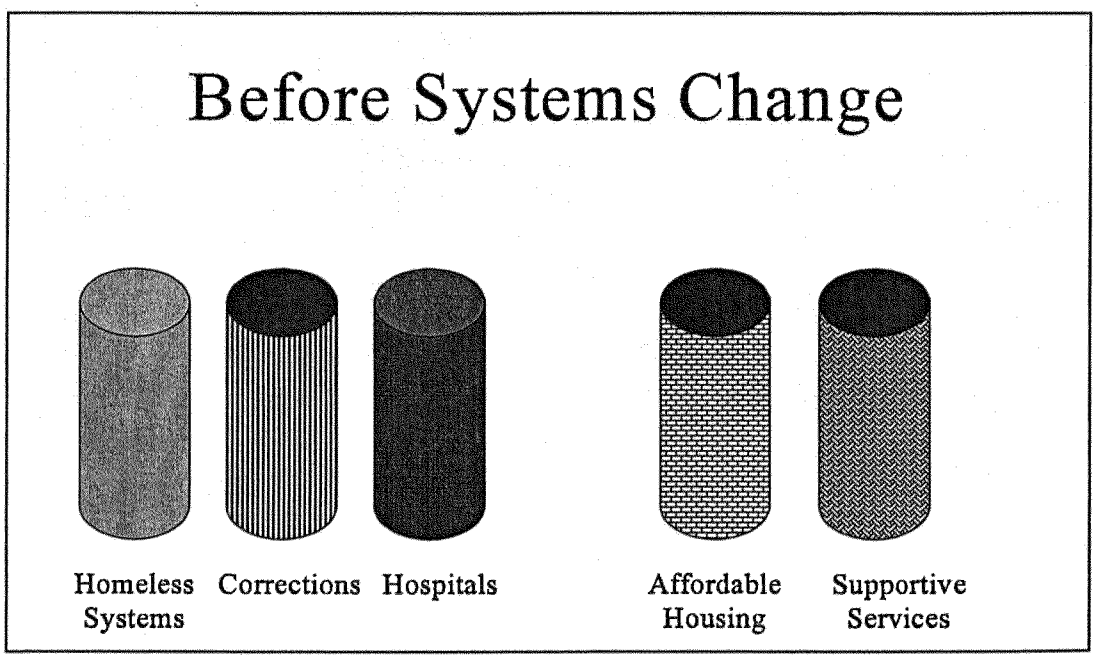
b) Review the myriad of rent assistance programs operated by the City of Portland, Multnomah County, HAP and others, and create a system that is streamlined, efficient and accessible to homeless and special needs populations.

6. **Create new resources dedicated to special needs housing.** *(Relates to Goal 2. Enough Housing)*
   a) Support the creation of a Real Estate Transfer Tax for affordable housing; a local bond issue for affordable housing development; and establishment of a National Housing Trust Fund.
   b) Establish goals within any new housing funds to be spent for people with special needs;
   c) Increase the proportion of housing funds, from all public and private sources, used for housing for people with special needs.
   d) Short and long-term rent subsidy programs should be expanded.
   e) Develop strategies to attract private lending capital.

RESULTS

We believe that, if we implement the Action Steps above in the next two years, and embrace the long-term strategies in Appendix D, we will be creating the conditions for permanent system change. We will know if we have succeeded, because both our housing and service systems will be different. The systems will be more integrated, and some funding will shift to support a Housing + Services strategy. As a result, fewer people with special needs will cycle through shelters, jails, hospitals and the street, and people with special needs will no longer be over-represented in the homeless system. Figures 7 and 8 illustrate the "before" and "after" of system change.

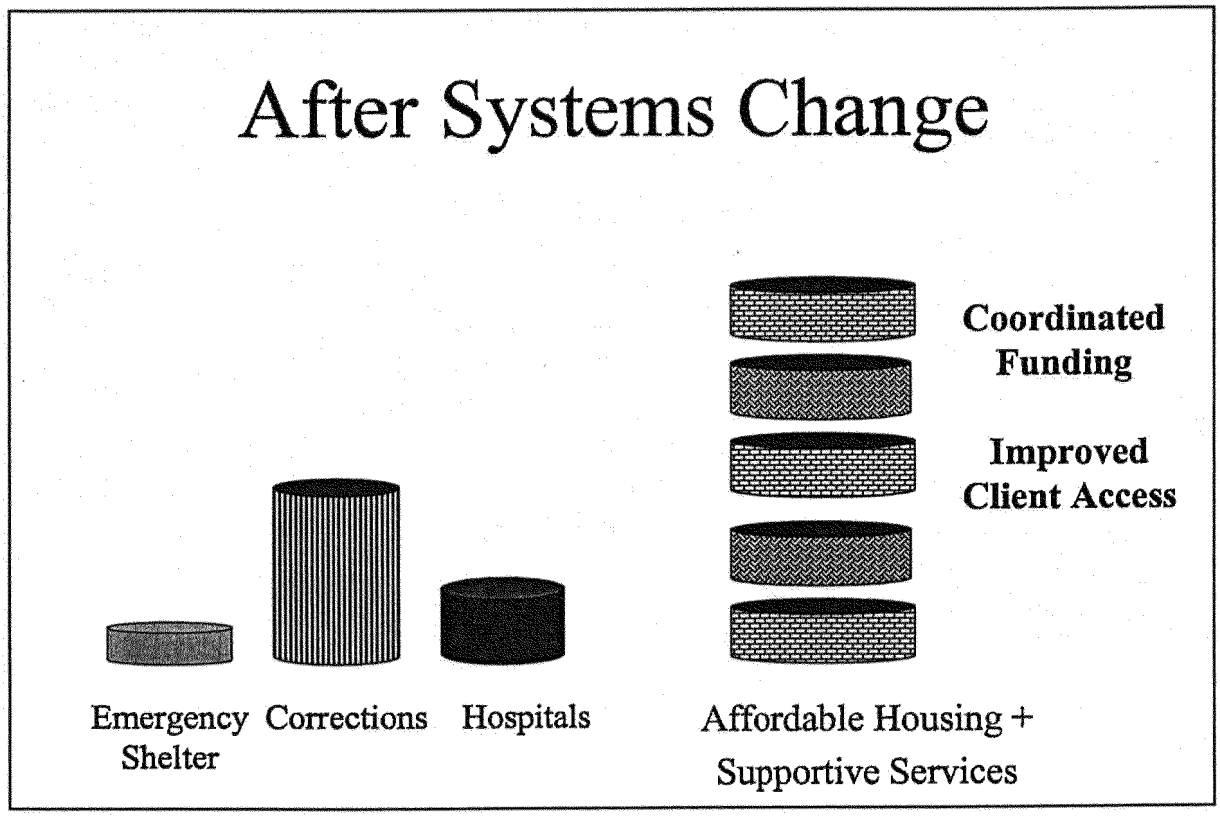
FIGURE 7



Currently, the homeless, corrections, hospital, affordable housing, and supportive service systems are structured in cylinders of separated services. Within each of these silos may be multiple separate agencies or funding streams, each with its own rules and eligibility criteria. Staff in all these cylinders know that there are too many people with special needs cycling through the homeless system, jails, and hospitals, and that the affordable housing and supportive service systems have not responded adequately, but the separate systems have not effected the necessary change to prevent this.

In the system we envision, people with special needs will not be over-represented in our homeless, hospital or corrections systems.

FIGURE 8



The homeless system will be smaller, and will be limited to emergency shelter. Hospital beds will be used for medical and mental health crises only. The affordable housing and supportive service systems will be coordinated at the personal level, the residential project level, the funding level, and the systems level resulting in improved client access, staff cross-training, a larger volume of special needs housing development, and increased housing retention rates. More people with special needs will be successfully housed, and thus have the opportunity to enjoy a good quality of life.

RESPECTFULLY SUBMITTED ON JULY 2, 2003.

THE HOUSING AND COMMUNITY DEVELOPMENT COMMISSION

Bill Van Vliet, Co-Chair
Catherine Such, Co-Chair

Janet Byrd
Paul Dagle
Linda Kaeser
Diane Meisenhelter[37]
Roger Meyer
Kevin Montgomery-Smith
Louis A. Ornelas
Roserria Roberts
Terri Silvis
Joe Wykowski

HCDC Staff
Beth Kaye

County Staff
Linda Grimes
Gail Wilson

BHCD Staff
Molly Rogers
Ruth Benson

THE SPECIAL NEEDS COMMITTEE[36]

Linda Kaeser, Chair

John Ball
Neal Beroz
Mary Carroll
Rosanne Costanzo
Serena Cruz
Peter Davidson, MD
Tracy Davies
Susan Dietsche
Betty Dominguez
Joyce Dougherty
Rachael Duke
Jamaal Folsom
Leslie Ford
Joanne Fuller
Bernie Giusto
Leah Halstead
Richard Harris
Jim Hlava
Carol Islam
Liv Jenssen
Christine Kirk
Anthony Lincoln
Heather Lyons
Seth Lyon
Diane Luther
Martha McLennan
Roger Meyer
Andy Miller
Susan Montgomery
Tim Moore
Terri Naito
Rachel Post
Paul Parker
Tonya Parker
Virginia Seitz
Vicki Skryha
Andy Smith
Cathy Spofford
Kim Tierney
Andreé Tremoulét
H.C. Tupper
Bill Van Vliet
Steve Weiss
Sherry Willmschen
Keren Brown Wilson
Nancy Wilton
Jim Wrigley

[36] Over the course of the year, participation by some of the committee's most thoughtful and experienced members was lost due to budget cuts, restructurings, and reassignments. The report benefited greatly from their contributions: Jim McConnell, Jacob Mestman, Howard Klink, May Simeone, Dan Noelle, Bethany Wertz, and Peter Wilcox. The committee also benefited from the perspective of Jim Winkler, who resigned when his term on HCDC elapsed.
[37] Ms. Meisenhelter's term on HCDC expired June 30, 2003.

APPENDICES

BEFORE THE BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

RESOLUTION NO. 02-070

Adopting Policy Direction to Charge the Housing and Community Development Commission Special Needs Housing Committee

The Multnomah County Board of Commissioners Finds:

a) Multnomah County, by Ordinance 719, and the City of Portland, and the City of Gresham have each designated the Housing and Community Development Commission to serve as the primary public forum for policy development, resource coordination, and civic leadership to address the County's affordable housing problems;

b) The Portland Development Commission plays an important role in financing and developing housing for persons with special needs;

c) The Housing Authority of Portland plays a critical role in providing housing for persons with special needs through its public housing and Section 8 programs;

d) The mission of HCDC is to increase the effectiveness of the housing delivery system by providing coordination among diverse public agencies which implement housing programs and by serving as a centralized liaison between those agencies and the governing bodies of the jurisdictions on issues regarding housing policies, goals, programs, and related allocation of public funds;

e) The jurisdictions named in paragraph 1 above provided in the Consolidated Plan 2000-2005 that their first priority was to provide affordable rental housing to, among others, low- income persons with special needs;

f) The Consolidated Plan 2000-2005 Needs Assessment and further studies undertaken by the jurisdictions document that there is a shortage of affordable housing with links to needed services for persons with special needs;

g) There are numerous barriers to the development of additional affordable housing with links to services for people with special needs, including financial, regulatory, and historical barriers;

h) Some persons with special needs who have affordable housing face barriers to success at maintaining in the housing;

i) For lack of suitable housing and services, people with special needs become inpatients at hospitals, are incarcerated, or occupy shelter space;

j) An adequate supply of special needs housing would ease the pressure on the mental health system, the corrections system, and the homeless system while focusing our resources in a more compassionate and economically efficient way;

The Multnomah County Board of Commissioners Resolves:

1. The Housing and Community Development Commission, by and through its Special Needs Committee, shall undertake to do the following:

   - assess the need for special needs housing County wide, including the specific housing needs of individual special needs populations;
   - make policy recommendations to advance the development of special needs housing and to improve the success of housing outcomes for persons with special needs;
   - coordinate local, regional, state, and federal housing and service resources to stimulate the development of special needs housing;
   - develop hard, realistic, and measurable targets for additional housing for persons with special needs;
   - leverage new resource streams for special needs housing development and operation;
   - create models for special needs housing development and operation; and
   - evaluate success of special needs housing development and operation; and
   - periodically assess the need for additional committee work, with the first assessment not later than June 2003

2. The Multnomah County Board of Commissioners will, with the advice of the Housing and Community Development Commission, annually review the progress that has been made toward the goal of providing each person with special needs with affordable housing linked to appropriate services.

3. That all Departments are directed to provide information requested by HCDC concerning resources, policies, and practices affecting the development and operation of special needs housing.

ADOPTED this 16th day of May 2002.

BOARD OF COUNTY COMMISSIONERS FOR MULTNOMAH COUNTY, OREGON

Diane M. Linn, Chair

REVIEWED:

THOMAS SPONSLER, COUNTY ATTORNEY
FOR MULTNOMAH COUNTY, OREGON

By_____
John S. Thomas, Assistant County Attorney

RESOLUTION NO. 36060

Charge the Housing and Community Development Commission with policy planning on special needs housing development and operation.

WHEREAS, by ordinance and pursuant to Portland City Code 3.38, the jurisdictions of Multnomah County, City of Portland, and the City of Gresham have designated the Housing and Community Development Commission to serve as the primary public forum for policy development, resource coordination, and civic leadership to address the County's affordable housing problems; and

WHEREAS the Portland Development Commission plays an important role in financing and developing housing for persons with special needs; and

WHEREAS the Housing Authority of Portland plays a critical role in providing housing for persons with special needs through its public housing and Section 8 programs; and

WHEREAS, the mission of HCDC is to increase the effectiveness of the housing delivery system by providing coordination among diverse public agencies which implement housing programs and by serving as a centralized liaison between those agencies and the governing bodies of the jurisdictions on issues regarding housing policies, goals, programs, and related allocation of public funds; and

WHEREAS, the jurisdictions provided in the Consolidated Plan 2000-2005 that their first priority was to provide affordable rental housing to, among others, low- income persons with special needs; and

WHEREAS, the Consolidated Plan 2000-2005 Needs Assessment and further studies undertaken by the jurisdictions document that there is a shortage of affordable housing with links to needed services for persons with special needs; and

WHEREAS, there are numerous barriers to the development of additional affordable housing with links to services for people with special needs, including financial, regulatory, and historical barriers; and

WHEREAS, some persons with special needs who have affordable housing face barriers to success at maintaining in the housing; and

WHEREAS, for lack of suitable housing and services, people with special needs become inpatients at hospitals, are incarcerated, or occupy shelter space; and

WHEREAS, an adequate supply of special needs housing would ease the pressure on the mental health system, the corrections system, and the homeless system while focusing our resources in a more compassionate and economically efficient way;

NOW, THEREFORE, BE IT RESOLVED THAT the Housing and Community Development Commission, by and through its Special Needs Committee, shall undertake to do the following:

- assess the need for special needs housing County wide, including the specific housing needs of individual special needs populations;
- make policy recommendations to advance the development of special needs housing and to improve the success of housing outcomes for persons with special needs;
- coordinate local, regional, state, and federal housing and service resources to stimulate the development of special needs housing;
- develop hard, realistic, and measurable targets for additional housing for persons with special needs;
- leverage new resource streams for special needs housing development and operation;
- create models for special needs housing development and operation; and
- evaluate success of special needs housing development and operation; and
- periodically assess the need for additional committee work, with the first assessment not later than June 2003; and

BE IT FURTHER RESOLVED THAT the Multnomah County Board of Commissioners, the Portland City Council, the Gresham City Council, the Portland Development Commission, and the Board of the Housing Authority of Portland will annually review, with the advice of the Housing and Community Development Commission, what progress has been made towards the goal of providing each person with special needs with affordable housing linked to appropriate services; and

BE IT FURTHER RESOLVED THAT all responsible agencies, departments, divisions, and bureaus be directed to provide information to HCDC and its staff on resources, policies, and practices affecting the development and operation of special needs housing.

Adopted by the Portland City Council: MAR 20 2002

GARY BLACKMER
Auditor of the City of Portland

By /S/ Susan Parsons
Deputy

Commissioner Erik Sten
Beth K. Kaye
March 14, 2002

BACKING SHEET INFORMATION

AGENDA NO. 267-2002

ORDINANCE/RESOLUTION/COUNCIL DOCUMENT NO. 36060

COMMISSIONERS VOTED AS FOLLOWS:		
	YEAS	NAYS
FRANCESCONI	X	
HALES	X	
SALTZMAN	X	
STEN	X	
KATZ	X	

Multnomah County and City of Portland

Data sources for Special Needs Housing

Report: May, 2003

The following data is an attempt to identify the need for permanent special needs housing for disabilities listed below in Column 1. Columns 2, 3, & 4 represent the information available to assist in describing need from different data sources. Data Reports and Sources are listed on separate page.

(1) Special Needs Group	(2) Multiple Source Housing Need Data	(3) City-County Homeless Data	(4) Multnomah County Housing Needs Report
Severe & Persistent Mental Illness			
Number needing Permanent Housing	1,019-3,251 OMHAS[1] (114 Cascadia Waitlist)	1,090 (200 ONSC)[2]	900
Substance Abuse			
Number needing Permanent Housing	2,143 State OMHAS (499 CCC Wait List) (46 Cascadia Waitlist)	2,506 (371)[3]	1,814
Developmental Disabilities			
Number needing Permanent Housing	300 ARC Data 175 MCDDS 25 ILR	53	175
Physical /Functional Disabilities			
Number needing Permanent Housing	610 MC ADS Emergency Housing	Not Available	1,649
AIDS/HIV			
Number needing Permanent Housing	682-1,035 EMA Plan	195	488-838
Multiple Disabilities[4]			
Number needing Permanent Housing	(231 Cascadia Waitlist)	751	1,326
Totals			
Number needing Permanent Housing	**4,954-7,539**	**4,595**	**6,352-6,702**

Definitions: **MCADS**- Multnomah County Aging & Disability Services **ARC**-Association of Retarded Citizens of Multnomah County
ILR-Independent Living Resources **MCDDS** -Multnomah County Developmental Disability Services
MCMHS -Multnomah County Mental Health Services **OMHAS**-State Office of Mental Health & Addiction Services

Footnotes

1. OMHAS has two reports: One identifies the number of homeless, and the other, special housing needs. The Fall 2002 Report estimates 3,251 persons with MI needed Residential Treatment Facilities or Adult Care Homes, or Supportive Housing. FY01-02 Report indicates 1,019 clients with MI were homeless at point of enrollment in services.
2. ONSC - One Night Shelter Count Report 3/27/002, number with Mental Illness
3. ONSC - One Night Shelter Count Report 3/27/002, number with Alcohol and Drug Abuse Issues
4. The Category Multiple Disabilities includes any combination of diagnoses which results in a functional disability including physical, developmental, cognitive, mental and chemical.

Sources of Data

- Portland EMA HIV/AIDS Housing Plan, June 2000; prepared for the City of Portland Bureau of Housing and Community Development by AIDS Housing of Washington;
- FY 2001 – 2002, City of Portland and Multnomah County Information Sheet on Homeless;
- Multnomah County Special Needs Housing Report: Attempting to Quantify the Gap;
- Multnomah County Aging & Disability Services 2001-2002 Emergency Housing Report;
- Multnomah County 1 Night Shelter and Turn Away Count Report November 28, 2001;
- Homeless Shelter 1 Day Count Report November 2001;
- City of Portland-Multnomah County Annual GAP Analysis Report, 2001 – 2002;
- Homeless One Week Count Reports 2000 –2001, and 2001 –2002;
- Cascadia Mental Health Housing Facility Data;
- Cascadia Mental Health Housing Waiting Lists Disability Data, November 15, 2002;
- Multnomah County Mental Health and Addiction Services monthly Client Verity/Verity Plus and Client Service Reports July 02 – March 03;
- Results of the Fall 2000 Mental Health Housing Survey, October 2001, State Office of Mental Health and Addictions Services (OMHAS), prepared by Vicki Skryha;
- State OMHAS Housing Needs Data for Persons with Psychiatric Disabilities, Prepared September 2002;
- State OMHAS, Living Arrangements for Persons with Mental Health or Addiction Disorders, FY 01 –02, Table #3 and 4, Unduplicated adults with MH and Unduplicated adults with addiction disorders; Tables # 7, 8, 11 and 12: Unduplicated adults MH and Addiction disorders, November 2001 and March 2002;
- State of Oregon FY 2002 PATH Application, Attachment A, Homeless Data from CPMS FY 2000-2001;
- Central City Concerns, 2001 –2202 Waiting List;
- Multnomah County Developmental Disabilities November 2002 Client Report;
- RASP 2001-2002 Housing Report;
- ARC of Multnomah County, 2002 –2003 Client Housing Data;
- Multnomah County Department of Community Justice Transitional Services Client Special Needs Reports, FY 01 –02, and 02 –03;
- Multnomah County ADS, September 2002 Monthly Client Report;
- State Seniors and People with Disabilities MMIS Report # SJM5010R-A (Sept 27, 2002;

- **The Booking Frequency Pilot Project, Multnomah County, January 2002;**
- **Public Safety Coordinating Council Report of the Work Group on Mental Health Treatment Needs of Offenders; February 7, 1997;**

Multnomah County Special Needs Housing Options and Capacity

Type of Housing	**# Housing Facilities/ Properties**	**# Units or Bed Capacity**	*Services* On Site	Off Site	**# Clients or Residents**	***Licensed*** Yes/No/Other
Adult Foster Care Homes (AFCH)	571	2,855 (max. 5 residents per home)	X	X	**1,037 *ADS*** **206 *DD*** 55 **MH**	**Yes,** by Multnomah County Aging & Disability Services (ADS)
Room & Board Homes (R & B)	10	68	X		**12 ADS** **5 DD** **? MH**	Yes, by Multnomah County ADS
Assisted Living Facilities (ALF)	17 (12 accept Medicaid)	1,400	X	X	400 **ADS**	Yes, by State Seniors & Persons with Disabilities (SPD)
ADS Residential Care Homes (RCF)	46 (30 accept Medicaid)	2,105 **ADS**	X	X	**612 ADS**	**Yes,** by State SPD
MH Residential Care Homes	21	252 **MH**	X	X	**252 MH**	**Yes**, by State OMHAS
MH/ADS Enhanced Care Facility (ECF)	1	16 ***MH/ADS***	X	X	**16 MH/ADS**	**Yes,** by State MH and SPD
Type of Housing	**# Housing Facilities/ Properties**	**# Units or Bed Capacity**	*Services* On Site	Off Site	**# Clients or Residents**	***Licensed*** Yes/ NO / Other
Type of	**# Housing Facilities/**	**# Units or Bed**	*Services*		**# Clients or**	

Housing	Properties	Capacity	On Site	Off Site	Residents	*Licensed* Yes/ NO / Other
MH (Cascadia) Independent Housing	30	340 **HIV** **14 A&D** **48 MH/A&D** **103 MH homeless** **164 MH**		X	**340** **MH, HIV, A&D** (plus 391 on waitlist)	No
Mental Health (CCC) ADFH	1 single adults 15 families	68 238			transitional housing	No
DD Group Homes	106 (24/7)	453	X	X	453 **DD**	Yes, by State
DD Supported Housing	7 providers	122 varies	X	X	122 **DD**	Providers Certified by State
DD Semi-Independent Living	**10 providers**	75 varies	X	X	**75** **DD**	Providers Certified by State
Oxford House of Oregon (A & D)	36 total in Mult Co 28 M 6 F 2 FC	273			*273* *A&D*	Chapters
HIV/AIDS (Central City Concerns (CCC), Cascade AID's Project)	1 single adults	52	X	X	52 HIV	No
A&D (CCC, Early Recovery	4 families	78 units (2 and 3 bedrms)			transitional housing	No
Employment Linked (CCC)	**2 single adults**	81	X	X	transitional housing	No

Type of Housing	# Housing Facilities/ Properties	# Units or Bed Capacity	*Services* On Site	Off Site	# Clients or Residents	***Licensed*** Yes/ NO / Other
ADFC Permanent [CCC, REACH, TPI]	4 single adults 2 Fair Market Rate	290 ADFC 195		X X	Permanent Housing	No
Nursing Facilities (NF)	32	2,630 beds in facilities that accept Medicaid	X	X	1,351 ***ADS***	Yes, by State SPD
ADS Specialized Living Projects **- HAP Congregate Housing Service Project** (ages: seniors and younger disabled) - Quad Inc (ages 18 –64) - Pine Point (ages 18 –64) - Kamphe (18 – 64) (Brain Injured)	 4 2 1 1	 120 40 19 19	 X X X X	 X X X X	 120 **ADS** 40 ADS 19 ADS 19 ADS	**No License; services paid through special contract with State SPD, with service assessment and authorization by Multnomah County ADS**

SPD – State Seniors and Persons with Disabilities;
CCC – Central City Concerns;
ADS – Multnomah County Aging & Disability Services;
OMHAS – State Office of Mental Health and Addiction Services

TABLE 3 - ANALYSIS OF BARRIERS (SORTED)

Barrier	Client Perspective	Provider Perspective	Funding Issue	System Challenge
Housing not viewed as a piece of a prevention model – viewed as a reward	**It is hard to become stable when you do not have a home or your housing is not secure.**	**Not enough support for people to succeed in housing.**	**Prison, shelter, hospital all higher cost than housing.**	**Adopt preventive model.**
Agency boundaries balkanized; compartmentalizatio n of services	**Difficult to navigate system; lack of assistance with process; Unable to find out whether assistance may be available; services not linked to housing**	**No clear funding stream.**	**Funding administered through agencies**	**Front door access to services; use funding moment as a point to make housing/service linkage; systems guide; systems navigator**
Cultural and language barriers	**People of color and people who speak a primary language other than English may encounter bias, difficulty obtaining culturally appropriate services or information and services in their language.**	**Can be hard to communicate with clients of other cultures and languages. Will take time to build multi-cultural competency, multi-lingual information and service provision.**	**Resources required to build multi-cultural competency, multi-lingual information systems and service provision.**	**All programs must address cultural and language diversity of client populations.**
Role of State DHS	Difficult to navigate system.	Funding uncertain.	Controls important funding streams; budget face severe cuts.	Open dialogue.
Incomplete client assessments	**Failure to diagnose means failure to treat.**	**Not set up to do assessments.**	**Funding streams tied to categorical eligibility requirements.**	**To provide integrated assessment regardless of client point of entry.**

Undiagnosed disability	May impair ability to find and keep job. Difficult to obtain diagnosis. May need advocate.	No funding streams.	Not connected with funding stream	Complete assessment early on and repeat periodically
Unpredictability of Need	**Need for support varies over time; need may be non-existent, cyclical, episodic, or steady; moving as service needs change is destabilizing.**	**Needs predictability to plan staffing**	**Relatively rigid funding models persist**	**To build flexibility in funding model to match variations in individual's condition; to plan for the delivery of the continuum of services.**
Falling between cracks (Lack of capacity to house people excluded from private RE industry and not eligible for service enriched housing)	Not eligible for services, barred from other housing	Cannot develop without a funding stream.	Identify resources for these populations.	To plan for this population.
Shallow needs in multiple areas	Unable to get help needed	No funding streams	Affects eligibility	Plan for this population.
Co-occurring mental health or A/D will exclude limited functioning adult	Unable to get help needed.	No funding stream, no service supports.	Prison, shelter, hospital all higher cost than housing. Identify resource.	Plan for these populations.
Separate systems for children/youth/ seniors	Difficult to locate/maintain care and level of service during transitions between age-based systems,	Interruptions in funding stream.	Different funding streams for each age band.	Plan for continuity during transitions and straddle periods.

Lack of coordination on discharge from institutions.	**Difficult to get help needed on discharge from institution (prison/hospital/other)**	**Need to reestablish funding stream.**	**Different funding streams for inside/outside institution. Who pays for coordination?**	**Improve coordination.**
Inadequate case management/co-ordination	**Lack of treatment impairs ability to function independently.**	**Tenants who are not receiving adequate case management may not be able to meet requirements of tenancy.**	**Expensive to treat person who has decompensated due to lack of case management/co-ordination.**	**Improve system. Favor systems that incentivize consistent case management/co-ordination. Expand on models like JOIN.**
Consumers not empowered	Don't know where to go for information about choices/rights.	Individual provider has only incomplete information.	Cost of establishing and updating consumer information.	Explore whether Housing Connections will a sufficient empowerment tool when services component is on-line. Provide technical assistance for special needs populations to use housing Connections.
Lack of consumer involvement in policy planning.	**Consumer preferences not reflected in policy making.**	**Consumers lack sophistication about funding streams, program design, etc.**	**Cost of consumer involvement.**	**Include consumers/ consumer advocates in policy planning process.**
Lack of preventive /maintenance services	**Sometimes a small amount of help can assist a person to maintain in housing and prevent the situation from deteriorating into a crisis (hospitalization, lost housing, lost benefits, etc.)**	**Landlords ill-equipped to provide preventative services; may not be aware of tenant's special needs or whom to contact.**	**Prison, shelter, hospital all higher cost than housing. Prevention always the most cost-effective option.**	**Favor systems that provide or incentivize preventive services to help people maintain in housing. Expand on models like JOIN.**

Compliance with rules on house-keeping/super-vision	Hard to under-stand/follow; need life skills training	Difficult for landlord/owner to negotiate with tenant	Deterioration of unit can be more expensive than prevention.	To connect with life skills training and support
Need for food security	Some unable to afford food; some require assistance with meal preparation and/or feeding.	Match food security programs to needs of clients.	Funding available from many sources for food security. Expensive to install cooking facilities in every complex.	Maximize use of available food security programs, including U.S.D.A. supported meals programs, food pantries, food stamps, etc. Provide training on nutrition, cooking, etc.
Need for life skills	Life skills would allow person to live with increased level of independence.	Tenant unable to fulfill obligations of tenancy without life skills.	Investment in life skills training would allow person to live with increased level of independence (at lower cost). What are funding streams?	Include life skills training as part of transitioning individual to housing.
Functional illiteracy	Navigating system very difficult without basic literacy.	Communication with tenants more difficult.	Some cost associated with providing assistance with information. Some people may not be receiving funding for which they are eligible.	Identify if literacy is an issue early in process. Provide remedial education, if appropriate, and assistance in managing information.
Lack of community/ need for natural supports	**Need community.**	**Isolated tenant lacks support in times of crisis, increases burden on landlord.**	**Limited funds for investment in community centers and programs.**	**Plan for populations to go beyond subsistence issues of food and shelter, to include planning for community development.**
Conflict between autonomy/safety	Desire for autonomy; some unwilling to have care.	Hard to plan for individual preference; can make difficult tenants.	People who turn down needed care can be very expensive.	To provide a range of housing options to meet individual preferences; to contain costs.
Client cannot direct his/her own services	Most programs are for people who can direct their own services	Requires attention of caseworker or service coordinator.	Higher level of care available in more expensive licensed facilities	Provide for people who need off-site monitoring.

Disincentives to success are built in.	Clients who do well may lose the services and support that helped them to become successful and are necessary to maintain success.	With limited funds, must "graduate" some to be able to fund care for other.	Over long term, less expensive to help individual maintain successes than to pay for intervention later.	Analyze extent of this barrier for special needs populations. Incentivize programs that help individuals maintain successes.
Tension between size of project and affordability.	**Usually, scattered site or smaller housing developments are more attractive to consumers.**	**It is less expensive to develop large, multi-unit properties. Operating costs (including on-site supervision) can be spread over a greater base.**	**Keeping rents affordable can mean denser development.**	**Explore better design to overcome disadvantages of density. Find balance between cost and affordability.**
Service delivery to scattered sites	Prefer to live in scattered site housing	Expensive; hard to provide on-site management	Expensive – prefer single site	Explore ways to improve service delivery to scattered sites; improve quality of higher density housing options.
Underwriter's reluctance	Fewer units available to people with most severe needs.	Unwilling to develop specialized physical structure without assurance of service dollars; unwilling to finance without assurance of service dollars; unwilling to finance high maintenance costs	Limits funding available from private market.	Need info re whether service up-front improves project's long range financial performance
Risk management for socially-conscious housing providers	Desire housing opportunities in CDC owned housing.	High costs of tenant bombing out, turn-over, vacancies, wear and tear	Investment in socially-conscious housing providers could provide housing opportunities for the hard-to-house.	Technical support for socially-conscious housing providers in risk management; support for tenants to succeed in tenancies.

Providers have insufficient information about needs of tenants with special needs .	Concerns about privacy. Want to increase number of private landlords who will rent to people with special needs,	Fair Housing Act and Section 504 limit landlords for asking for detailed information about disability of prospective or current tenant. Landlords not in special needs business uncomfortable about renting to person with disability. Landlords handicapped by lack of information from making compassionate and appropriate response to tenant needs.	Low cost for education programs.	Consumer education for tenants about ability to volunteer information to landlords; training for landlords about renting to tenants with special needs. Look at JOIN and other sponsorship models.
Lack of market study on optimal mix of special needs housing that reflects client preferences	Insufficient supply of units that meet client preferences for studios and larger units. Too much institutional housing.	Develops not in special needs housing industry don't know what to build.	Special needs population too low-income to send signals to market in conventional way. Larger units more expensive.	Develop plan that recognizes complexity of market and reflects customer preference.
High cost of housing	Inability to pay much rent; housing cost more than 30% of income	Need to cover cost	Limited funds to provide rent subsidies or to develop debt-free housing and provide operating subsidies.	More rent subsidies or debt-free housing with operating subsidies
Lack of employment	Lack of income; most persons with special needs have monthly incomes between 0-17% AMI	Tenant unable to pay own way for housing and services		Improved linkage to workforce programs; living wage
Temporary disability	Can destabilize situation	Tenant cannot pay rent	Not connected with funding stream	Plan for this population.
Lack of childcare	Hard to hold job without childcare.	Property managers cannot provide child care.	Limits ability to tenants to pay rent. Childcare expensive.	Expand childcare options.

High cost of moving	Stuck in place. Hard to move to better situation because costs are so high.	High cost of turn-over.	Limited funds to provide for moving expenses.	Flexible funds for moving expenses.
Siting	Close to services, transportation, neighborhood amenities.	NIMBY opposition.	Adds cost to project.	To remove barriers to siting; to develop community acceptance for special needs housing.
Discrimination based on Section 8	Cannot find suitable housing that will accept Section 8. (17% turn-back rate)	Section 8 comes with additional restrictions on landlord rights and places additional duties on landlord.	We should maximize use of this federal resource.	Law reform: bar discrimination based on Section 8 and/or decrease burden on landlords who accept Section 8.
Discrimination based on mental illness	Reduces housing opportunities.	Concern about potential exposure, concern about potentially high cost of reasonable accommodation.		Law enforcement
Sub-standard housing, e.g. flops, properties with hazardous conditions	Conditions may pose health risks or exacerbate existing medical conditions.	Little or no incentive to improve conditions. Expensive to bring up to standard.	Tie funding for repairs to term of affordability.	Code development; code enforcement; replacement strategy
Criminal justice history	Irrevocable.	Increased exposure to liability; risk.	Disqualifies individual from some services depending on crimes.	Expand on models like Fresh Start
Landlord screening criteria	Presents a barrier to housing that might otherwise be suitable and available.	Insufficient incentives to house people who may be capable of independent living with support.	Some need for funding to provide security to landlord to offset perception of risk.	Increase incentives; expand on models like JOIN and Fresh Start.
D/V	Need for safety, support	May have poor tenant history	Few resources for support.	Planning around long-term housing needs of people with special needs who have history of D/V.

APPENDIX D: VISION, GOALS AND LONG TERM STRATEGIES

The Special Needs Committee developed a vision and long-term goals to create a picture of the future we want to see, and then determined the changes that will be necessary to get there. The Committee then created long-term strategies which would move us toward these goals. These long-term strategies were assessed in light of current circumstances, and feasible Recommended Action Steps for 2003-05 developed (see body of the Report).

VISION: In Multnomah County, people with special needs have decent stable affordable housing for themselves and their families, along with the support and services they need for a good quality of life.

LONG-TERM GOALS:

Goal 1: Coordinate housing + services to maximize success of people with special needs in permanent housing.

Goal 2: Create enough housing for people with special needs, including housing linked to services and housing for the hard-to-house.

Goal 3: Improve access to housing + services, including outreach to the hard-to-house.

LONG-TERM STRATEGIES:

Strategies to Achieve Goal 1:

Coordinate housing + services to maximize success of people with special needs in permanent housing.

Coordination Strategies

These strategies address inter- and intra-jurisdictional issues. They express the SNC's recommendation that complexity be addressed at the administrative level, rather than leaving complexities for housing and service providers to sort out.

1. Establish an on-going interagency/interjurisdictional forum that coordinates, and brings resources to bear upon, housing and services targeted toward people with special needs.
2. Use data to inform process, make improvements, and show success. Align with existing information/resource systems.
3. Improve coordination across service systems for people who are or should be in more than one system.

Funding Strategies:

These strategies encourage a systematic approach to filling funding gaps as resources become available. They express the SNC's recommendation that all parties adopt a shared orientation of protecting special needs populations and individual clients.

1. Maximize mainstream resources (e.g. Medicaid, Medicaid Waivers, Federally Qualified Health Center status, U.S. Department of Agriculture food assistance, various housing and service block grants) to leverage local contributions to supportive housing for special needs populations.
2. Establish sustained coordinated funding mechanisms and administration.
3. Review rent assistance models that promote housing stability and assess effectiveness, ease of access, and whether priority special needs populations have been well served.

Service Delivery Strategies:

1. Within the service system, establish housing retention/stability goals and track outcomes for all special needs populations.
2. Within the service system, establish food security goals and track outcomes for all special needs populations.
3. Facilitate and support partnerships among implementers of supportive housing to ensure housing and service access for "hardest-to-house" people.

Strategies to Achieve Goal 2:

Create <u>enough housing</u> for people with special needs, including housing linked to services and housing for the hard-to-house.

1. Develop concrete goals and set targets for the following strategies for 3, 5 and 10 year periods.
2. Commit to supportive housing set-aside "express lane" in existing development pipeline for projects that propose to house and serve people with special needs. Administer pipeline under oversight of interagency body to ensure resource commitment, coordination, and accountability.
3. Establish shared timelines to implement consolidated funding cycles that package housing financing (including rent/operating subsidies) and services. Establish a proposal review committee that includes specific expertise in supportive housing development and operation.
4. Link services to the Housing Authority of Portland, community development corporations, and other key housing providers to better leverage and facilitate special needs occupancy of existing inventory.
5. Stimulate new development targeted to meeting identified gaps.

6. Create more service capacity to support increased level of housing development.
7. Develop some affordable housing with all services off-site so that, in the event of service cuts, housing will survive.
8. Establish policy regarding the conversion of Section 8 vouchers to project-based Section 8 to support the development of additional housing capacity.
9. Seek new competitive funding, such as the March 2003 proposal submitted jointly by the City of Portland, Multnomah County, and HCDC to the Corporation for Supportive Housing "Taking Health Care Home Initiative," which aims to:
   a. Institute financial incentives for projects that serve and house people who have multiple needs, have been homeless for the longest periods of time, and are at high risk of failing to sustain housing.
   b. Shift funding over time from projects and programs that do not support long-term permanent housing for homeless people with special needs to ones that do, without compromising the strength of the safety net.
   c. Provide housing to those not currently served by, or considered clients of, the mainstream service system.
   d. Reduce duplication and fragmentation between homeless systems and special need service system.
10. Support efforts to develop a stable local funding source for affordable housing, with a portion of revenues earmarked for supportive housing.

Strategies to Achieve Goal 3:

Improve access to housing + services, including outreach to the hard-to-house.

1. Offer each client, regardless of point of entry, a comprehensive and culturally competent service plan that includes access/placement/stabilization/retention resources for housing, service, and food security needs. This includes an integrated plan for clients discharged from facilities (*e.g.* jails, shelters, hospitals).

2. Design services so that they can be altered when client needs intensify or lessen.

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Portland, Oregon 97204-1966

APPENDIX E: LETTER TO HAP

To: Rose Bak, HAP

From: Linda Kaeser, Chair
HCDC Special Needs Committee

Re: Using March 2003 RFP for Project- Based Section 8 to address current crisis of imminent displacement of residents of special needs facilities

Date: January 29, 2003

The HCDC Special Needs Housing Committee appreciates HAP's invitation to explore how HAP may assist in the community response to imminent displacement of residents of facilities that face down-sizing and closure due to inadequate service funding. The particulars of the financial difficulties facing facilities like the Taft, the Hoodview, and the William-Elaine have been well-documented in the press and at our committee meetings.

HAP has offered to use some of its Project-Based Section 8 resource to address this imminent crisis. HAP expects to have 250 Project-Based Section 8 vouchers available over the course of FY 2003-2004. The vouchers typically become available at the rate of 10 or 20 each month. The vouchers are issued for a one-year period. It is HAP's practice to renew them automatically for up to 10 years.

The Project-Based Section 8 resource is currently being allocated on a pilot basis using criteria established through an extensive public process. The criteria ensure that this resource is used to serve people who face significant barriers to securing housing on the open market. Currently, in HAP's selection process for allocating Project-Based Section 8, preferences are given to projects serving people at 0-30% MFI -- with an emphasis on 0-10% MFI; people with chronic mental illness; people with alcohol or drug issues; people with mobility or disability issues; people with criminal history; people with poor credit history; people with no rental history or a history of evictions; people who are victims of domestic violence; and people who require on-site services to live independently. Projects are also required to meet financial feasibility requirements, and project sponsors are required to be financially sound.

Members of the SNC met with HAP staff and reviewed the current criteria. SNC recommends that HAP augment its list of criteria for receiving an allocation of Project-Based Section 8 to include the following additional factor:

> "Housing projects serving people most at risk of inappropriate placement in institutions, such as jails, shelters, hospitals, nursing facilities, or on the street, with a priority for people who are at risk of

displacement due to the imminent closure or downsizing of their residences."

In some cases, this may mean allocating Project-Based vouchers to the facility slated for closure or downsizing. In other cases, this it might be appropriate to allocate Project-Based vouchers to other housing that could immediately accommodate a group of people at risk of displacement due to imminent facility closure or down-sizing. We believe that HAP's selection committee will be in the best position to make this judgment, based on the totality of information presented to it.

The SNC asks that HAP give projects satisfying this additional criterion preference over other projects.

The SNC also recommends that HAP make some alterations in its standard RFP process for allocating the Project-Based vouchers, as follows:

1. Do outreach to encourage proposals from facilities facing closure or down-sizing, as well as current and potential providers of special needs housing.
2. Hold a pre-bid orientation session to explain how Project-Based contracts work, the RFP, the allocation process and the selection criteria.
3. Offer technical assistance to prospective bidders, including site visits to assess whether a property would (or could) meet Section 8 program qualifications. If possible, provide referrals to a list of individuals with expertise in service funding to assist applicants in preparing a financially-feasible proposal.
4. Require bidders that intend to provide supportive services (*e.g.* case management, mental health, medical) to residents of the proposed project to submit a letter explaining the source of funding for those services with their application.
5. Use an impartial review committee that includes at least one person who is familiar with service funding.

Once again, we appreciate the opportunity to consult with HAP on this important issue.

cc: Multnomah County Chair
Diane Linn
Mayor Vera Katz
Commissioner Erik Sten
Mayor Charles Becker
Tonya Parker, BHCD
Bill Van Vliet, HCDC
Rachael Duke, HAP
Paul Parker, HAP
Catherine Such, HCDC
Diane Luther, Multnomah County
Andree Tremoulet, City of Gresham
Andy J. Smith, Multnomah County

VISION: IN MULTNOMAH COUNTY, PEOPLE WITH SPECIAL NEEDS HAVE DECENT STABLE AFFORDABLE HOUSING FOR THEMSELVES AND THEIR FAMILIES, ALONG WITH THE SUPPORT AND SERVICES THEY NEED FOR A GOOD QUALITY OF LIFE.

GOAL 1. COORDINATE HOUSING + SERVICES TO MAXIMIZE SUCCESS OF PEOPLE WITH SPECIAL NEEDS IN PERMANENT HOUSING.

LONG TERM STRATEGIES	POTENTIAL OUTCOMES	POTENTIAL TASKS
Within the service system, establish housing retention/stability goals and track outcomes for all special needs populations.	By 2006, we will track housing outcomes for all special needs populations and use housing outcomes to evaluate programs and inform funding decisions.	Form goal-setting teams within each service sector, including housing expertise.
		To promote retention, expand access to appropriate levels of case management and wrap-around service for people whoa re already in housing.
		Create flexibility in funding to respond to unusual needs that can jeopardize housing stability.
		Assist clients to "transition in place" by providing varying levels of support to each client in his/her own home.
Review rent assistance models that promote housing stability, and assess effectiveness, ease of access, and whether priority populations are well served.	By 2004, we will fund models that promote housing stability. We will differentiate between transitional and permanent housing. We will have outcome data for people assisted.	Reprogram current rent assistance models to models that are most effective at promoting housing stability, offering easy access, and serving priority populations.

LONG TERM STRATEGIES	POTENTIAL OUTCOMES	POTENTIAL TASKS
Regulatory strategy to increase leveraging of local resources with state and federal resources. Maximize local match to increase Medicaid funds. Reduce or eliminate barriers among Medicaid Waivers (e.g. mental health, DD, and long-term care).	By 2006, a person with a high degree of functional disability will be qualified for wrap-around services. There will be no distinctions based on diagnosis to disqualify an individual from needed services.	Empower direct service staff to fund housing-related expenses out of service streams to meet housing goals
Build working relationships between housing and service providers by cross-educating and cross-communicating.	Greater housing accessibility and retention.	Promote concept of multi-disciplinary teams
		Develop model for coordination of case management among service providers focused on "high users of institutions" with multiple problems.
		Develop standardized training program. Improve training in services for housing providers; improve training in housing for service providers. Offer food security training to all.
		Explore ways to maintain stability in service/housing providers

LONG TERM STRATEGIES	POTENTIAL OUTCOMES	POTENTIAL TASKS
Complete shifts in budgets from back-end Solutions to front-end Prevention	By 2007, provide the funding for subsidized housing with easily available and accessible services. By 2007, **50%** of Special Needs populations, who are in need of permanent housing, will be housed in permanent housing with supportive services (including meals). By 2009, **60%** of Special Needs population, who are in need of permanent housing, will be housed in permanent housing with supportive services (including meals).	Research and articulate overall savings Develop political support and leadership Advocate for adequate funding levels to ensure success
Joint planning for each population to promote housing security, food security, health care, dental care, employment	City Commissioner of Housing and County Chair appoint ongoing planning group, composed of appropriate Division and Department Staff and Decision-makers, to develop plans and strategies for an integrated system for providing support services and housing.	Continue active engagement of all stakeholders: consumers, providers, funders, from all service and housing cylinders Expand access to food and nutrition services through housing models Improve linkages to workforce programs and employment that pays a living wage. Expand access to affordable child care.
Develop information system with multiple uses, e.g. accessing services, case management, tracking outcomes, (perhaps build on Housing Connections)	By 2004, have Homeless Management Information System in place with 50% of public and private agencies participating.	Develop information system for consumers. Develop information system for providers.

LONG TERM STRATEGIES	POTENTIAL OUTCOMES	POTENTIAL TASKS
Improve coordination across service systems for people who are or should be in more than one system	By 2004, have interagency agreements in place that permit information sharing with client consent among agencies.	
Create structure for accountability that includes the highest-level policy makers as well as the direct service providers. Monitor implementation	By 2004, designate a new or existing multi-jurisdictional body with the authority to promote and oversee collaboration efforts.	Ensure at least annual report-back on goals progress from Department heads to elected officials
		Explore creation of an inter-agency task-force with clear roles/responsibilities and methods of coordination.
		Explore designation of new or existing multi-jurisdictional authority to oversee collaborative efforts
		Provide continuing political leadership

GOAL 2: CREATE ENOUGH HOUSING FOR PEOPLE WITH SPECIAL NEEDS, INCLUDING HOUSING LINKED TO SERVICES AND HOUSING FOR THE HARD-TO-HOUSE.		
LONG TERM STRATEGIES	**POTENTIAL OUTCOMES**	**POTENTIAL TASKS**
Link services to HAP, CDCs, private landlords and other key housing providers to better leverage and facilitate special needs occupancy at existing inventory	By 2005, develop a formal information, referral and support program for landlords, property managers and case managers serving residents with special needs. By 2006, have an inventory of locations (non-institutional permanent housing) that accept and are appropriate for persons with special needs Increase number of households assisted to become stable in permanent housing by 2005.	Modify existing models and programs (such as Fresh Start, Home Safe, etc.), to develop agreements with housing providers to house persons with special needs who are high-risk renters by reducing real and perceived risk. Educate landlords, housing providers, managers about renting to people with disabilities, and how to obtain assistance Provide service support to housing providers, owners, and managers to house hardest to house and other special needs populations.
Address underwriters' resistance to financing special needs housing	By 2004, establish relationships with three underwriters to participate in special needs housing pipeline.	Adopt strategies to make the case to underwriters about the financial viability of special needs housing. Educate underwriters on service systems and funding.

LONG TERM STRATEGIES	POTENTIAL OUTCOMES	POTENTIAL TASKS
Stimulate new development targeted to meeting identified gaps	By 2005, develop 400 new supportive housing units for people with special needs By 2004, create an implementation strategy for addressing identified supportive housing gaps. By 2005, develop technical assistance for assembling development and service funding packages.	Inventory existing housing resources to identify needs and gaps by population.
		Develop and prioritize targeted special needs production goals, by type and severity of disability, including co-occurring disabilities.
		Coordinate housing and service funding streams – where possible – to stimulate new development to meet specific targets. Fund viable models.

		Develop a variety of best practices and models for special needs housing that balance cost efficiencies and consumer preferences (e.g. efficiencies vs. one bedroom units; scattered sites vs. dense developments). Example: flexible mixed-use housing.
		Develop approval process that includes analysis of service needs/impact prior to funding development of project
		Track and report on inventory and progress toward goals
Attract more special needs housing developers with private capital to invest.	More special needs housing developers with private capital will be operating housing in Multnomah County.	Outreach to special needs housing developers regarding special needs housing goals, housing development and service funding availability, technical assistance, etc.
Increase number of available housing subsidies.	By 2007, 1000 more people with special needs with incomes of 0-20% MFI who require housing subsidies will get them. By 2010, 2000 people with incomes of 0-20% MFI who require housing subsidies will get them.	Explore reallocation of existing resources and development of new resources.
Maintain existing housing serving residents with special needs.	Housing resources and service systems have stable funding commitments.	Create systems that support quality asset management of units that house special needs populations. Coordinate services and services funding to maintain existing special needs housing.

LONG TERM STRATEGIES	POTENTIAL OUTCOMES	POTENTIAL TASKS
Establish new and increased funding for the development of special needs housing.	Twenty percent of new funding for affordable housing will be for special needs housing.	Work with allies on development of new housing resources (e.g. RETT, bond measures, more Section 8 vouchers) Seek set-asides of existing funds for special needs housing. Advocate at state and federal levels to have more funding allocated to housing for people with special needs.
Create more service capacity to support increased level of housing development	By 2006, system will have the capacity to provide necessary services to 600 additional people.	Work with allies on development of new service resources. Explore ways to use potential expanded funding for affordable housing to pay for services (e.g. underwrite increased operating expenses.) Lobby at state and federal levels to have more funds allocated to services for people with special needs.
For interim period, appoint City/County ombudsman to facilitate development of special needs housing by addressing housing/service funding coordination issues.	Ombudsman facilitates development of special needs housing through 2006, while larger systems change work builds.	
Develop community support for special needs housing	Reduced neighborhood resistance to siting special needs housing, and increased public support for funding special needs housing.	Educate neighbors: door-to-door, at community centers, caring communities, parks, neighborhood associations, etc.

LONG TERM STRATEGIES	POTENTIAL OUTCOMES	POTENTIAL TASKS
Better integrate current homeless system clients with mainstream housing.	By 2005, 20% of all people who have experienced homeless ness for one year or longer will be place in housing with appropriate service supports. By 2007, shelter count will show reductions in numbers of people sheltered and numbers turned away.	Consolidate homeless delivery systems with special needs delivery systems where appropriate to merge housing access and support services
		Move funding from "back" end (shelter, hospital, jail) to "front" end (housing and services).
		Develop "front-end" system. Coordinate/consolidate resources across departments (state, county, city) in order to streamline effort and use of dollars.
Provide housing to those not currently served or considered to be "clients" of the mainstream service system.	By 2010, have outreach methods in place to make housing opportunities available to these "non-clients." Decrease street count of homeless people from 2003 levels by 20% in 2005, by 50% in 2007, and maintain low numbers of people on the street for future years.	Devise methods to reach these individuals and offer them permanent housing
Reduce duplication and fragmentation between homeless systems and special needs service system	By 2005, increase provider access to mainstream funding by 25%. By 2006, reduce homeless- specific funding for special needs services by same amount.	Implement integrated Housing First model across all systems of care

LONG TERM STRATEGIES	POTENTIAL OUTCOMES	POTENTIAL TASKS
Shift some of budget from end-line services (jails/hospitals/shelters) to homeless prevention services that show success in attaining housing and health outcomes	By 2005, invest enough housing and service dollars to create a pipeline of 400 supportive housing units. By 2006, house an additional 250 "hard to house" chronically homeless individuals through "Housing First" model. By 2007, shift resources from savings in hospitals, jails, and shelters to supportive housing models. By 2007, reduce reliance of homeless services on CDBG public service dollars by 25% and allocate savings to special needs housing development.	Develop small prevention demonstration project out of end-service budget lines to show cost-effectiveness Track success and expand as appropriate Develop demonstration project of a coordinated/ consolidated interdepartmental system to streamline provision of services to clients at risk of homelessness. Track success and expand as appropriate.
Create better coordination between mainstream service providers and permanent long-term providers for persons poised for transition out of institutions	By 2005, implement cross-system comprehensive discharge plan that ensures housing stability for 60% of homeless people released from institutions. By 2007, increase to 75%.	

GOAL 3: IMPROVE ACCESS TO HOUSING + SERVICES, INCLUDING OUTREACH TO THE HARD-TO-HOUSE.		
LONG TERM STRATEGIES	**POTENTIAL OUTCOMES**	**POTENTIAL TASKS**
Design comprehensive and culturally-competent screening and assessment tool, including a housing need assessment component, for use by social service agencies	By 2006, demonstrate a comprehensive screening and assessment tool in selected populations. By 2010, 100% of people with special needs accessing County services will have been screened and assessed using the comprehensive tool.	Examine current assessment models: ADS, Cascadia, CAP, etc. Develop model assessment protocol Coordinate entry for services (DD, MH, ADS) and housing as much as possible (e.g. single point of application, single application, comprehensive needs analysis).
Offer clients a comprehensive service plan that includes access/placement/ stabilization/retention resources for both housing and social service needs. Service plans will be client-centered and culturally competent Comprehensive service plans will include food security, intervention services, life skills training, and remedial literacy as needed	By 2010, 100% of special needs applicants accessing county services, regardless of point of entry, will have a comprehensive service plan that includes access/placement/ stabilization/retention resources for both housing and social service needs. This includes an integrated plan for clients discharged from facilities. By 2004, develop agreements between housing and service providers to facilitate coordinated service plans. By 2006, all partners will use one resource database for all resources, including DD, MH, ADS, DV	Explore ways to jointly administer housing rent subsidy programs and service programs (e.g. Medicaid), so that individuals eligible for services would also receive rent subsidies. Align flexible housing and rental assistance funds with service delivery systems.

		Create and map inventory of available resources
Have funding follow the client.		Identify the current funding configurations for typical populations
		Map the movement of the individual and the funding streams through types of housing
		Chart and evaluate the impacts of such a potential change.
Conduct outreach and marketing that reaches special needs clients where they are, using non-traditional partners such as courts, hospitals, and retailers	By 2008, 80% of people with special needs will know how to access services	Identify and map non-traditional partners. Develop culturally competent informational materials about available resources, with culturally specific content as needed. Develop kiosks, web sites, storefront displays, and public event booths.
Offer "safe haven" and low barrier shelter. Increase respite	By 2006, there will be 100 units of safe haven and low barrier shelter. By 2006, there will be 15 medical respite beds available in the system.	

PORTLAND-VANCOUVER INCOME LIMITS FOR YEAR 2003 AND THE FAIR MARKET LIMITS FOR 2003 EFFECTIVE IMMEDIATELY

Median Income Percentages Year 2003

65,800

FY 2003

Household Size	30%	50%	60%	80%	100%
1	13,800	23,050	27,650	36,850	46,050
2	15,800	26,300	31,600	42,100	52,650
3	17,750	29,600	35,550	47,400	59,200
4	19,750	32,900	39,500	52,650	**65,800**
5	21,300	35,550	42,650	56,850	71,050
6	22,900	38,150	45,800	61,050	76,350
7	24,500	40,800	48,950	65,250	81,600
8	26,050	43,450	52,100	69,500	86,850

(Based on the HUD Portland Area Median Income as of December 31,2002: **$65,800** for a family of four. Figures are rounded to the nearest $50.00).

These new guidelines should be used to determine program eligibility and to track beneficiaries. Most BHCD programs are tracked at 30% (very low income), 50% (low income) and 80% (moderate income).

For questions about applicability of these guidelines to particular programs or funding agreements, please contact your Program manager.

FAIR MARKET RENT FOR 2003

BEDROOM SIZE	FMR
0	$ 508
1	$ 625
2	$ 771
3	$1,073
4	$1,164

APPENDIX H: ACRONYMS

Acronym	Description
ADS	Aging and Disability Services, Division of Dept. of County Human Services
AFCH	Adult Foster Care Home
ALF	Assisted Living Facility
ADL	Activities of Daily Living
A&D	Alcohol and Drug
AMI	Area Median Income
BHCD	Bureau of Housing and Community Development, City of Portland
CDBG	Community Development Block Grant
CEBN	Emergency Basic Needs
CFC	Oregon's Consolidated Funding Cycle
CM	Case Management
DCHS	Multnomah County Dept. of County Human Services
DCJ	Multnomah County Dept. of Community Justice
DD	Developmental Disability
DHS	Department of Human Services, State of Oregon
EMO	Ecumenical Ministries of Oregon
ESRD	Emergency Services
FFS	
FHLB	Federal Home Loan Bank
HAP	Housing Authority of Portland
HCDC	Housing and Community Development Commission
HELP	State Homeless Federal Funding
HOME	The name of a grant. Not an acronym.
HUD	U.S. Dept of Housing and Urban Development
IRCO	Immigrant and Refugee Community Organization
JOIN	Organization that places homeless people into housing.
LIHTC	Low Income Housing Transfer Credit
MCCJ	Multnomah County Criminal Justice
MFI	Median Family Income
MH	Mental Health
MHS	Mental Health System
NARA	National Alliance of Rehabilitation
NOFA	Notice of Funding Availability (Federal)
OCF	Office of Children and Families (no longer exists)
OHCS	Oregon Housing and Community Services
OHP	Oregon Health Plan
PATH	Mental health homeless program
PDC	Portland Development Commission
RASP	Rental Assistance Support Program
RCF	Residential Care Facility
RFP	Request For Proposal

SNC	Special Needs Committee
SNF	Skilled Nursing Facility
SSD	Social Security Disability
SSI	Social Security Income
SRO	Subsidized Rent Occupancy
TIF	Tax Increment Financing
TSU	Multnomah County DCJ Transition Services Unit

BEFORE THE BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

RESOLUTION NO. 03-139

Accepting the Report of the Special Needs Committee of the Housing and Community Development Commission, and Implementing the Recommendations Therein

The Multnomah County Board of Commissioners Finds:

a. Through parallel resolutions, Multnomah County, the City of Portland and the Housing Authority of Portland (the Partners) created and staffed the Special Needs Committee (SNC) of the Housing and Community Development Commission (HCDC) to assess the need for special needs housing in Multnomah County and make recommendations to stimulate its development.

b. On July 2, 2003, HCDC adopted the SNC's report with recommendations intended to result in development of more housing coordinated with services for special needs populations. For purposes of this resolution, the term "special needs populations" means those with disabilities, including severe and persistent mental illnesses, substance abuse disabilities, developmental disabilities, physical disabilities and multiple disabilities. Although most members of this population live alone, some are accompanied by family members and need larger housing units and family-oriented services.

c. Many persons with special needs served by Multnomah County and its contract agencies are unable to succeed because of lack of stable, affordable housing. Barriers to housing for these populations can include lack of income, lack of services that support housing success, criminal records, and unusual behaviors. As a result, people with special needs are disproportionately served by jails, hospitals, shelters, health clinics and other publicly and community-funded resources. Research shows that providing supportive housing to people with special needs is more cost effective and humane than continuing to use these scarce public resources. It is in the County's interest that significant new housing resources for special needs populations be created and preserved.

d. The SNC report describes a gap of 7890 units of Permanent Supportive Housing for people age 18-64, resulting in a chronically homeless population of about 3500 people with special needs in Multnomah County.

e. Filling the gap of 7890 units of permanent supportive housing resources should be a very high priority for available housing and services funds during the next few years. The community should set a target of meeting 50% of this housing need during the next five years. The need can be met by constructing new housing units, acquiring existing buildings for conversion to housing, refinancing

existing units to accommodate lower resident incomes, provision of permanent rent subsidies, and other means.

f. In order to fill the gap, Federal, State and local funds, including rent subsidy resources and tax increment funds generated by urban renewal districts, must be committed to developing more special needs housing. The County does not intend to decrease current funding in existing poverty programs to fund this effort.

g. The County and its Partners need to coordinate services with housing so that people with special needs can access and succeed in housing.

h. The efforts of the Special Needs Committee and its members have already resulted in new awareness, relationships and initiatives that are moving ahead to develop supportive housing. Those initiatives include obtaining a large grant from the Corporation for Supportive Housing for systems change to develop 400 new units of supportive housing for chronically homeless people with disabling health conditions; and the first-ever issuance of a coordinated Request For Proposals for special needs housing projects using Project Based Section 8 vouchers administered by the Housing Authority of Portland linked with City-controlled federal housing funds.

The Multnomah County Board of Commissioners Resolves:

1. The Board accepts and approves the Report of the Special Needs Committee of HCDC; and appreciates the work of all members of the Committee, in particular its Chair, Linda Kaeser.

2. The Board urges the City of Portland, the Portland Development Commission, the Housing Authority of Portland, the State of Oregon, and the City of Gresham to give the highest priority for housing funds to permanent housing for special needs populations until the gap is filled.

3. The County and its departments will join with Partners, including the City of Portland, the Housing Authority of Portland, the Portland Development Commission, nonprofit community housing and social service providers, the State of Oregon, and others to coordinate services with housing and implement the recommendations contained in the Report to create new permanent supportive housing units.

4. The County will implement certain recommendations in the SNC Report, including

   - finding new ways to expand Medicaid resources in order to create new housing-related services;

   - using Federally Qualified Health Center status to provide services to special needs populations that support housing success;

- strengthening partnerships between its services systems and the social housing industry through improving communications, creating training programs, participating in private market access programs, and incorporating housing relationships into social and human service program designs and plans; and

- developing, with its Partners, significant specialized new housing and service opportunities for the "hardest-to-house," i.e. chronically homeless people with special needs.

5. The County recognizes that implementing the recommendations in the Special Needs Committee report will be a critical element in the Portland area's efforts to end homelessness.

6. The County will participate in a review of existing rent assistance programs operated by the County and by others, to create a system that is streamlined, efficient and accessible to homeless and special needs populations.

7. The County will actively support strategies and tools to create new capital, operating and services resources for affordable housing, and will seek commitments at every opportunity to include supportive housing for special needs populations in any new housing resources that become available.

8. The Board requests that the Special Needs Committee oversee implementation of recommendations contained in the Report, including how to identify special needs families and improve their access to services and housing.

ADOPTED this 2nd day of October 2003.

BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

Diane M. Linn, Chair

REVIEWED:

AGNES SOWLE, COUNTY ATTORNEY
FOR MULTNOMAH COUNTY, OREGON

By _____
Agnes Sowle, County Attorney

Housing and Community Development Commission

SPECIAL NEEDS COMMITTEE REPORT

July 2003

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EXECUTIVE SUMMARY

This is the first report of the Special Needs Committee (SNC), of the Housing and Community Development Commission (HCDC) for Multnomah County.

Our community is experiencing a crisis in special needs housing. People with special needs, some of the most vulnerable members of our community, are unable to find safe, decent housing linked with the appropriate level of service. For lack of suitable supportive housing, too many people with special needs become inpatients at hospitals, are incarcerated, or enter the homeless system. This is neither humane nor financially prudent.

We believe that, if we can provide an adequate supply of supportive housing, we can ease the pressure on the mental health system, the corrections system, and the homeless system, as well as provide people with the homes and services they need and deserve. We can refocus resources in a more compassionate and economically efficient way.

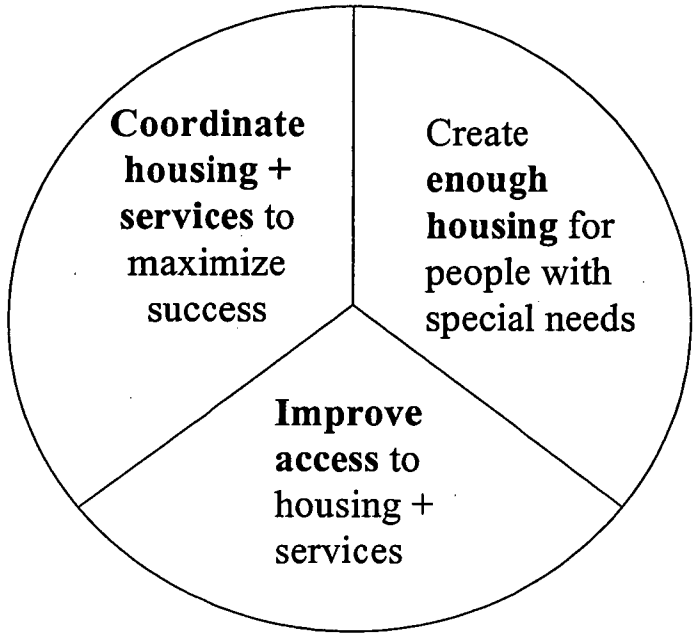
Throughout this report, we have used two important terms:

> **People with Special Needs**: are those with a severe and persistent mental illness, a substance abuse disability, a developmental disability, a serious physical disability, or a combination of these resulting in serious functional impairment. In this report, we focus on people who: meet these special needs criteria, are low income, do not have permanent housing, and will need some type of support to succeed in housing.
>
> **Housing + Services**: means the provision of permanent housing and support services in a linked or coordinated manner, although not necessarily by the same provider.

Over the past year there were almost 8,000 people with special needs in Multnomah County who needed – but did not have – permanent housing for all or part of the year. Of these, 3,500 were chronically homeless. People with special needs are more likely to have repeated episodes of homelessness and to remain homeless for longer periods.

Significant barriers stand in the way of developing and maintaining an adequate supply of special needs housing: lack of housing and service resources; lack of a shared understanding between housing experts and service experts; and lack of public awareness and support for vulnerable people and their housing needs.

The Special Needs Committee recommends an approach to reducing these barriers that requires improvements in three areas:



Public policy that supports **coordinating services with housing** will assist individuals with special needs to succeed in housing, and will encourage housing providers to make units available to people with special needs. Focusing mainstream services on the hardest-to-house can reduce homelessness. Cross training of housing managers and case managers strengthens both the service and housing systems.

We can **create enough housing for people with special needs** over time by increasing the proportion of housing resources – development funds and rent assistance – allocated to people with special needs. We can dedicate an "express lane" in the development pipeline for projects that package housing funds and service commitments. We can leverage more public and private resources.

We can **improve access to housing and services** by providing a comprehensive and culturally competent service plan to each individual, addressing housing, services, and food security needs. We can work with people with special needs who are currently hospitalized or incarcerated to make sure they have a service plan in place prior to discharge.

We believe that achieving success in all three areas will result in Multnomah County becoming a community where people with special needs live in decent, stable and affordable housing that is coupled with the support they need.

PROCESS

In late 2001, the Housing and Community Development Commission[1] (HCDC) assembled a Special Needs Committee (SNC) comprised of people knowledgeable about the current systems and with enough authority to direct and implement changes. The group included senior policy makers, funders, housing providers, service providers, and advocates. A list of members appears on the last page of this Report.

In spring of 2002, the Multnomah County Commission, the Portland City Council, and the Housing Authority of Portland Board of Directors charged the Housing and Community Development Commission's Special Needs Committee, through parallel resolutions (Appendix A), to:

- Assess the need for special needs housing Countywide, including the specific housing needs of individual special needs populations;
- Coordinate housing and service resources to stimulate development of special needs housing;
- Develop hard, realistic, and measurable targets for additional housing for persons with special needs;
- Leverage new resource streams for special needs housing development and operation; and
- Create models for special needs housing development and operation;
- Make policy recommendations to advance the development of special needs housing.

The Special Needs Committee met monthly from January 2002 through June 2003. The first meetings were devoted to an exchange of basic information about the affordable housing world and the discrete service systems for people with severe and persistent mental illness, physical disabilities, developmental disabilities, and/or substance abuse disabilities. The SNC also received information about the challenges faced by people with special needs in the corrections and community justice systems. The result of these discussions is a committee whose members now have a more holistic view of the challenges in special needs housing, and a common language for discussing them.

Tools developed to analyze the current situation include:

- Review of housing need and homelessness data for people with special needs and an inventory of special needs housing. (Appendix B summarized in Table 1, p. 16)

[1] HCDC is a fifteen-member volunteer citizen advisory Commission serving Multnomah County, the City of Portland and the City of Gresham. HCDC is designated as "the primary public forum in which policy development, resource coordination, and civic leadership are provided to address the County's affordable housing problems."

- Matrices of resources for: housing development, emergency housing, housing subsidies, and services.[2]
- An analysis of barriers to special needs housing. (Appendix C)

Based on this foundation, the committee developed:

- The Committee's vision, goals and long-term strategies for special needs housing. (Appendix D)
- Priorities for funding decisions about new housing projects, emphasizing housing for those with: the lowest income; the greatest risk of inappropriate institutionalization in shelters, hospitals, jails, or nursing facilities; and the greatest degree of disability. *See p. 24.*
- Criteria for allocation of project-based Section 8 resources, at the request of the Housing Authority of Portland, based upon SNC priorities but factoring in the risk of displacement. (Appendix E)
- Input on preserving facilities threatened with closure, including the Taft, Hoodview Residential Care Facility, and William-Elaine Residential Care Facility. (These projects also provided good "case studies" of special needs housing challenges, and catalyzed dialogue and increased understanding of the housing/social service relationship.)
- A Long-Range Goal Matrix, setting out the long-range goals and identifying strategies, and outcomes. (Appendix F)

Along with this Report, current initiatives of the SNC and its members include:

- Support of, and participation in, the application for the federal Interagency Council on Homelessness (ICH) grant, the "Collaborative Initiative to Help End Chronic Homelessness." If funded, mental health and addiction treatment, health care, and permanent housing with support services would be provided for 150 people.
- Participating with the Multnomah County Department of Community Justice in developing the "Social Security Income Continuum" project, along with representatives of other federal, state and county agencies. The SSI Continuum will connect disabled prison and jail inmates to entitlements before discharge, enabling them to receive benefits within 30-60 days after release. Access to SSI and Medicaid resources will enable special needs offenders to receive the housing and services they need to live stable, crime-free lives.

[2] The Committee intends to convert these matrixes to web-based resources that can be updated. Copies of the matrixes are available upon request.

- The City of Portland, Portland Development Commission, and the Housing Authority of Portland ("HAP") released a first-ever joint Solicitation of Interest for Special Needs and Affordable Housing Development, Columbia Villa Off-Site Replacement Housing, and a Project-Based Section 8 Pilot Project. This marks a concerted effort by the funders in our community to allocate a variety of scarce housing resources to special needs housing. These projects will inaugurate an "express lane" for special needs housing in the housing development pipeline for projects that package housing development dollars and service funding.
- HCDC has received a $5,000 grant from Eli Lilly and Company for a symposium to explore new ways to bridge housing and services resources to expand the supply of service enriched housing for people with special needs.
- Multnomah County Department of Human Services has agreed to work with affordable housing providers to help special need residents succeed and housing projects to remain stable. If a resident is experiencing a mental health crisis and is at risk of losing housing, the housing provider can use the Call Center to obtain emergency mental health services for the resident.

A major success for our community has resulted from the SNC committee's partnership with Multnomah County, the City of Portland, and other key stakeholders in a successful application to the Corporation for Supportive Housing (CSH) for a "Taking Health Care Home" grant funded by the Robert Wood Johnson Foundation.

This grant will fund systems change directed at ending chronic homelessness. The target population is people who have experienced long-term and episodic homelessness and have disabling health conditions, which is a significant cohort of the special needs population.

After this report has been accepted, the chartering jurisdictions will be asked to adopt a joint memorandum of understanding that will guide implementation of the recommendations in this report.

POPULATION

The Committee has focused on special needs populations who are the most *under-housed:* meaning those who do not have a place to live where they can remain indefinitely. The most under-housed special needs groups are extremely low-income[3] adults between the ages of 18 and 64, and unaccompanied minors. Their low incomes, service needs and problematic behaviors create challenges in obtaining and retaining housing. While most of the people in this group live in households of one, some live in families with minor children or with other household members. Because extremely low-income seniors 65+ are significantly under-served in mental health and addiction services, and have trouble accessing services if their disability is due to mental illness (other than dementia) or substance abuse, they are also included as a focus population.

DEFINITION:

A PERSON WITH SPECIAL NEEDS is an individual with a severe and persistent mental illness, substance abuse disability, developmental disability, serious physical disability, or multiple disabilities.

Focus Populations for the Special Needs Committee

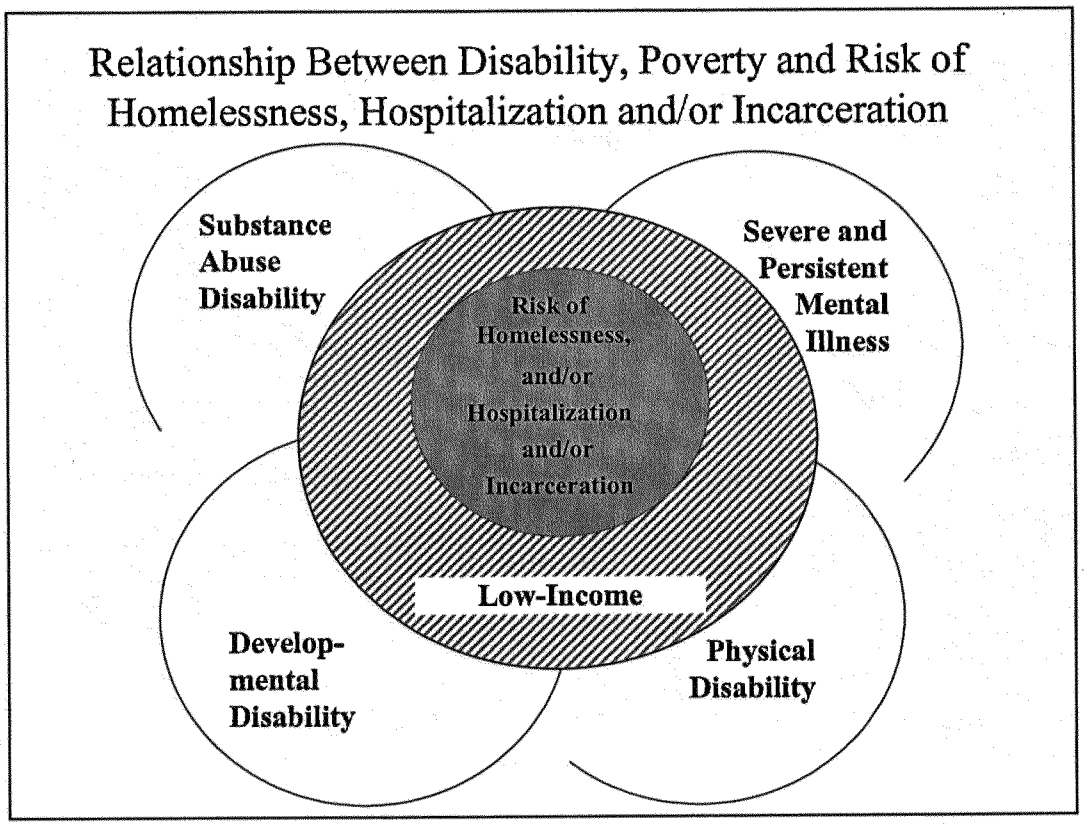
Focus Populations	Special Needs
Unaccompanied Minors	☑ Severe and Persistent Mental Illness ☑ Substance Abuse Disability ☑ Developmental Disability ☑ Serious Physical Disability ☑ Multiple Disabilities: two or more of the above
Extremely Low-Income Adults Age 18-64	☑ Severe and Persistent Mental Illness ☑ Substance Abuse Disability ☑ Developmental Disability ☑ Serious Physical Disability ☑ Multiple Disabilities: two or more of the above
Extremely Low-Income Seniors Age 65+	☑ Severe and Persistent Mental Illness ☑ Substance Abuse Disability ☐ Developmental Disability[4] ☐ Serious Physical Disability[4] ☑ Multiple Disabilities: two or more of the above

[3] HUD defines low-income as a household with income up to 50% of the Median Family Income (MFI). Extremely low-income households have incomes up to 30% MFI. MFI is set by HUD annually for the Portland Metropolitan Statistical Area. *See* Appendix H. For 2003, the MFI is $46,050 for a single person and $ 65,800 for a family of four. The 2003 federal poverty level for a household of one is $8,980 and a household of four is $18,400. This is equivalent to 20% MFI for a single person household and 28% MFI for a household of four. *See* discussion on "Effect of Poverty," p. 19.

[4] Services, often linked with housing, for these populations are funded by Medicaid community-based waivers, through County Developmental Disabilities and Aging & Disability Services.

These focus populations include individuals who often find themselves on the streets, or in the community justice system, homeless shelters, or hospitals. Lack of stable, affordable housing with adequate supports is a major contributor to homelessness and recidivism. An adequate supply of housing coordinated with services would reduce pressure on the jails, shelters, and hospitals of Multnomah County.

FIGURE 2



It is difficult enough to cope with a disability. This figure shows that, when disabilities overlap, or are combined with poverty, the risk of homelessness, hospitalization and/or incarceration increases sharply.

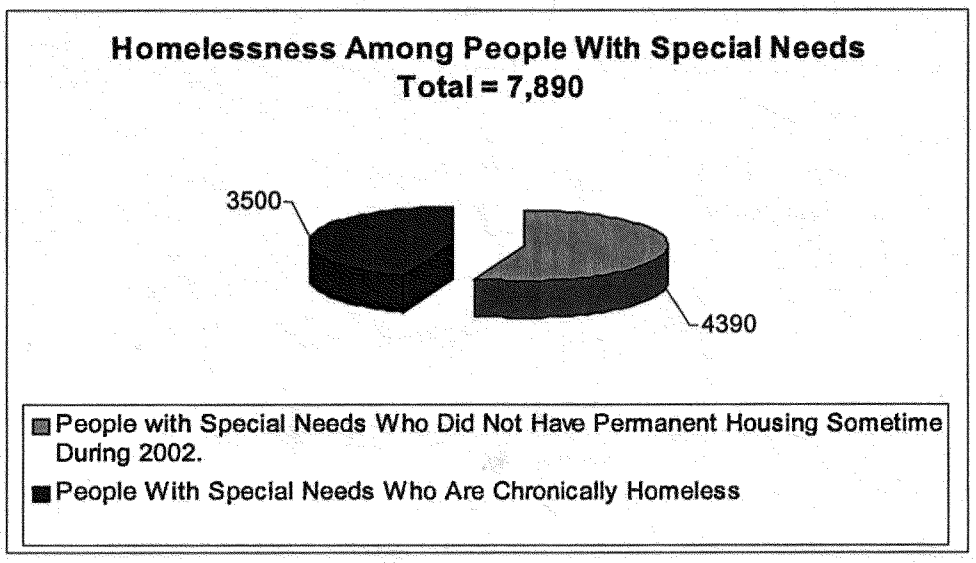
ESTIMATE OF NEED FOR HOUSING LINKED WITH SERVICES

Multnomah County is home to a large number of people with severe and persistent mental illness, physical disabilities, developmental disabilities, and/or substance abuse disabilities, many of whom have multiple disabilities.

The SNC has had difficulty collecting and analyzing data related to these populations. Each housing and service system uses different definitions and maintains different types of data. Additionally, clients often use multiple resources. Although the data below builds on reliable sources and attempts to unduplicate client counts, it lacks the certainty we would prefer. Nevertheless, our research clearly shows the lack of permanent housing and the extent of homelessness for those with special needs.

HOMELESSNESS AND SPECIAL NEEDS: During 2002, 7,890 County residents with special needs did not have permanent housing for part or all of the year, including about 3,500 persons experiencing chronic homelessness.[5] Chronic homelessness means a person has been homeless for more than a year or more than four times in a three-year period.[6]

FIGURE 3



Not only are a large number of people with special needs without stable housing, but people with disabilities are also greatly over-represented among the chronically homeless. They are more likely to have repeated episodes of homelessness and to remain homeless for longer periods.

A survey was taken of those seeking emergency shelter on March 27, 2002. Twenty-nine percent reported that they were eligible for services directed to the psychiatrically disabled, developmentally disabled, substance abusing and dual-diagnosed populations. Fifty-five percent of households of every size, and sixty percent of single adults, indicated a disability as the primary reason for their homelessness (e.g., substance abuse, mental illness, or a medical problem).[7]

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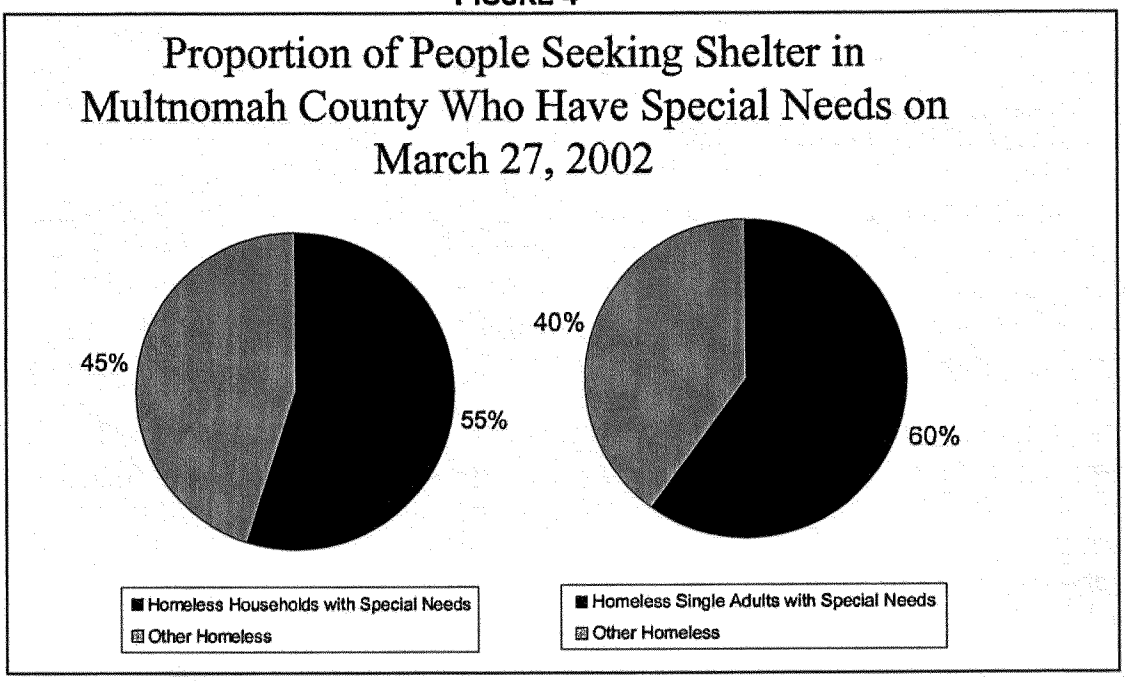
[5] This estimate is a blend of point-in-time and annualized data, as those who experience homelessness multiple times in a year are likely over-represented in point-in-time data.

[6] The federal definition of a Chronically Homeless Person is "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three years. To be considered chronically homeless, persons must have been sleeping in a place not meant for human habitation (*i.e.* streets) and/or in an emergency homeless shelter during that time."

[7] March 27, 2002 One Night Shelter Count, Multnomah County Office of School and Community Partnerships

FIGURE 4



A discouraging picture thus emerges of the shelter system as one of our main resources for housing low-income people with special needs.

LACK OF SHELTER: On any given night, our current homeless system is unable to serve approximately 17 percent of homeless people who seek assistance.[8] A street count found 1,672 unduplicated people sleeping outside on April 22, 2002.[9] One survey of Safe Haven in Portland showed the average length of time people with severe and persistent mental illness were homeless was 49 weeks, while the longest was 36 years.[10]

OFFENDERS WITH SPECIAL NEEDS: A study conducted on a small number of "the most frequently booked" in jails determined that about a fifth of these "frequent flyer" inmates were homeless and repeatedly cycled through jails, hospitals and shelters.[11] Other studies have confirmed that persons with disabilities are disproportionately represented in jails. Of the 1,010 offenders served by the Department of Community Justice Transitional Services Unit (TSU), 802 of them (79%) had at least one special need;[12] 80% of these had alcohol or drug abuse disorders as one of their diagnoses.

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[8] Based on turn-away rates from 1999-2002 One Night Shelter Counts.
[9] JOIN street count, April 22, 2002
[10] Housing and Community Development Commission Weeklong Needs and Gaps Survey, Feb. 25-March 3, 2002
[11] The Booking Frequency Pilot Project Report, Multnomah County's Sheriff's Office, January 2002
[12] Multnomah County Community Justice Department's Transitional Services Unit (TSU) enrollment records

A sub-population of people with severe and persistent mental illness is responsible for a disproportionate number of incarcerations. In 2000, for example, 3,800 individuals with identified mental health problems were booked into Multnomah County jails a total of 5,700 times. Nearly one-third were diagnosed with a serious mental disorder.[13]

HALF OF OREGON'S HOMELESS LIVE HERE: The statewide March 27, 2002 One Night Shelter Count shows that a disproportionate number of Oregon's homeless persons seek emergency services in Multnomah County. While 19% of the state's adult population reside in Multnomah County (666,350 of 3.4 million), 51% of Oregon's homeless single adults sought shelter in Multnomah County.

Of all the adults seeking shelter in Oregon who were homeless due to chemical dependency, mental illness, and/or medical problems, over half sought shelter in Multnomah County.[14] Of 3,813 homeless adults enrolled in state substance abuse treatment services during the 2001-02 fiscal year, Multnomah County served 2,143 (56%).[15]

HOMELESS FAMILIES

It is difficult to obtain comprehensive data on homeless families. Again, we know more about families that seek shelter through the homeless families system than about families that live doubled-up, or in cars, or camp in our local parks. According to the November 2002 One Night Shelter Count, 38.6% of the homeless family population that sought shelter statewide was in Multnomah County.

The homeless family system does not currently collect data on special needs. In one study sponsored by the Robert Wood Johnson Foundation, 41% of adults in homeless families self-declared that they were suffering from alcohol or drug dependencies or addictions, or had used hard drugs during the past year. In an annual progress report filed by one local homeless family agency, out of 144 families, 4 presented with mental illness, 3 self-reported for substance abuse, and 5 had a physical disability. However, these numbers may be misleading, since homeless families coming from substance abuse treatment are directed primarily to other agencies.

There is a clear need to develop better data on homeless families with special needs, to inform policy and program development.

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[13] From 1995 to 2001, the number of individuals with mental health problems in Multnomah County jails increased from 1,500 to 3,400, with a peak of 3,800 during 2000. Nearly one-third of the 3800 were diagnosed with a serious mental disorder. *See Mentally Ill Treatment*, by Bill Midkiff, Health Services Administrator, Multnomah County Health Department, Corrections Health Division, November 2002.

[14] March 27, 2002 One Night Shelter Count, Oregon Office of Housing and Community Services

[15] Oregon Department of Human Services, Office of Mental Health and Addictive Services

HOMELESS YOUTH

It is difficult to obtain a comprehensive data picture of homeless youth with special needs. Of the population of homeless youth, only a fraction apply for services and go through the initial screening process. This is what we know: In calendar year 2002, 465 youth presented for screening into the homeless youth continuum of services. At this time, youth reported information about their medications, on-going health problems, and desire for services. Twenty-five percent of them reported that they had an on-going health problem at the time of screening, and 30% requested services for health care. Only 5% requested drug and alcohol treatment.

Homeless program staff completed 299 actual assessments in 2002. At this time, the youth have an opportunity to give information about their mental health and substance abuse disability history. Nearly one-third reported that they had previously attempted suicide. More than half had received counseling in the past. Nineteen percent had received psychiatric counseling, and 16% had received residential treatment of some kind. Eight percent indicated that they would like to receive mental health services/counseling at the time of the assessment, and were referred.

We cannot ascertain at this time what percentage of homeless youth have either physical or developmental disabilities. This information is not specifically requested under current practice, although the caseworker could enter the data in the comments filed.

There is a clear need to develop better data on homeless youth with special needs, to inform policy and program development.

SUMMARY OF NEED – ADULTS 18 - 64

We have developed a summary of the need and unmet need for permanent housing for people with special needs, compiling data from many sources with the intent to be as comprehensive as possible, while avoiding duplication where feasible. This section attempts to quantify the number of permanent housing units required to meet the needs of people who:

- **have special needs**, defined as: a severe and persistent mental illness, a substance abuse disability, a developmental disability, a serious physical disability, or any combination of these conditions resulting in a serious functional impairment; and
- **are age 18-64**; and
- **are extremely low income**, defined as 0 to 20% of Median Family Income[16]; and
- **do not have permanent housing** (i.e. are homeless, sleeping on someone's couch or in their car, in jail, or in transitional housing with no place to go); and

[16] See footnote No. 3.

- **are likely to need some kind of supportive services** and/or enhanced housing management to succeed in community-based housing.

TABLE 1. SUMMARY OF NEED AND UNMET NEED FOR PERMANENT SUPPORTIVE HOUSING

Selected Special Need Populations Age 18-64	Estimate of Need For Special Needs Permanent Housing	Current Permanent Unlicensed Housing[17]	Unmet Need for Permanent Housing
Severe & Persistent Mental Illness	1,683	464	1,219[18]
Substance Abuse Disability	3,086	572	2,514[19]
Developmental Disability	520	20	500[20]
Serious Physical/ Functional Disability (includes AIDS/HIV)	2,540	209	2,331[21]
Multiple Disabilities[22]	1,375	49	1,326[23]
Totals	**9,204**	**1,314[24]**	**7,890**

In 2002, 9,204 people age 18 to 64, with extremely low-incomes and special needs, required a combination of permanent Housing + Services. Currently 1,314 units of such housing are available, leaving an unmet need for 7,890 additional units.

- **Annual:** Numbers are annual, e.g. 1,219 people with a severe and persistent mental illness did not have permanent housing for part or all of last year.

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[17] Reflects current unlicensed housing only.
[18] Number derived from combination of OMHAS CMPS Report FY 01-02 identifying 1,019 MH clients who were homeless at time of service enrollment, plus March 2002 One Night Shelter Report identifying 200 with Mental Illness.
[19] Number derived from a combination of the OMHAS FY 01-02 Report identifying 2,143 clients who were homeless at time of service enrollment, plus 371 persons from the March 2002 One Night Shelter Report.
[20] Number derived from data from data from 3 Agencies: MCDDS, ARC of Multnomah County, and ILR.
[21] Number includes 682 persons from Portland EMA AIDS/HIV Housing Plan plus 1,649 persons from Multnomah County Housing Needs Report.
[22] The category, Multiple Disabilities, are people who were reported in this category as having includes a combination of conditions resulting in a functional impairment, including: developmental, mental, physical, chemical, and cognitive.
[23] Number derived from Multnomah County 2001 Housing Needs Report and includes any combination of conditions including physical, developmental, mental, cognitive, and chemical
[24] Of these, 946 units support people with special needs who have been homeless or are at-risk of homelessness

- **Unlicensed:** The inventory of housing in this table is all unlicensed housing for specific populations, with varying degrees of linkage to services. While some people without permanent housing may qualify for licensed housing (e.g. foster homes, group homes, or residential care facilities, which serve people requiring a greater intensity of services), we believe most do not.

- **Current Permanent Housing:** This is the current inventory of permanent housing which is affordable to those with extremely low incomes, identifiable for a specific disability group, and linked to services.

- **Housing + Services:** Most people reflected in this table will need housing linked with some kind of enhanced property management or supportive services to succeed in maintaining permanent housing.

- **System Contact:** The table represents those who had contact with the system in some way – who sought services or shelter, and/or who were found during the one-night shelter/street counts that attempted to locate all homeless people.

- **Homelessness:** The focus is on people with special needs who need but do not have permanent housing, which is not the same as being homeless: some are only at risk of being homeless. Only homeless people who also have special needs are included.

- **Families:** No firm data is available on how many single adults, couples, or families are included; indicators support estimating about 10% of those in each category represent people living in families, and 90% singles or couples.

- **Gap:** The current unmet need is for 7,890 units of special needs housing. This gap results in a large population that is constantly homeless (such as the 3,500 people with special needs who experienced chronic homelessness last year), or who are at risk of homelessness (such as the 4,390 people with special needs who cycled into homeless at some time last year). The gap in housing may be met by licensed or unlicensed units.

- **Multiple Disabilities:** The numbers probably under-represent the number of people with multiple diagnoses, due to different methods of collecting data, different definitions of disabilities, limitations of self-reporting, and masking by more overt symptoms. However, an increase in multiple disabilities would likely result in a decrease in single diagnosis categories.

- **Duplication:** There may be some duplication in the table, as it is not currently possible to sort by client name or identifier among the various service systems' databases. We do not believe the duplication is large.

- **Undercount:** We believe, however, that this data significantly undercounts the need for permanent housing for people with special

needs, because many have not made contact with any system for shelter or services.

Unaccompanied Minors with Special Needs

We found no reliable data on the number of unaccompanied minors with special needs. There is a clear need to develop data on unaccompanied minors with special needs, to inform policy and program development.

Seniors over age 65 with Mental Illness or Substance Abuse Disorder

Older adults age 65+ with a primary diagnosis of mental illness, or with a combination of mental illness and other conditions resulting in a functional impairment, have similar needs for housing coordinated with services as the 18-64 population. The most critical need is for low-income seniors who have both a physical disability and mental illness.[25] According to Multnomah County Aging and Disability Service's Housing Placement Specialist, the most frequent reason case managers sought assistance for locating an Adult Foster Home or Residential Care Home was to serve these seniors, whose medical needs and/or mental illness had exhausted family and mainstream housing providers. During the three-year period from 1996-1999, ADS worked with 633 clients who fit this profile.

The second most critical need is for low-income seniors with only a primary mental health diagnosis. They are under-served by the mental health system and, if they do not have a physical impairment, they are not eligible for Medicaid-funded services.

Increasing Need: Budget cuts this fiscal year and anticipated in the next biennium will likely increase the numbers of individuals and families who will lose stable housing due to cuts in their services and/or income supports. This will increase the number of people experiencing homelessness. For example:

- 1,090 adults with disabilities who had not yet qualified for federal Social Security Income (SSI) or Social Security Disability (SSD) benefits lost their income, due to the elimination of the state-funded General Assistance (GA) program on January 31, 2003. Of these, 125 recipients were already homeless.
- 1,100 ADS long-term care clients, who primarily live at home, lost care services provided under a Medicaid waiver.

In Multnomah County, voters do not want services cut. Some of the support for Measure 26-48, the temporary local income tax passed in May 2003, was from voters who wanted to restore a portion of the safety net for low-income people. Likewise, legislators are considering changes to the State budget to partially

[25] There is consensus among the ADS Public Guardian Office, the ADS Adult Protective Service Office, social workers and the senior community service network that seniors with very low incomes, mental illness and medical needs are most in need of Housing + Services. There are few housing/service options that can handle both.

restore some previous service cuts. The following cuts may be partially or temporarily reversed:

- Eligibility for the Oregon Health Plan has been reduced to mandatory groups. Low-income people who could previously qualify for a range of medical, mental health, and addiction treatment services under OHP may now only qualify for prescription medications, subject to co-pays and premiums.[26]
- Oregon has eliminated the Medically Needy program, resulting in loss of mental health treatment, medical transportation, alcohol and drug treatment, and prescriptions for 1,955 ADS clients.
- 4,000 previously eligible Multnomah County mental health consumers became ineligible for mental health services after State mental health program reductions and OHP cuts.
- Between 460-750 Multnomah County residents lost coverage to pay for methadone due to OHP cuts.

Effect of Poverty

Many of the housing challenges faced by people with special needs are directly related to income. Although some people with special needs earn a sufficient wage to purchase housing and health care, those with severe disabilities are often unable to earn enough to provide for their basic needs. Lack of ability to earn a good income, and thus reliance on low wages or public benefit levels, severely limits or eliminates housing choice.

The U.S. Department of Housing and Urban Development (HUD) issues the Area Median Income for Multnomah County on an annual basis. *See* Appendix .No more than 30% of income should be spent on rent. Recipients of SSI have income supplemented up to $552/month, or 14% of the Area Median Income for a single person household, and should spend no more than $165 on rent and utilities. The average recipient of SSD has an income of $800/month, or 19% of Area Median Income, and should spend no more than $240 on rent and utilities. However, fair market rent in Multnomah County in 2003 for a studio apartment is $508 per month; a one-bedroom apartment is $625; and a two-bedroom is $771.

In Multnomah County's housing market, low income has extremely harsh consequences. The Consolidated Plan for Multnomah County, prepared by HCDC to meet HUD requirements, has documented a significant loss of housing affordable to low-income people within the County over the past 12 years. Increasing market rents and loss of restricted-rent housing projects have similarly resulted in greater levels of homelessness for people with special needs locally and throughout the nation.

[26] 2,100 ADS clients had OHP services significantly reduced or eliminated.

In the late 1990s, the City of Portland created the Housing Investment Fund to develop subsidized units, producing a record 4,000 units over 5 years. However, no concerted effort was made to link persons with special needs to these units. Looking at this situation, the City Club of Portland has recently recommended priority funding for housing for people with special needs, and a massive program of rent assistance so that people with special needs can rent on the open market.[27]

THE HARDEST-TO-HOUSE

Another set of challenges relates to people whose level of disability or combination of disabilities puts them into the "hardest to house" category. The hardest-to-house tend to exhibit problematic behaviors, have poor rental histories marked by multiple evictions, and often have criminal records. People with psychiatric disabilities, especially those with a co-occurring addiction disorder or another additional disability, are often in this group of hard-to-house people.[28]

Even when rental subsidies are available, people who are hard-to-house will find it difficult to secure housing.

The Challenge of Housing the Hardest to House

The "hard to house" population becomes the "chronically homeless," living on the streets, in shelters or transitional housing, cycling through jails, hospitals, and nursing homes, and using resources disproportionate to their numbers. Some of the recommendations in this report target this population specifically, with the belief that better serving this group will increase the cost-effectiveness of our human service, housing and corrections systems.

The Housing Authority of Portland reports that its Section 8 voucher program has a 17% turn-back rate. This means that 17% of people with a voucher guaranteeing that the federal government will pay the difference between 30% of their income and a reasonable rent cannot find a landlord willing to rent to them. HAP's analysis shows that many of those who turn back their vouchers fall in this hard-to-house category.

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[27] *See* the City Club of Portland Report: *Affordable Housing in Portland*, February 2002. See the report at http://www.pdxcityclub.org/afhous.pdf

[28] Research done by the Multnomah County Mental Health Design Team, created in 2000, supports this. They noted the difficulties of housing and serving persons with a psychiatric disability who also have an additional issue, such as: being under 25; having substance abuse issues; having a developmental disability; having involvement in the criminal justice system; or being physically compromised.

SUPPORTIVE SERVICE NEEDS

The most vulnerable people with special needs often require supportive services to succeed in housing. The variety of needed services - from medication management to housekeeping assistance to food security to money management – calls for a variety of housing and service models.[29]

DEFINITION: SUPPORTIVE SERVICES – the range of supports needed for people to be successful in housing.

The SNC has developed the term **HOUSING + SERVICES** to mean the combination of housing and the appropriate level of services to meet the individual's needs.[30] When a family member has a disability, services may extend to the needs of other family members, including arranging for childcare, and providing transportation to school and medical appointments for the children in the household.

DEFINITION: HOUSING + SERVICES – Permanent housing that incorporates supportive services into housing operations, and/or coordinates with outside service providers for supportive services to meet the resident's needs.

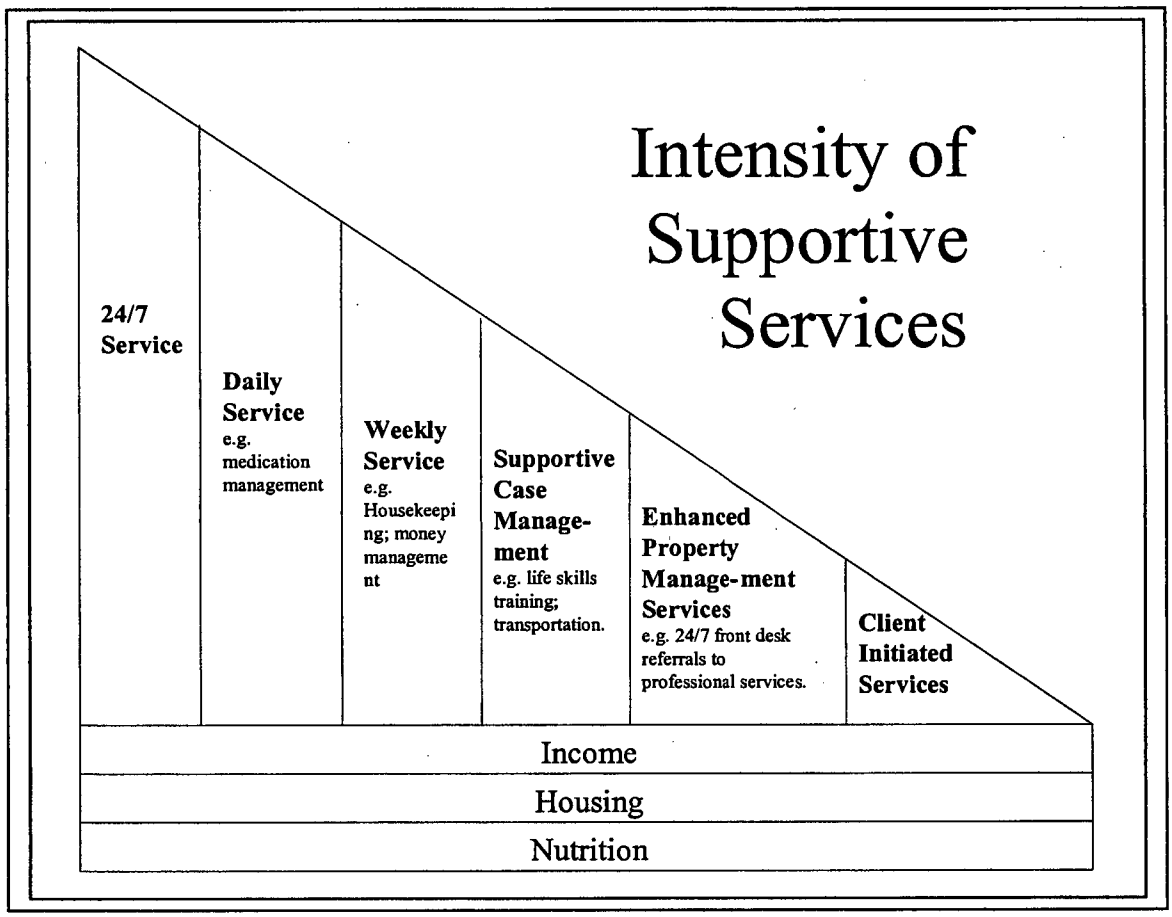
The continuum of Housing + Services types ranges from a licensed care facility with 24-hour care provided on-site, to a standard affordable apartment with client-initiated services provided off-site. There are currently a variety of options available, albeit in limited quantities. Future work should include evaluation of these models for suitability, cost-effectiveness, and adaptability to changing funding levels.

[29] Professional medical and dental treatment is an important issue that falls beyond the scope of the Special Needs Committee and this Report.

[30] We use Housing + Services instead of the more commonly used "supportive housing," because we found that "supportive housing" has some very specific definitions in certain contexts, resulting in confusion.

The table below describes the spectrum of intensity of supportive services. Many of these services could be provided on-site or off-site. The housing provider could provide them, or other providers could coordinate their services with the housing. Generally, more intense services are more expensive. However, even the most intense services are less expensive than homelessness, incarceration, or hospitalization.

FIGURE 5



New and innovative Housing + Service models may be needed to match service capacity to housing, especially given Oregon's current cutbacks in service delivery.

VISION & GOALS

VISION FOR THE FUTURE

Although significant barriers stand in the way, we believe that it is possible to develop and maintain an adequate supply of special needs housing and coordinated services.

> **VISION FOR THE FUTURE:**
>
> In Multnomah County, people with special needs have decent stable affordable housing for themselves and their families, along with the support and services they need for a good quality of life.

REORIENTING TOWARDS HOUSING + SERVICES

Experience shows that housing coordinated with services is a critical element to the success of people with special needs. Recent research shows that homeless people with disabilities who moved to permanent supportive housing experienced marked reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated. [31]

In Multnomah County, we can significantly reduce homelessness and inappropriate institutionalization of low-income people with special needs if we **reorient** our social service and housing systems to do three things[32]:

1. Coordinate housing + services to maximize success of people with special needs in permanent housing.
2. Create enough housing for people with special needs, including housing linked to services and housing for the hard-to-house.
3. Improve access to housing + services, including outreach to the hard-to-house.

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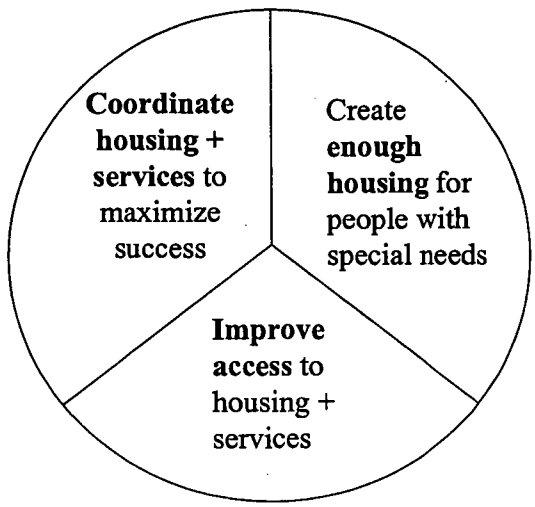
[31] Research by Corporation for Supportive Housing, in January 2003 issue of their publication, *Opening Doors*. In 2001, the University of Pennsylvania's Center for Mental Health Policy and Services Research compared 4,500 homeless people with severe mental illness who moved into supportive housing, with a control group who were not offered permanent housing. They found that those who moved into supportive housing experienced marked reductions in shelter use, hospitalizations , and time incarcerated. Prior to living in permanent supportive housing, the people in the study used an average of $40,449 per person per year in such services; after supportive housing, there was an average reduction in service use of $16,282.

[32] These recommendations are consistent with those made by the Multnomah County Mental Health Design Team and the Multnomah County Health Department, Corrections Health Division Administrator.

These three necessary actions have become our primary goals, and are used to organize our recommended strategies, tasks and outcomes.

FIGURE 6



Adequate funding is obviously an issue for both housing and services. But we also believe that when the systems are reoriented towards these goals, resources will be used more effectively, outcomes in housing stability will be improved, and the strain on shelters, jails, and hospitals, will be reduced.

GOALS

1. <u>Coordinate housing + services</u> to maximize success of people with special needs in permanent housing.

Service systems are generally based on a person-centered model: the client is either eligible or not eligible for services at different times; services may be reduced or eliminated based on federal, state, or local budget levels; or the client could experience a crisis that may or may not be referred to or responded to by service systems. Cutbacks or reconfigurations of the service systems can destabilize clients.

The affordable housing system, on the other hand, is asset based. The housing project itself must be managed to remain healthy – *i.e.* residents must be safe, staff must feel safe, rent must be collected to ensure financial solvency, and the physical premises must be maintained. Clients who experience "unmanaged" crises often create stress for staff and other residents, and are often unable to make rent payments. Eviction is frequently the result.

Large cutbacks or reconfigurations in social services systems can destabilize entire housing projects by significantly altering or eliminating subsidies and services that have allowed tenants with special needs to succeed in housing. The effects of large-scale reconfigurations may be felt for years. Housing

providers, after experiencing unreliability in social services, can become unwilling to continue to make units available to people with special needs.

Social services from each system (mental health, substance abuse, developmental disabilities, corrections, and aging and disability services) need to be reliable and coordinated with housing availability if we are to be successful in providing more special needs housing opportunities. This is a policy issue that should be discussed and resolved at the highest levels.

2. Create enough housing for people with special needs, including housing linked to services and housing for the hard-to-house.

Housing Supply

The Consolidated Plan for Multnomah County, prepared by HCDC to meet HUD requirements, documents that there is an inadequate supply of housing affordable to people earning less than 30% of the area median income.[33] This market fact has created a bottleneck, preventing people from moving out of shelters and transitional housing into permanent housing.

Limited public funding has been the main engine of special needs housing development. Legislative efforts to create a sustainable funding source, such as a real estate transfer tax, should be supported vigorously, but may not succeed. Accordingly, the proportion of public funds allocated to special needs housing must be increased.

Rent subsidy programs, coordinated with appropriate services, can help match some special needs households with the private housing market. Short-term, as well as long-term, rent subsidy programs should be expanded.

We must also increase the number of willing housing providers. One tool is the Fresh Start program.[34] Fresh Start helps overcome barriers to housing by creating a partnership between case managers, landlords/property managers and tenants. Landlords/property managers agree to rent to people who would not qualify under standard screening criteria, in return for commitment by the tenant's case manager to provide ongoing support to the tenant. By bringing the

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[33] HUD regulations state that housing is "affordable" if rent plus utilities do not exceed 30% of the household's gross income. An individual receiving SSI of $552 per month can afford a rent of $166. Fair market rent for a studio apartment in the Portland metropolitan service area is $508 per month. Thus, a renter with SSI income, who is unable to secure a Section 8 certificate or other subsidized housing, can expect to pay over 90% of his or her income on housing.

[34] Fresh Start was developed in 1998 by a coalition of property management, legal and social service providers to meet the needs of the downtown singles population. Between March 1998 and August 2000, 210 units were rented to people using Fresh Start referrals. 77% of these tenants (167) went on to become successful renters. The one social service agency that made 70 percent of the referrals had a 79 percent success rate. Recently, the Bureau of Housing and Community Development (BHCD) has decided to bring the Fresh Start program in-house to ensure quality control and monitoring.

landlord/property manager, case manager and tenant together to resolve rental problems as they arise, Fresh Start helps prevent evictions and has had success in breaking the cycle of homelessness for 77% of participants.

We must also develop a public consensus that results in neighborhoods that are welcoming to housing for people with special needs. This may require assurance to neighbors that adequate, long-term services will be provided to support the new residents' special needs.

Housing Funding Priorities

The committee developed criteria to be used in evaluating and prioritizing projects to assist special needs populations.

Projects that meet all three criteria and show linkage with services should receive the highest priority.

CRITERIA FOR FUNDING
SPECIAL NEEDS HOUSING PROPOSALS

1. Serves people with incomes at or below 30% of area median income, with an emphasis on those with incomes below 20% AMI.
2. Serves those at risk of becoming homeless or otherwise institutionalized inappropriately.
3. Serves those with the greatest degree of disability.

Private Sector Investment

There is a lack of private sector understanding of the funding programs for special needs housing, especially with the multiple sources and delivery points, and inconsistent program requirements. The unpredictable stream of funding for these programs, and the lack of a seamless delivery mechanism, adds to confusion. The current budget situation amplifies risks for private lenders on such projects, and jeopardizes future investment. Some degree of certainty is critical to attract private sector resources to produce much needed housing for people with special needs.

Housing + Service Funding Opportunities

Services that allow a person with special needs to be successful in housing typically cannot be funded by affordable housing development funds[35].

[35] There is a statutory prohibition against using tax increment funds for services. Community Development Block Grant funds may be used for services, but are subject to a "public services" cap of 15%.

Therefore funding that can be used for services must be aggressively sought. For example, some believe that federal Medicaid matching funds could be increased, to provide services coordinated with housing.

A barrier to this goal is that each service system offers a different menu of services to its eligible individuals. This is especially problematic when individuals have multiple disabilities or service needs not readily served by the menu offered.

There are also large gaps in service availability, excluding many people who need assistance. Others receive some but not all of the help needed. Federal Medicaid regulations for each program, and corresponding Oregon Medicaid Waivers (the plans approved by federal officials that govern how Medicaid programs are provided), are focused on each population separately, also contributing to gaps in coverage. Although Oregon has some of the most significant waivers in the nation, there are limited State resources for "match," forcing difficult decisions about whom to serve and what services to provide.

Frequently, there are barriers to using funds in ways that would maximize our ability to provide and support housing. The SNC believes there is opportunity to better leverage our limited state and local financial resources, and believes we should actively work with the state to seek better coordination of state policy, and improved Medicaid Waivers. We also believe there is the ability, even under existing regulations, to do more to support people in housing.

3. <u>Improve access</u> to housing + services, including outreach to the hard-to-house.

While access would naturally improve for many people if increased amounts of housing and services are available, other major barriers to access would remain.

Providers of both supportive services and housing frequently fail to refer to each other. Social service providers may not understand housing alternatives or actively link their clients to needed housing. Landlords and property managers generally do not see their role as linking tenants to needed services, and both public and private housing providers need education about available services. Policy and funding priorities should encourage housing and service providers to work together to ensure that individuals with special needs are offered both housing and services, as needed.

However, some people with special needs do not seek permanent housing, fail to access or are rejected from social services, or are otherwise hard-to-house. Persistent outreach is needed to maintain contact with hard-to-house people, and individualized plans should assist them to accept and succeed in permanent housing. While the intensive level of supportive services needed for this population is expensive, we believe the investment will be more than recovered with savings from police, corrections, shelter, and hospitalizations.

RECOMMENDED ACTION STEPS FOR 2003-2005

After developing our vision and long-term goals, the Committee created long-term strategies, which would move us toward these goals. See Appendix G. We then assessed these strategies in light of current circumstances, including budget cut backs. We recommend the following action steps for the 2003-05 period.

1. **Increase financial resources for social services related to housing.** Find new ways to leverage County and other financial resources to expand services associated with supportive housing, and implement additional ways to coordinate housing and service funding streams. *(Relates to Goal 1. Coordinate Housing + Services)*
    a) Find new ways to match housing operations resources with Medicaid.
    b) Explore creating a County General Assistance program using funds currently used for rent assistance, housing subsidies, etc. Seek reimbursement from the Social Security Administration when the client is deemed eligible for SSI or SSDI.
    c) Maximize use of Federally Qualified Health Center status to provide psychiatric services, case management, etc., to support housing stability, thus obtaining more federal matching funds.
    d) Maximize other federal resources such as USDA food programs, social service and criminal justice block grants, McKinney, Community Development Block Grant (CDBG), and workforce support programs.
2. **Increase the proportion of housing funds allocated to housing for people with special needs.** *(Relates to Goal 2. Enough Housing)*
    a) All involved jurisdictions (City of Portland, Portland Development Commission, City of Gresham, State of Oregon, HUD, the Housing Authority of Portland and Multnomah County) should make development and preservation of supportive housing a high priority for use of publicly-funded housing development resources.
    b) A significant portion of Urban Renewal District revenues should be dedicated to housing for people with special needs.
3. **Strengthen the partnership between the human service system and the social housing system.** Strengthen both systems through shared priorities and increased cooperation. *(Relates to Goal 1. Coordinate Housing + Services)*
    a) Expand and develop the ongoing group composed of human services management personnel and social housing leadership; focus on maximizing the success of people with special needs

within housing environments, e.g. provide updates, cross-educate, plan new service and housing opportunities, and coordinate responses to new issues.

b) Service systems and housing providers should work together to protect housing assets that serve special needs populations from destabilization resulting from cutbacks and reconfigurations in social service systems.

c) Expand programs that provide incentives for non-profit and for-profit landlords to house people with special needs. Fully implement the Fresh Start program.

d) Use capital and rent subsidies to buy down rents of units currently affordable to households at or above 50% MFI, reprogramming admission criteria to target the "hardest-to-house."

e) Create a cross-training program for housing management personnel who deal with special needs residents, and for case managers to learn about housing opportunities and challenges.

4. **Continue the City/County/HAP partnership** that has created new understandings, policy directions and systems changes in the direction of maintaining and creating new special needs housing. Include the City of Gresham. *(Relates to Goal 2. Enough Housing)*

   a) Provide for HCDC oversight of implementation of these recommendations. Adopt outcome indicators and measure progress towards our **Housing + Services** goals.

   b) Create an "express lane" in the development pipeline for special needs housing projects (especially those targeted to homeless) by coordinating resources into joint RFPs, and packaging development dollars and service commitments.

   c) Create and staff a high level interagency body of funders with authority to integrate funding streams and create and maintain the "express lane" for special needs housing projects.

   d) Continue the City-County Pilot Special Needs Housing Set Aside for at least another three years while the "express lane" in the pipeline is developed.

   e) Underwrite new housing projects (or re-underwrite old ones) that serve special needs tenants to provide for Enhanced Property Management, which provides extra support ON SITE at housing projects serving people with special needs. This model has been developed successfully in Seattle, WA.

5. **Develop services and housing targeted to the "hardest-to-house."** *(Relates to Goal 1. Coordinate Housing + Services, Goal 2. Enough Housing, and Goal 3. Improve Access)*

a) Develop specialized activities targeted specifically to chronically homeless people with disabilities. Expand the Assertive Community Treatment (ACT) team model. The ACT team model engages chronically homeless individuals, houses them, and arranges for mainstream health, mental health, addictions, employment and other services after a person is initially housed. ACT teams effect a resolution of the problems that cause homelessness.

b) Review the myriad of rent assistance programs operated by the City of Portland, Multnomah County, HAP and others, and create a system that is streamlined, efficient and accessible to homeless and special needs populations.

6. **Create new resources dedicated to special needs housing.** *(Relates to Goal 2. Enough Housing)*

   a) Support the creation of a Real Estate Transfer Tax for affordable housing; a local bond issue for affordable housing development; and establishment of a National Housing Trust Fund.

   b) Establish goals within any new housing funds to be spent for people with special needs;

   c) Increase the proportion of housing funds, from all public and private sources, used for housing for people with special needs.

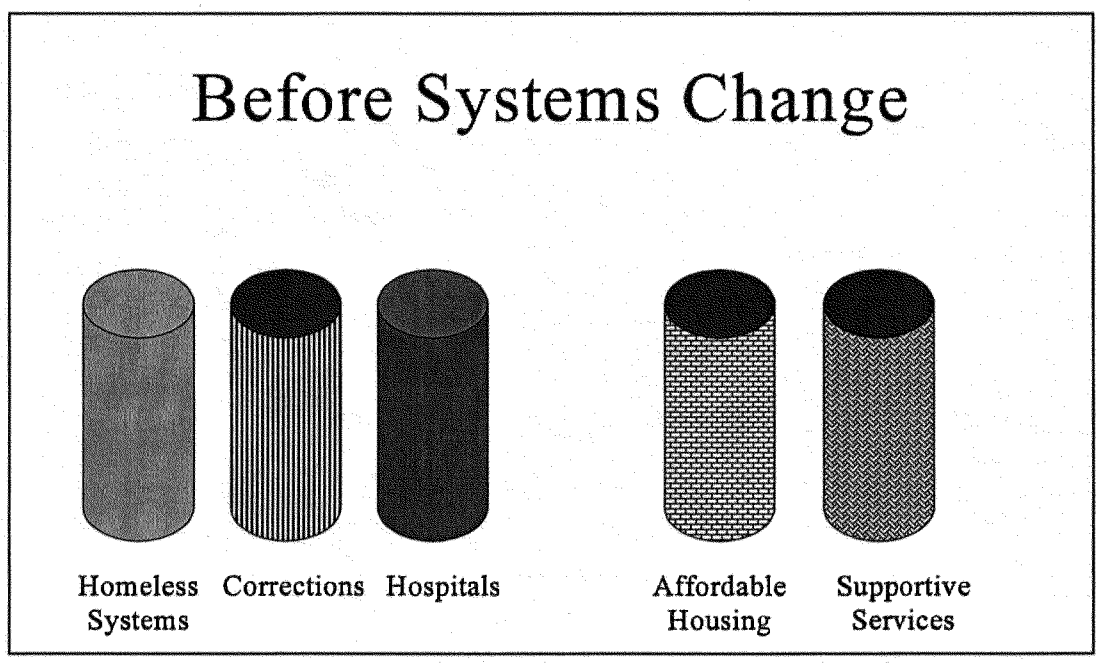
   d) Short and long-term rent subsidy programs should be expanded.

   e) Develop strategies to attract private lending capital.

RESULTS

We believe that, if we implement the Action Steps above in the next two years, and embrace the long-term strategies in Appendix D, we will be creating the conditions for permanent system change. We will know if we have succeeded, because both our housing and service systems will be different. The systems will be more integrated, and some funding will shift to support a Housing + Services strategy. As a result, fewer people with special needs will cycle through shelters, jails, hospitals and the street, and people with special needs will no longer be over-represented in the homeless system. Figures 7 and 8 illustrate the "before" and "after" of system change.

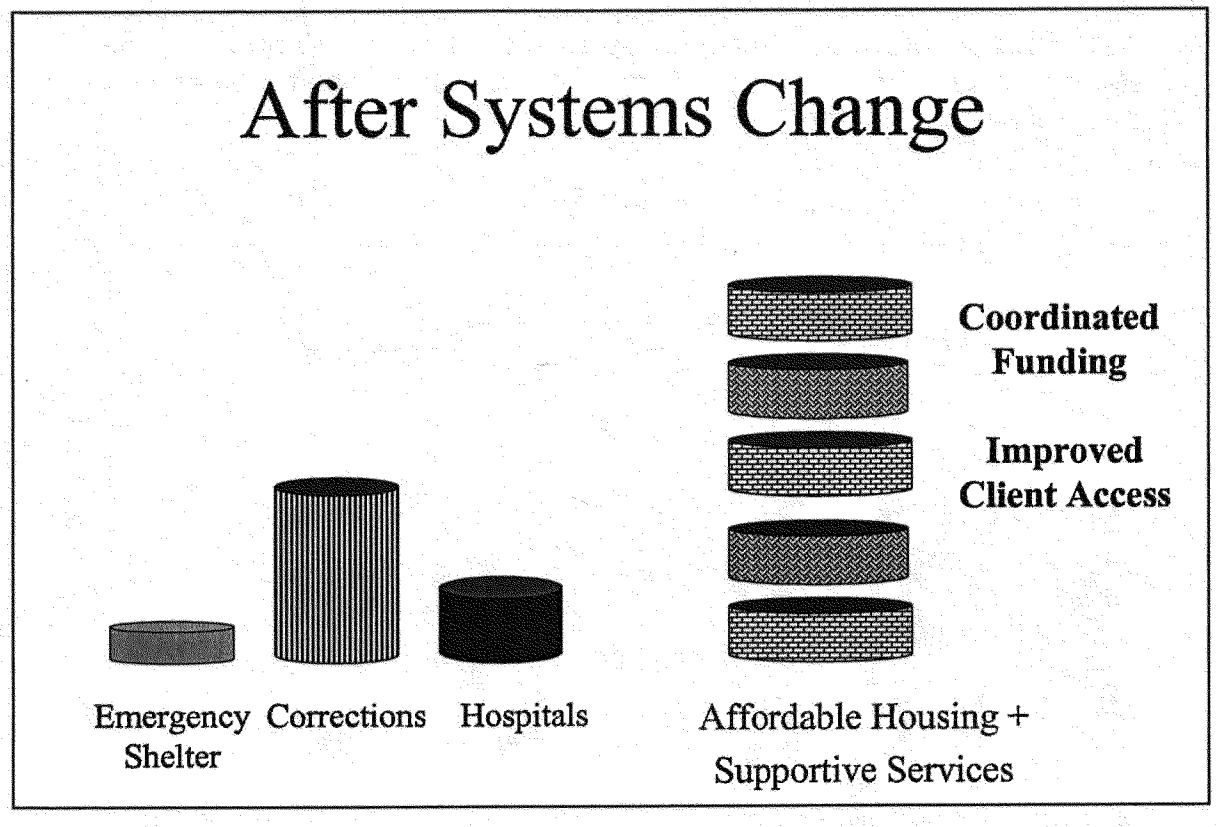
FIGURE 7



Currently, the homeless, corrections, hospital, affordable housing, and supportive service systems are structured in cylinders of separated services. Within each of these silos may be multiple separate agencies or funding streams, each with its own rules and eligibility criteria. Staff in all these cylinders know that there are too many people with special needs cycling through the homeless system, jails, and hospitals, and that the affordable housing and supportive service systems have not responded adequately, but the separate systems have not effected the necessary change to prevent this.

In the system we envision, people with special needs will not be over-represented in our homeless, hospital or corrections systems.

FIGURE 8



The homeless system will be smaller, and will be limited to emergency shelter. Hospital beds will be used for medical and mental health crises only. The affordable housing and supportive service systems will be coordinated at the personal level, the residential project level, the funding level, and the systems level resulting in improved client access, staff cross-training, a larger volume of special needs housing development, and increased housing retention rates. More people with special needs will be successfully housed, and thus have the opportunity to enjoy a good quality of life.

RESPECTFULLY SUBMITTED ON JULY 2, 2003.

THE HOUSING AND COMMUNITY DEVELOPMENT COMMISSION

Bill Van Vliet, Co-Chair
Catherine Such, Co-Chair

Janet Byrd
Paul Dagle
Linda Kaeser
Diane Meisenhelter[37]
Roger Meyer
Kevin Montgomery-Smith
Louis A. Ornelas
Roserria Roberts
Terri Silvis
Joe Wykowski

HCDC Staff
Beth Kaye

County Staff
Linda Grimes
Gail Wilson

BHCD Staff
Molly Rogers
Ruth Benson

THE SPECIAL NEEDS COMMITTEE[36]

Linda Kaeser, Chair

John Ball
Neal Beroz
Mary Carroll
Rosanne Costanzo
Serena Cruz
Peter Davidson, MD
Tracy Davies
Susan Dietsche
Betty Dominguez
Joyce Dougherty
Rachael Duke
Jamaal Folsom
Leslie Ford
Joanne Fuller
Bernie Giusto
Leah Halstead
Richard Harris
Jim Hlava
Carol Islam
Liv Jenssen
Christine Kirk
Anthony Lincoln
Heather Lyons
Seth Lyon
Diane Luther
Martha McLennan
Roger Meyer
Andy Miller
Susan Montgomery
Tim Moore
Terri Naito
Rachel Post
Paul Parker
Tonya Parker
Virginia Seitz
Vicki Skryha
Andy Smith
Cathy Spofford
Kim Tierney
Andreé Tremoulét
H.C. Tupper
Bill Van Vliet
Steve Weiss
Sherry Willmschen
Keren Brown Wilson
Nancy Wilton
Jim Wrigley

[36] Over the course of the year, participation by some of the committee's most thoughtful and experienced members was lost due to budget cuts, restructurings, and reassignments. The report benefited greatly from their contributions: Jim McConnell, Jacob Mestman, Howard Klink, May Simeone, Dan Noelle, Bethany Wertz, and Peter Wilcox. The committee also benefited from the perspective of Jim Winkler, who resigned when his term on HCDC elapsed.
[37] Ms. Meisenhelter's term on HCDC expired June 30, 2003.

APPENDICES

BEFORE THE BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

RESOLUTION NO. 02-070

Adopting Policy Direction to Charge the Housing and Community Development Commission Special Needs Housing Committee

The Multnomah County Board of Commissioners Finds:

a) Multnomah County, by Ordinance 719, and the City of Portland, and the City of Gresham have each designated the Housing and Community Development Commission to serve as the primary public forum for policy development, resource coordination, and civic leadership to address the County's affordable housing problems;

b) The Portland Development Commission plays an important role in financing and developing housing for persons with special needs;

c) The Housing Authority of Portland plays a critical role in providing housing for persons with special needs through its public housing and Section 8 programs;

d) The mission of HCDC is to increase the effectiveness of the housing delivery system by providing coordination among diverse public agencies which implement housing programs and by serving as a centralized liaison between those agencies and the governing bodies of the jurisdictions on issues regarding housing policies, goals, programs, and related allocation of public funds;

e) The jurisdictions named in paragraph 1 above provided in the Consolidated Plan 2000-2005 that their first priority was to provide affordable rental housing to, among others, low- income persons with special needs;

f) The Consolidated Plan 2000-2005 Needs Assessment and further studies undertaken by the jurisdictions document that there is a shortage of affordable housing with links to needed services for persons with special needs;

g) There are numerous barriers to the development of additional affordable housing with links to services for people with special needs, including financial, regulatory, and historical barriers;

h) Some persons with special needs who have affordable housing face barriers to success at maintaining in the housing;

i) For lack of suitable housing and services, people with special needs become inpatients at hospitals, are incarcerated, or occupy shelter space;

j) An adequate supply of special needs housing would ease the pressure on the mental health system, the corrections system, and the homeless system while focusing our resources in a more compassionate and economically efficient way;

The Multnomah County Board of Commissioners Resolves:

1. The Housing and Community Development Commission, by and through its Special Needs Committee, shall undertake to do the following:

   - assess the need for special needs housing County wide, including the specific housing needs of individual special needs populations;
   - make policy recommendations to advance the development of special needs housing and to improve the success of housing outcomes for persons with special needs;
   - coordinate local, regional, state, and federal housing and service resources to stimulate the development of special needs housing;
   - develop hard, realistic, and measurable targets for additional housing for persons with special needs;
   - leverage new resource streams for special needs housing development and operation;
   - create models for special needs housing development and operation; and
   - evaluate success of special needs housing development and operation; and
   - periodically assess the need for additional committee work, with the first assessment not later than June 2003

2. The Multnomah County Board of Commissioners will, with the advice of the Housing and Community Development Commission, annually review the progress that has been made toward the goal of providing each person with special needs with affordable housing linked to appropriate services.

3. That all Departments are directed to provide information requested by HCDC concerning resources, policies, and practices affecting the development and operation of special needs housing.

ADOPTED this 16th day of May 2002.

BOARD OF COUNTY COMMISSIONERS FOR MULTNOMAH COUNTY, OREGON

Diane M. Linn, Chair

REVIEWED:

THOMAS SPONSLER, COUNTY ATTORNEY
FOR MULTNOMAH COUNTY, OREGON

By_____
John S. Thomas, Assistant County Attorney

RESOLUTION NO. 36060

Charge the Housing and Community Development Commission with policy planning on special needs housing development and operation.

WHEREAS, by ordinance and pursuant to Portland City Code 3.38, the jurisdictions of Multnomah County, City of Portland, and the City of Gresham have designated the Housing and Community Development Commission to serve as the primary public forum for policy development, resource coordination, and civic leadership to address the County's affordable housing problems; and

WHEREAS the Portland Development Commission plays an important role in financing and developing housing for persons with special needs; and

WHEREAS the Housing Authority of Portland plays a critical role in providing housing for persons with special needs through its public housing and Section 8 programs; and

WHEREAS, the mission of HCDC is to increase the effectiveness of the housing delivery system by providing coordination among diverse public agencies which implement housing programs and by serving as a centralized liaison between those agencies and the governing bodies of the jurisdictions on issues regarding housing policies, goals, programs, and related allocation of public funds; and

WHEREAS, the jurisdictions provided in the Consolidated Plan 2000-2005 that their first priority was to provide affordable rental housing to, among others, low- income persons with special needs; and

WHEREAS, the Consolidated Plan 2000-2005 Needs Assessment and further studies undertaken by the jurisdictions document that there is a shortage of affordable housing with links to needed services for persons with special needs; and

WHEREAS, there are numerous barriers to the development of additional affordable housing with links to services for people with special needs, including financial, regulatory, and historical barriers; and

WHEREAS, some persons with special needs who have affordable housing face barriers to success at maintaining in the housing; and

WHEREAS, for lack of suitable housing and services, people with special needs become inpatients at hospitals, are incarcerated, or occupy shelter space; and

WHEREAS, an adequate supply of special needs housing would ease the pressure on the mental health system, the corrections system, and the homeless system while focusing our resources in a more compassionate and economically efficient way;

NOW, THEREFORE, BE IT RESOLVED THAT the Housing and Community Development Commission, by and through its Special Needs Committee, shall undertake to do the following:

- assess the need for special needs housing County wide, including the specific housing needs of individual special needs populations;
- make policy recommendations to advance the development of special needs housing and to improve the success of housing outcomes for persons with special needs;
- coordinate local, regional, state, and federal housing and service resources to stimulate the development of special needs housing;
- develop hard, realistic, and measurable targets for additional housing for persons with special needs;
- leverage new resource streams for special needs housing development and operation;
- create models for special needs housing development and operation; and
- evaluate success of special needs housing development and operation; and
- periodically assess the need for additional committee work, with the first assessment not later than June 2003; and

BE IT FURTHER RESOLVED THAT the Multnomah County Board of Commissioners, the Portland City Council, the Gresham City Council, the Portland Development Commission, and the Board of the Housing Authority of Portland will annually review, with the advice of the Housing and Community Development Commission, what progress has been made towards the goal of providing each person with special needs with affordable housing linked to appropriate services; and

BE IT FURTHER RESOLVED THAT all responsible agencies, departments, divisions, and bureaus be directed to provide information to HCDC and its staff on resources, policies, and practices affecting the development and operation of special needs housing.

Adopted by the Portland City Council: MAR 20 2002

GARY BLACKMER
Auditor of the City of Portland

Commissioner Erik Sten
Beth K. Kaye
March 14, 2002

By /S/ Susan Parsons
Deputy

BACKING SHEET INFORMATION

AGENDA NO. 267-2002

ORDINANCE/RESOLUTION/COUNCIL DOCUMENT NO. 36060

COMMISSIONERS VOTED AS FOLLOWS:		
	YEAS	NAYS
FRANCESCONI	X	
HALES	X	
SALTZMAN	X	
STEN	X	
KATZ	X	

Multnomah County and City of Portland

Data sources for Special Needs Housing

Report: May, 2003

The following data is an attempt to identify the need for permanent special needs housing for disabilities listed below in Column 1. Columns 2, 3, & 4 represent the information available to assist in describing need from different data sources. Data Reports and Sources are listed on separate page.

(1) Special Needs Group	(2) Multiple Source Housing Need Data	(3) City-County Homeless Data	(4) Multnomah County Housing Needs Report
Severe & Persistent Mental Illness			
Number needing Permanent Housing	1,019-3,251 OMHAS[1] (114 Cascadia Waitlist)	1,090 (200 ONSC)[2]	900
Substance Abuse			
Number needing Permanent Housing	2,143 State OMHAS (499 CCC Wait List) (46 Cascadia Waitlist)	2,506 (371)[3]	1,814
Developmental Disabilities			
Number needing Permanent Housing	300 ARC Data 175 MCDDS 25 ILR	53	175
Physical /Functional Disabilities			
Number needing Permanent Housing	610 MC ADS Emergency Housing	Not Available	1,649
AIDS/HIV			
Number needing Permanent Housing	682-1,035 EMA Plan	195	488-838
Multiple Disabilities[4]			
Number needing Permanent Housing	(231 Cascadia Waitlist)	751	1,326
Totals			
Number needing Permanent Housing	**4,954-7,539**	**4,595**	**6,352-6,702**

Definitions: MCADS- Multnomah County Aging & Disability Services ARC-Association of Retarded Citizens of Multnomah County
ILR-Independent Living Resources MCDDS -Multnomah County Developmental Disability Services
MCMHS -Multnomah County Mental Health Services OMHAS-State Office of Mental Health & Addiction Services

Footnotes

1. OMHAS has two reports: One identifies the number of homeless, and the other, special housing needs. The Fall 2002 Report estimates 3,251 persons with MI needed Residential Treatment Facilities or Adult Care Homes, or Supportive Housing. FY01-02 Report indicates 1,019 clients with MI were homeless at point of enrollment in services.
2. ONSC - One Night Shelter Count Report 3/27/002, number with Mental Illness
3. ONSC - One Night Shelter Count Report 3/27/002, number with Alcohol and Drug Abuse issues
4. The Category Multiple Disabilities includes any combination of diagnoses which results in a functional disability including physical, developmental, cognitive, mental and chemical.

Sources of Data

- Portland EMA HIV/AIDS Housing Plan, June 2000; prepared for the City of Portland Bureau of Housing and Community Development by AIDS Housing of Washington;
- FY 2001 – 2002, City of Portland and Multnomah County Information Sheet on Homeless;
- Multnomah County Special Needs Housing Report: Attempting to Quantify the Gap;
- Multnomah County Aging & Disability Services 2001-2002 Emergency Housing Report;
- Multnomah County 1 Night Shelter and Turn Away Count Report November 28, 2001;
- Homeless Shelter 1 Day Count Report November 2001;
- City of Portland-Multnomah County Annual GAP Analysis Report, 2001 – 2002;
- Homeless One Week Count Reports 2000 –2001, and 2001 –2002;
- Cascadia Mental Health Housing Facility Data;
- Cascadia Mental Health Housing Waiting Lists Disability Data, November 15, 2002;
- Multnomah County Mental Health and Addiction Services monthly Client Verity/Verity Plus and Client Service Reports July 02 – March 03;
- Results of the Fall 2000 Mental Health Housing Survey, October 2001, State Office of Mental Health and Addictions Services (OMHAS), prepared by Vicki Skryha;
- State OMHAS Housing Needs Data for Persons with Psychiatric Disabilities, Prepared September 2002;
- State OMHAS, Living Arrangements for Persons with Mental Health or Addiction Disorders, FY 01 –02, Table #3 and 4, Unduplicated adults with MH and Unduplicated adults with addiction disorders; Tables # 7, 8, 11 and 12: Unduplicated adults MH and Addiction disorders, November 2001 and March 2002;
- State of Oregon FY 2002 PATH Application, Attachment A, Homeless Data from CPMS FY 2000-2001;
- Central City Concerns, 2001 –2202 Waiting List;
- Multnomah County Developmental Disabilities November 2002 Client Report;
- RASP 2001-2002 Housing Report;
- ARC of Multnomah County, 2002 –2003 Client Housing Data;
- Multnomah County Department of Community Justice Transitional Services Client Special Needs Reports, FY 01 –02, and 02 –03;
- Multnomah County ADS, September 2002 Monthly Client Report;
- State Seniors and People with Disabilities MMIS Report # SJM5010R-A (Sept 27, 2002;

- **The Booking Frequency Pilot Project, Multnomah County, January 2002;**
- **Public Safety Coordinating Council Report of the Work Group on Mental Health Treatment Needs of Offenders; February 7, 1997;**

Multnomah County Special Needs Housing Options and Capacity

Type of Housing	**# Housing Facilities/ Properties**	**# Units or Bed Capacity**	*Services* On Site	Off Site	**# Clients or Residents**	***Licensed*** Yes/No/Other
Adult Foster Care Homes (AFCH)	571	2,855 (max. 5 residents per home)	X	X	**1,037 *ADS*** **206 *DD*** 55 **MH**	**Yes,** by Multnomah County Aging & Disability Services (ADS)
Room & Board Homes (R & B)	10	68	X		**12 ADS** **5 DD** **? MH**	Yes, by Multnomah County ADS
Assisted Living Facilities (ALF)	17 (12 accept Medicaid)	1,400	X	X	400 **ADS**	Yes, by State Seniors & Persons with Disabilities (SPD)
ADS Residential Care Homes (RCF)	46 (30 accept Medicaid)	2,105 **ADS**	X	X	**612 ADS**	**Yes,** by State SPD
MH Residential Care Homes	21	252 **MH**	X	X	**252 MH**	**Yes**, by State OMHAS
MH/ADS Enhanced Care Facility (ECF)	1	16 ***MH/ADS***	X	X	**16 MH/ADS**	**Yes,** by State MH and SPD
Type of Housing	**# Housing Facilities/ Properties**	**# Units or Bed Capacity**	*Services* On Site	Off Site	**# Clients or Residents**	***Licensed*** Yes/ NO / Other
Type of	**# Housing Facilities/**	**# Units or Bed**	*Services*		**# Clients or**	

Housing	Properties	Capacity	On Site	Off Site	Residents	*Licensed* Yes/ NO / Other
MH (Cascadia) Independent Housing	30	340 **HIV** **14 A&D** **48 MH/A&D** **103 MH homeless** **164 MH**		X	**340** **MH, HIV, A&D** (plus 391 on waitlist)	No
Mental Health (CCC) ADFH	1 single adults 15 families	68 238			transitional housing	No
DD Group Homes	106 (24/7)	453	X	X	453 **DD**	Yes, by State
DD Supported Housing	7 providers	122 varies	X	X	122 **DD**	Providers Certified by State
DD Semi-Independent Living	**10 providers**	75 varies	X	X	**75** **DD**	Providers Certified by State
Oxford House of Oregon (A & D)	36 total in Mult Co 28 M 6 F 2 FC	273			*273* *A&D*	Chapters
HIV/AIDS (Central City Concerns (CCC), Cascade AID's Project)	1 single adults	52	X	X	52 HIV	No
A&D (CCC, Early Recovery	4 families	78 units (2 and 3 bedrms)			transitional housing	No
Employment Linked (CCC)	**2 single adults**	81	X	X	transitional housing	No

Type of Housing	# Housing Facilities/ Properties	# Units or Bed Capacity	*Services* On Site	Off Site	# Clients or Residents	***Licensed*** Yes/ NO / Other
ADFC Permanent [CCC, REACH, TPI]	4 single adults 2 Fair Market Rate	290 ADFC 195		X X	Permanent Housing	No
Nursing Facilities (NF)	32	2,630 beds in facilities that accept Medicaid	X	X	1,351 ***ADS***	Yes, by State SPD
ADS Specialized Living Projects **- HAP Congregate Housing Service Project** (ages: seniors and younger disabled)	4	120	X	X	120 **ADS**	**No License; services paid through special contract with State SPD, with service assessment and authorization by Multnomah County ADS**
	2	40	X	X	40 ADS	
- Quad Inc (ages 18 –64)	1	19	X	X	19 ADS	
- Pine Point (ages 18 –64)	1	19	X	X	19 ADS	
- Kamphe (18 – 64) (Brain Injured)						

SPD – State Seniors and Persons with Disabilities;
CCC – Central City Concerns;
ADS – Multnomah County Aging & Disability Services;
OMHAS – State Office of Mental Health and Addiction Services

TABLE 3 - ANALYSIS OF BARRIERS (SORTED)

Barrier	Client Perspective	Provider Perspective	Funding Issue	System Challenge
Housing not viewed as a piece of a prevention model – viewed as a reward	**It is hard to become stable when you do not have a home or your housing is not secure.**	**Not enough support for people to succeed in housing.**	**Prison, shelter, hospital all higher cost than housing.**	**Adopt preventive model.**
Agency boundaries balkanized; compartmentalizatio n of services	**Difficult to navigate system; lack of assistance with process; Unable to find out whether assistance may be available; services not linked to housing**	**No clear funding stream.**	**Funding administered through agencies**	**Front door access to services; use funding moment as a point to make housing/service linkage; systems guide; systems navigator**
Cultural and language barriers	**People of color and people who speak a primary language other than English may encounter bias, difficulty obtaining culturally appropriate services or information and services in their language.**	**Can be hard to communicate with clients of other cultures and languages. Will take time to build multi-cultural competency, multi-lingual information and service provision.**	**Resources required to build multi-cultural competency, multi-lingual information systems and service provision.**	**All programs must address cultural and language diversity of client populations.**
Role of State DHS	Difficult to navigate system.	Funding uncertain.	Controls important funding streams; budget face severe cuts.	Open dialogue.
Incomplete client assessments	**Failure to diagnose means failure to treat.**	**Not set up to do assessments.**	**Funding streams tied to categorical eligibility requirements.**	**To provide integrated assessment regardless of client point of entry.**

Undiagnosed disability	May impair ability to find and keep job. Difficult to obtain diagnosis. May need advocate.	No funding streams.	Not connected with funding stream	Complete assessment early on and repeat periodically
Unpredictability of Need	**Need for support varies over time; need may be non-existent, cyclical, episodic, or steady; moving as service needs change is destabilizing.**	**Needs predictability to plan staffing**	**Relatively rigid funding models persist**	**To build flexibility in funding model to match variations in individual's condition; to plan for the delivery of the continuum of services.**
Falling between cracks (Lack of capacity to house people excluded from private RE industry and not eligible for service enriched housing)	Not eligible for services, barred from other housing	Cannot develop without a funding stream.	Identify resources for these populations.	To plan for this population.
Shallow needs in multiple areas	Unable to get help needed	No funding streams	Affects eligibility	Plan for this population.
Co-occurring mental health or A/D will exclude limited functioning adult	Unable to get help needed.	No funding stream, no service supports.	Prison, shelter, hospital all higher cost than housing. Identify resource.	Plan for these populations.
Separate systems for children/youth/ seniors	Difficult to locate/maintain care and level of service during transitions between age-based systems,	Interruptions in funding stream.	Different funding streams for each age band.	Plan for continuity during transitions and straddle periods.

Lack of coordination on discharge from institutions.	**Difficult to get help needed on discharge from institution (prison/hospital/other)**	**Need to reestablish funding stream.**	**Different funding streams for inside/outside institution. Who pays for coordination?**	**Improve coordination.**
Inadequate case management/co-ordination	**Lack of treatment impairs ability to function independently.**	**Tenants who are not receiving adequate case management may not be able to meet requirements of tenancy.**	**Expensive to treat person who has decompensated due to lack of case management/co-ordination.**	**Improve system. Favor systems that incentivize consistent case management/co-ordination. Expand on models like JOIN.**
Consumers not empowered	Don't know where to go for information about choices/rights.	Individual provider has only incomplete information.	Cost of establishing and updating consumer information.	Explore whether Housing Connections will a sufficient empowerment tool when services component is on-line. Provide technical assistance for special needs populations to use housing Connections.
Lack of consumer involvement in policy planning.	**Consumer preferences not reflected in policy making.**	**Consumers lack sophistication about funding streams, program design, etc.**	**Cost of consumer involvement.**	**Include consumers/ consumer advocates in policy planning process.**
Lack of preventive /maintenance services	**Sometimes a small amount of help can assist a person to maintain in housing and prevent the situation from deteriorating into a crisis (hospitalization, lost housing, lost benefits, etc.)**	**Landlords ill-equipped to provide preventative services; may not be aware of tenant's special needs or whom to contact.**	**Prison, shelter, hospital all higher cost than housing. Prevention always the most cost-effective option.**	**Favor systems that provide or incentivize preventive services to help people maintain in housing. Expand on models like JOIN.**

Compliance with rules on house-keeping/super-vision	Hard to under-stand/follow; need life skills training	Difficult for landlord/owner to negotiate with tenant	Deterioration of unit can be more expensive than prevention.	To connect with life skills training and support
Need for food security	Some unable to afford food; some require assistance with meal preparation and/or feeding.	Match food security programs to needs of clients.	Funding available from many sources for food security. Expensive to install cooking facilities in every complex.	Maximize use of available food security programs, including U.S.D.A. supported meals programs, food pantries, food stamps, etc. Provide training on nutrition, cooking, etc.
Need for life skills	Life skills would allow person to live with increased level of independence.	Tenant unable to fulfill obligations of tenancy without life skills.	Investment in life skills training would allow person to live with increased level of independence (at lower cost). What are funding streams?	Include life skills training as part of transitioning individual to housing.
Functional illiteracy	Navigating system very difficult without basic literacy.	Communication with tenants more difficult.	Some cost associated with providing assistance with information. Some people may not be receiving funding for which they are eligible.	Identify if literacy is an issue early in process. Provide remedial education, if appropriate, and assistance in managing information.
Lack of community/ need for natural supports	**Need community.**	**Isolated tenant lacks support in times of crisis, increases burden on landlord.**	**Limited funds for investment in community centers and programs.**	**Plan for populations to go beyond subsistence issues of food and shelter, to include planning for community development.**
Conflict between autonomy/safety	Desire for autonomy; some unwilling to have care.	Hard to plan for individual preference; can make difficult tenants.	People who turn down needed care can be very expensive.	To provide a range of housing options to meet individual preferences; to contain costs.
Client cannot direct his/her own services	Most programs are for people who can direct their own services	Requires attention of caseworker or service coordinator.	Higher level of care available in more expensive licensed facilities	Provide for people who need off-site monitoring.

Disincentives to success are built in.	Clients who do well may lose the services and support that helped them to become successful and are necessary to maintain success.	With limited funds, must "graduate" some to be able to fund care for other.	Over long term, less expensive to help individual maintain successes than to pay for intervention later.	Analyze extent of this barrier for special needs populations. Incentivize programs that help individuals maintain successes.
Tension between size of project and affordability.	**Usually, scattered site or smaller housing developments are more attractive to consumers.**	**It is less expensive to develop large, multi-unit properties. Operating costs (including on-site supervision) can be spread over a greater base.**	**Keeping rents affordable can mean denser development.**	**Explore better design to overcome disadvantages of density. Find balance between cost and affordability.**
Service delivery to scattered sites	Prefer to live in scattered site housing	Expensive; hard to provide on-site management	Expensive – prefer single site	Explore ways to improve service delivery to scattered sites; improve quality of higher density housing options.
Underwriter's reluctance	Fewer units available to people with most severe needs.	Unwilling to develop specialized physical structure without assurance of service dollars; unwilling to finance without assurance of service dollars; unwilling to finance high maintenance costs	Limits funding available from private market.	Need info re whether service up-front improves project's long range financial performance
Risk management for socially-conscious housing providers	Desire housing opportunities in CDC owned housing.	High costs of tenant bombing out, turn-over, vacancies, wear and tear	Investment in socially-conscious housing providers could provide housing opportunities for the hard-to-house.	Technical support for socially-conscious housing providers in risk management; support for tenants to succeed in tenancies.

Providers have insufficient information about needs of tenants with special needs .	Concerns about privacy. Want to increase number of private landlords who will rent to people with special needs,	Fair Housing Act and Section 504 limit landlords for asking for detailed information about disability of prospective or current tenant. Landlords not in special needs business uncomfortable about renting to person with disability. Landlords handicapped by lack of information from making compassionate and appropriate response to tenant needs.	Low cost for education programs.	Consumer education for tenants about ability to volunteer information to landlords; training for landlords about renting to tenants with special needs. Look at JOIN and other sponsorship models.
Lack of market study on optimal mix of special needs housing that reflects client preferences	Insufficient supply of units that meet client preferences for studios and larger units. Too much institutional housing.	Develops not in special needs housing industry don't know what to build.	Special needs population too low-income to send signals to market in conventional way. Larger units more expensive.	Develop plan that recognizes complexity of market and reflects customer preference.
High cost of housing	Inability to pay much rent; housing cost more than 30% of income	Need to cover cost	Limited funds to provide rent subsidies or to develop debt-free housing and provide operating subsidies.	More rent subsidies or debt-free housing with operating subsidies
Lack of employment	Lack of income; most persons with special needs have monthly incomes between 0-17% AMI	Tenant unable to pay own way for housing and services		Improved linkage to workforce programs; living wage
Temporary disability	Can destabilize situation	Tenant cannot pay rent	Not connected with funding stream	Plan for this population.
Lack of childcare	Hard to hold job without childcare.	Property managers cannot provide child care.	Limits ability to tenants to pay rent. Childcare expensive.	Expand childcare options.

High cost of moving	Stuck in place. Hard to move to better situation because costs are so high.	High cost of turn-over.	Limited funds to provide for moving expenses.	Flexible funds for moving expenses.
Siting	Close to services, transportation, neighborhood amenities.	NIMBY opposition.	Adds cost to project.	To remove barriers to siting; to develop community acceptance for special needs housing.
Discrimination based on Section 8	Cannot find suitable housing that will accept Section 8. (17% turn-back rate)	Section 8 comes with additional restrictions on landlord rights and places additional duties on landlord.	We should maximize use of this federal resource.	Law reform: bar discrimination based on Section 8 and/or decrease burden on landlords who accept Section 8.
Discrimination based on mental illness	Reduces housing opportunities.	Concern about potential exposure, concern about potentially high cost of reasonable accommodation.		Law enforcement
Sub-standard housing, e.g. flops, properties with hazardous conditions	Conditions may pose health risks or exacerbate existing medical conditions.	Little or no incentive to improve conditions. Expensive to bring up to standard.	Tie funding for repairs to term of affordability.	Code development; code enforcement; replacement strategy
Criminal justice history	Irrevocable.	Increased exposure to liability; risk.	Disqualifies individual from some services depending on crimes.	Expand on models like Fresh Start
Landlord screening criteria	Presents a barrier to housing that might otherwise be suitable and available.	Insufficient incentives to house people who may be capable of independent living with support.	Some need for funding to provide security to landlord to offset perception of risk.	Increase incentives; expand on models like JOIN and Fresh Start.
D/V	Need for safety, support	May have poor tenant history	Few resources for support.	Planning around long-term housing needs of people with special needs who have history of D/V.

APPENDIX D: VISION, GOALS AND LONG TERM STRATEGIES

The Special Needs Committee developed a vision and long-term goals to create a picture of the future we want to see, and then determined the changes that will be necessary to get there. The Committee then created long-term strategies which would move us toward these goals. These long-term strategies were assessed in light of current circumstances, and feasible Recommended Action Steps for 2003-05 developed (see body of the Report).

VISION: In Multnomah County, people with special needs have decent stable affordable housing for themselves and their families, along with the support and services they need for a good quality of life.

LONG-TERM GOALS:

Goal 1: Coordinate housing + services to maximize success of people with special needs in permanent housing.

Goal 2: Create enough housing for people with special needs, including housing linked to services and housing for the hard-to-house.

Goal 3: Improve access to housing + services, including outreach to the hard-to-house.

LONG-TERM STRATEGIES:

Strategies to Achieve Goal 1:

Coordinate housing + services to maximize success of people with special needs in permanent housing.

Coordination Strategies

These strategies address inter- and intra-jurisdictional issues. They express the SNC's recommendation that complexity be addressed at the administrative level, rather than leaving complexities for housing and service providers to sort out.

1. Establish an on-going interagency/interjurisdictional forum that coordinates, and brings resources to bear upon, housing and services targeted toward people with special needs.
2. Use data to inform process, make improvements, and show success. Align with existing information/resource systems.
3. Improve coordination across service systems for people who are or should be in more than one system.

Funding Strategies:

These strategies encourage a systematic approach to filling funding gaps as resources become available. They express the SNC's recommendation that all parties adopt a shared orientation of protecting special needs populations and individual clients.

1. Maximize mainstream resources (e.g. Medicaid, Medicaid Waivers, Federally Qualified Health Center status, U.S. Department of Agriculture food assistance, various housing and service block grants) to leverage local contributions to supportive housing for special needs populations.
2. Establish sustained coordinated funding mechanisms and administration.
3. Review rent assistance models that promote housing stability and assess effectiveness, ease of access, and whether priority special needs populations have been well served.

Service Delivery Strategies:

1. Within the service system, establish housing retention/stability goals and track outcomes for all special needs populations.
2. Within the service system, establish food security goals and track outcomes for all special needs populations.
3. Facilitate and support partnerships among implementers of supportive housing to ensure housing and service access for "hardest-to-house" people.

Strategies to Achieve Goal 2:

Create <u>enough housing</u> for people with special needs, including housing linked to services and housing for the hard-to-house.

1. Develop concrete goals and set targets for the following strategies for 3, 5 and 10 year periods.
2. Commit to supportive housing set-aside "express lane" in existing development pipeline for projects that propose to house and serve people with special needs. Administer pipeline under oversight of interagency body to ensure resource commitment, coordination, and accountability.
3. Establish shared timelines to implement consolidated funding cycles that package housing financing (including rent/operating subsidies) and services. Establish a proposal review committee that includes specific expertise in supportive housing development and operation.
4. Link services to the Housing Authority of Portland, community development corporations, and other key housing providers to better leverage and facilitate special needs occupancy of existing inventory.
5. Stimulate new development targeted to meeting identified gaps.

6. Create more service capacity to support increased level of housing development.
7. Develop some affordable housing with all services off-site so that, in the event of service cuts, housing will survive.
8. Establish policy regarding the conversion of Section 8 vouchers to project-based Section 8 to support the development of additional housing capacity.
9. Seek new competitive funding, such as the March 2003 proposal submitted jointly by the City of Portland, Multnomah County, and HCDC to the Corporation for Supportive Housing "Taking Health Care Home Initiative," which aims to:
   a. Institute financial incentives for projects that serve and house people who have multiple needs, have been homeless for the longest periods of time, and are at high risk of failing to sustain housing.
   b. Shift funding over time from projects and programs that do not support long-term permanent housing for homeless people with special needs to ones that do, without compromising the strength of the safety net.
   c. Provide housing to those not currently served by, or considered clients of, the mainstream service system.
   d. Reduce duplication and fragmentation between homeless systems and special need service system.
10. Support efforts to develop a stable local funding source for affordable housing, with a portion of revenues earmarked for supportive housing.

Strategies to Achieve Goal 3:

Improve access to housing + services, including outreach to the hard-to-house.

1. Offer each client, regardless of point of entry, a comprehensive and culturally competent service plan that includes access/placement/stabilization/retention resources for housing, service, and food security needs. This includes an integrated plan for clients discharged from facilities (*e.g.* jails, shelters, hospitals).

2. Design services so that they can be altered when client needs intensify or lessen.

HOUSING & COMMUNITY DEVELOPMENT COMMISSION

421 S.W. 6th Avenue
Suite 1100
Portland, Oregon 97204-1966

APPENDIX E: LETTER TO HAP

To: Rose Bak, HAP

From: Linda Kaeser, Chair
HCDC Special Needs Committee

Re: Using March 2003 RFP for Project- Based Section 8 to address current crisis of imminent displacement of residents of special needs facilities

Date: January 29, 2003

The HCDC Special Needs Housing Committee appreciates HAP's invitation to explore how HAP may assist in the community response to imminent displacement of residents of facilities that face down-sizing and closure due to inadequate service funding. The particulars of the financial difficulties facing facilities like the Taft, the Hoodview, and the William-Elaine have been well-documented in the press and at our committee meetings.

HAP has offered to use some of its Project-Based Section 8 resource to address this imminent crisis. HAP expects to have 250 Project-Based Section 8 vouchers available over the course of FY 2003-2004. The vouchers typically become available at the rate of 10 or 20 each month. The vouchers are issued for a one-year period. It is HAP's practice to renew them automatically for up to 10 years.

The Project-Based Section 8 resource is currently being allocated on a pilot basis using criteria established through an extensive public process. The criteria ensure that this resource is used to serve people who face significant barriers to securing housing on the open market. Currently, in HAP's selection process for allocating Project-Based Section 8, preferences are given to projects serving people at 0-30% MFI -- with an emphasis on 0-10% MFI; people with chronic mental illness; people with alcohol or drug issues; people with mobility or disability issues; people with criminal history; people with poor credit history; people with no rental history or a history of evictions; people who are victims of domestic violence; and people who require on-site services to live independently. Projects are also required to meet financial feasibility requirements, and project sponsors are required to be financially sound.

Members of the SNC met with HAP staff and reviewed the current criteria. SNC recommends that HAP augment its list of criteria for receiving an allocation of Project-Based Section 8 to include the following additional factor:

> "Housing projects serving people most at risk of inappropriate placement in institutions, such as jails, shelters, hospitals, nursing facilities, or on the street, with a priority for people who are at risk of

displacement due to the imminent closure or downsizing of their residences."

In some cases, this may mean allocating Project-Based vouchers to the facility slated for closure or downsizing. In other cases, this it might be appropriate to allocate Project-Based vouchers to other housing that could immediately accommodate a group of people at risk of displacement due to imminent facility closure or down-sizing. We believe that HAP's selection committee will be in the best position to make this judgment, based on the totality of information presented to it.

The SNC asks that HAP give projects satisfying this additional criterion preference over other projects.

The SNC also recommends that HAP make some alterations in its standard RFP process for allocating the Project-Based vouchers, as follows:

1. Do outreach to encourage proposals from facilities facing closure or down-sizing, as well as current and potential providers of special needs housing.
2. Hold a pre-bid orientation session to explain how Project-Based contracts work, the RFP, the allocation process and the selection criteria.
3. Offer technical assistance to prospective bidders, including site visits to assess whether a property would (or could) meet Section 8 program qualifications. If possible, provide referrals to a list of individuals with expertise in service funding to assist applicants in preparing a financially-feasible proposal.
4. Require bidders that intend to provide supportive services (*e.g.* case management, mental health, medical) to residents of the proposed project to submit a letter explaining the source of funding for those services with their application.
5. Use an impartial review committee that includes at least one person who is familiar with service funding.

Once again, we appreciate the opportunity to consult with HAP on this important issue.

cc: Multnomah County Chair Diane Linn
Mayor Vera Katz
Commissioner Erik Sten
Mayor Charles Becker
Tonya Parker, BHCD
Bill Van Vliet, HCDC
Rachael Duke, HAP
Paul Parker, HAP
Catherine Such, HCDC
Diane Luther, Multnomah County
Andree Tremoulet, City of Gresham
Andy J. Smith, Multnomah County

VISION: IN MULTNOMAH COUNTY, PEOPLE WITH SPECIAL NEEDS HAVE DECENT STABLE AFFORDABLE HOUSING FOR THEMSELVES AND THEIR FAMILIES, ALONG WITH THE SUPPORT AND SERVICES THEY NEED FOR A GOOD QUALITY OF LIFE.

GOAL 1. COORDINATE HOUSING + SERVICES TO MAXIMIZE SUCCESS OF PEOPLE WITH SPECIAL NEEDS IN PERMANENT HOUSING.		
LONG TERM STRATEGIES	**POTENTIAL OUTCOMES**	**POTENTIAL TASKS**
Within the service system, establish housing retention/stability goals and track outcomes for all special needs populations.	By 2006, we will track housing outcomes for all special needs populations and use housing outcomes to evaluate programs and inform funding decisions.	Form goal-setting teams within each service sector, including housing expertise.
		To promote retention, expand access to appropriate levels of case management and wrap-around service for people whoa re already in housing.
		Create flexibility in funding to respond to unusual needs that can jeopardize housing stability.
		Assist clients to "transition in place" by providing varying levels of support to each client in his/her own home.
Review rent assistance models that promote housing stability, and assess effectiveness, ease of access, and whether priority populations are well served.	By 2004, we will fund models that promote housing stability. We will differentiate between transitional and permanent housing. We will have outcome data for people assisted.	Reprogram current rent assistance models to models that are most effective at promoting housing stability, offering easy access, and serving priority populations.

LONG TERM STRATEGIES	POTENTIAL OUTCOMES	POTENTIAL TASKS
Regulatory strategy to increase leveraging of local resources with state and federal resources. Maximize local match to increase Medicaid funds. Reduce or eliminate barriers among Medicaid Waivers (e.g. mental health, DD, and long-term care).	By 2006, a person with a high degree of functional disability will be qualified for wrap-around services. There will be no distinctions based on diagnosis to disqualify an individual from needed services.	Empower direct service staff to fund housing-related expenses out of service streams to meet housing goals
Build working relationships between housing and service providers by cross-educating and cross-communicating.	Greater housing accessibility and retention.	Promote concept of multi-disciplinary teams
		Develop model for coordination of case management among service providers focused on "high users of institutions" with multiple problems.
		Develop standardized training program. Improve training in services for housing providers; improve training in housing for service providers. Offer food security training to all.
		Explore ways to maintain stability in service/housing providers

LONG TERM STRATEGIES	POTENTIAL OUTCOMES	POTENTIAL TASKS
Complete shifts in budgets from back-end Solutions to front-end Prevention	By 2007, provide the funding for subsidized housing with easily available and accessible services. By 2007, **50%** of Special Needs populations, who are in need of permanent housing, will be housed in permanent housing with supportive services (including meals). By 2009, **60%** of Special Needs population, who are in need of permanent housing, will be housed in permanent housing with supportive services (including meals).	Research and articulate overall savings Develop political support and leadership Advocate for adequate funding levels to ensure success
Joint planning for each population to promote housing security, food security, health care, dental care, employment	City Commissioner of Housing and County Chair appoint ongoing planning group, composed of appropriate Division and Department Staff and Decision-makers, to develop plans and strategies for an integrated system for providing support services and housing.	Continue active engagement of all stakeholders: consumers, providers, funders, from all service and housing cylinders Expand access to food and nutrition services through housing models Improve linkages to workforce programs and employment that pays a living wage. Expand access to affordable child care.
Develop information system with multiple uses, e.g. accessing services, case management, tracking outcomes, (perhaps build on Housing Connections)	By 2004, have Homeless Management Information System in place with 50% of public and private agencies participating.	Develop information system for consumers. Develop information system for providers.

LONG TERM STRATEGIES	POTENTIAL OUTCOMES	POTENTIAL TASKS
Improve coordination across service systems for people who are or should be in more than one system	By 2004, have interagency agreements in place that permit information sharing with client consent among agencies.	
Create structure for accountability that includes the highest-level policy makers as well as the direct service providers. Monitor implementation	By 2004, designate a new or existing multi-jurisdictional body with the authority to promote and oversee collaboration efforts.	Ensure at least annual report-back on goals progress from Department heads to elected officials
		Explore creation of an inter-agency task-force with clear roles/responsibilities and methods of coordination.
		Explore designation of new or existing multi-jurisdictional authority to oversee collaborative efforts
		Provide continuing political leadership

GOAL 2: CREATE ENOUGH HOUSING FOR PEOPLE WITH SPECIAL NEEDS, INCLUDING HOUSING LINKED TO SERVICES AND HOUSING FOR THE HARD-TO-HOUSE.		
LONG TERM STRATEGIES	**POTENTIAL OUTCOMES**	**POTENTIAL TASKS**
Link services to HAP, CDCs, private landlords and other key housing providers to better leverage and facilitate special needs occupancy at existing inventory	By 2005, develop a formal information, referral and support program for landlords, property managers and case managers serving residents with special needs. By 2006, have an inventory of locations (non-institutional permanent housing) that accept and are appropriate for persons with special needs Increase number of households assisted to become stable in permanent housing by 2005.	Modify existing models and programs (such as Fresh Start, Home Safe, etc.), to develop agreements with housing providers to house persons with special needs who are high-risk renters by reducing real and perceived risk. Educate landlords, housing providers, managers about renting to people with disabilities, and how to obtain assistance Provide service support to housing providers, owners, and managers to house hardest to house and other special needs populations.
Address underwriters' resistance to financing special needs housing	By 2004, establish relationships with three underwriters to participate in special needs housing pipeline.	Adopt strategies to make the case to underwriters about the financial viability of special needs housing. Educate underwriters on service systems and funding.

LONG TERM STRATEGIES	POTENTIAL OUTCOMES	POTENTIAL TASKS
Stimulate new development targeted to meeting identified gaps	By 2005, develop 400 new supportive housing units for people with special needs By 2004, create an implementation strategy for addressing identified supportive housing gaps. By 2005, develop technical assistance for assembling development and service funding packages.	Inventory existing housing resources to identify needs and gaps by population.
		Develop and prioritize targeted special needs production goals, by type and severity of disability, including co-occurring disabilities.
		Coordinate housing and service funding streams – where possible – to stimulate new development to meet specific targets. Fund viable models.

		Develop a variety of best practices and models for special needs housing that balance cost efficiencies and consumer preferences (e.g. efficiencies vs. one bedroom units; scattered sites vs. dense developments). Example: flexible mixed-use housing.
		Develop approval process that includes analysis of service needs/impact prior to funding development of project
		Track and report on inventory and progress toward goals
Attract more special needs housing developers with private capital to invest.	More special needs housing developers with private capital will be operating housing in Multnomah County.	Outreach to special needs housing developers regarding special needs housing goals, housing development and service funding availability, technical assistance, etc.
Increase number of available housing subsidies.	By 2007, 1000 more people with special needs with incomes of 0-20% MFI who require housing subsidies will get them. By 2010, 2000 people with incomes of 0-20% MFI who require housing subsidies will get them.	Explore reallocation of existing resources and development of new resources.
Maintain existing housing serving residents with special needs.	Housing resources and service systems have stable funding commitments.	Create systems that support quality asset management of units that house special needs populations. Coordinate services and services funding to maintain existing special needs housing.

LONG TERM STRATEGIES	POTENTIAL OUTCOMES	POTENTIAL TASKS
Establish new and increased funding for the development of special needs housing.	Twenty percent of new funding for affordable housing will be for special needs housing.	Work with allies on development of new housing resources (e.g. RETT, bond measures, more Section 8 vouchers) Seek set-asides of existing funds for special needs housing. Advocate at state and federal levels to have more funding allocated to housing for people with special needs.
Create more service capacity to support increased level of housing development	By 2006, system will have the capacity to provide necessary services to 600 additional people.	Work with allies on development of new service resources. Explore ways to use potential expanded funding for affordable housing to pay for services (e.g. underwrite increased operating expenses.) Lobby at state and federal levels to have more funds allocated to services for people with special needs.
For interim period, appoint City/County ombudsman to facilitate development of special needs housing by addressing housing/service funding coordination issues.	Ombudsman facilitates development of special needs housing through 2006, while larger systems change work builds.	
Develop community support for special needs housing	Reduced neighborhood resistance to siting special needs housing, and increased public support for funding special needs housing.	Educate neighbors: door-to-door, at community centers, caring communities, parks, neighborhood associations, etc.

LONG TERM STRATEGIES	POTENTIAL OUTCOMES	POTENTIAL TASKS
Better integrate current homeless system clients with mainstream housing.	By 2005, 20% of all people who have experienced homeless ness for one year or longer will be place in housing with appropriate service supports. By 2007, shelter count will show reductions in numbers of people sheltered and numbers turned away.	Consolidate homeless delivery systems with special needs delivery systems where appropriate to merge housing access and support services
		Move funding from "back" end (shelter, hospital, jail) to "front" end (housing and services).
		Develop "front-end" system. Coordinate/consolidate resources across departments (state, county, city) in order to streamline effort and use of dollars.
Provide housing to those not currently served or considered to be "clients" of the mainstream service system.	By 2010, have outreach methods in place to make housing opportunities available to these "non-clients." Decrease street count of homeless people from 2003 levels by 20% in 2005, by 50% in 2007, and maintain low numbers of people on the street for future years.	Devise methods to reach these individuals and offer them permanent housing
Reduce duplication and fragmentation between homeless systems and special needs service system	By 2005, increase provider access to mainstream funding by 25%. By 2006, reduce homeless- specific funding for special needs services by same amount.	Implement integrated Housing First model across all systems of care

LONG TERM STRATEGIES	POTENTIAL OUTCOMES	POTENTIAL TASKS
Shift some of budget from end-line services (jails/hospitals/shelters) to homeless prevention services that show success in attaining housing and health outcomes	By 2005, invest enough housing and service dollars to create a pipeline of 400 supportive housing units. By 2006, house an additional 250 "hard to house" chronically homeless individuals through "Housing First" model. By 2007, shift resources from savings in hospitals, jails, and shelters to supportive housing models. By 2007, reduce reliance of homeless services on CDBG public service dollars by 25% and allocate savings to special needs housing development.	Develop small prevention demonstration project out of end-service budget lines to show cost-effectiveness Track success and expand as appropriate Develop demonstration project of a coordinated/ consolidated interdepartmental system to streamline provision of services to clients at risk of homelessness. Track success and expand as appropriate.
Create better coordination between mainstream service providers and permanent long-term providers for persons poised for transition out of institutions	By 2005, implement cross-system comprehensive discharge plan that ensures housing stability for 60% of homeless people released from institutions. By 2007, increase to 75%.	

GOAL 3: IMPROVE ACCESS TO HOUSING + SERVICES, INCLUDING OUTREACH TO THE HARD-TO-HOUSE.		
LONG TERM STRATEGIES	**POTENTIAL OUTCOMES**	**POTENTIAL TASKS**
Design comprehensive and culturally-competent screening and assessment tool, including a housing need assessment component, for use by social service agencies	By 2006, demonstrate a comprehensive screening and assessment tool in selected populations. By 2010, 100% of people with special needs accessing County services will have been screened and assessed using the comprehensive tool.	Examine current assessment models: ADS, Cascadia, CAP, etc. Develop model assessment protocol Coordinate entry for services (DD, MH, ADS) and housing as much as possible (e.g. single point of application, single application, comprehensive needs analysis).
Offer clients a comprehensive service plan that includes access/placement/ stabilization/retention resources for both housing and social service needs. Service plans will be client-centered and culturally competent Comprehensive service plans will include food security, intervention services, life skills training, and remedial literacy as needed	By 2010, 100% of special needs applicants accessing county services, regardless of point of entry, will have a comprehensive service plan that includes access/placement/ stabilization/retention resources for both housing and social service needs. This includes an integrated plan for clients discharged from facilities. By 2004, develop agreements between housing and service providers to facilitate coordinated service plans. By 2006, all partners will use one resource database for all resources, including DD, MH, ADS, DV	Explore ways to jointly administer housing rent subsidy programs and service programs (e.g. Medicaid), so that individuals eligible for services would also receive rent subsidies. Align flexible housing and rental assistance funds with service delivery systems.

		Create and map inventory of available resources
Have funding follow the client.		Identify the current funding configurations for typical populations
		Map the movement of the individual and the funding streams through types of housing
		Chart and evaluate the impacts of such a potential change.
Conduct outreach and marketing that reaches special needs clients where they are, using non-traditional partners such as courts, hospitals, and retailers	By 2008, 80% of people with special needs will know how to access services	Identify and map non-traditional partners. Develop culturally competent informational materials about available resources, with culturally specific content as needed. Develop kiosks, web sites, storefront displays, and public event booths.
Offer "safe haven" and low barrier shelter. Increase respite	By 2006, there will be 100 units of safe haven and low barrier shelter. By 2006, there will be 15 medical respite beds available in the system.	

PORTLAND-VANCOUVER INCOME LIMITS FOR YEAR 2003 AND THE FAIR MARKET LIMITS FOR 2003 EFFECTIVE IMMEDIATELY

Median Income Percentages Year 2003

FY 2003					65,800
Household Size	30%	50%	60%	80%	100%
1	13,800	23,050	27,650	36,850	46,050
2	15,800	26,300	31,600	42,100	52,650
3	17,750	29,600	35,550	47,400	59,200
4	19,750	32,900	39,500	52,650	**65,800**
5	21,300	35,550	42,650	56,850	71,050
6	22,900	38,150	45,800	61,050	76,350
7	24,500	40,800	48,950	65,250	81,600
8	26,050	43,450	52,100	69,500	86,850

(Based on the HUD Portland Area Median Income as of December 31,2002: **$65,800** for a family of four. Figures are rounded to the nearest $50.00).

These new guidelines should be used to determine program eligibility and to track beneficiaries. Most BHCD programs are tracked at 30% (very low income), 50% (low income) and 80% (moderate income).

For questions about applicability of these guidelines to particular programs or funding agreements, please contact your Program manager.

FAIR MARKET RENT FOR 2003

BEDROOM SIZE	FMR
0	$ 508
1	$ 625
2	$ 771
3	$1,073
4	$1,164

APPENDIX H: ACRONYMS

Acronym	Description
ADS	Aging and Disability Services, Division of Dept. of County Human Services
AFCH	Adult Foster Care Home
ALF	Assisted Living Facility
ADL	Activities of Daily Living
A&D	Alcohol and Drug
AMI	Area Median Income
BHCD	Bureau of Housing and Community Development, City of Portland
CDBG	Community Development Block Grant
CEBN	Emergency Basic Needs
CFC	Oregon's Consolidated Funding Cycle
CM	Case Management
DCHS	Multnomah County Dept. of County Human Services
DCJ	Multnomah County Dept. of Community Justice
DD	Developmental Disability
DHS	Department of Human Services, State of Oregon
EMO	Ecumenical Ministries of Oregon
ESRD	Emergency Services
FFS	
FHLB	Federal Home Loan Bank
HAP	Housing Authority of Portland
HCDC	Housing and Community Development Commission
HELP	State Homeless Federal Funding
HOME	The name of a grant. Not an acronym.
HUD	U.S. Dept of Housing and Urban Development
IRCO	Immigrant and Refugee Community Organization
JOIN	Organization that places homeless people into housing.
LIHTC	Low Income Housing Transfer Credit
MCCJ	Multnomah County Criminal Justice
MFI	Median Family Income
MH	Mental Health
MHS	Mental Health System
NARA	National Alliance of Rehabilitation
NOFA	Notice of Funding Availability (Federal)
OCF	Office of Children and Families (no longer exists)
OHCS	Oregon Housing and Community Services
OHP	Oregon Health Plan
PATH	Mental health homeless program
PDC	Portland Development Commission
RASP	Rental Assistance Support Program
RCF	Residential Care Facility
RFP	Request For Proposal

SNC	Special Needs Committee
SNF	Skilled Nursing Facility
SSD	Social Security Disability
SSI	Social Security Income
SRO	Subsidized Rent Occupancy
TIF	Tax Increment Financing
TSU	Multnomah County DCJ Transition Services Unit