

ANNOTATED MINUTES

*Tuesday, May 3, 1994 - 9:00 AM
Multnomah County Courthouse, Room 602*

BUDGET WORK SESSION

WS-1 *Work Session to Review and Discuss the COMMUNITY AND FAMILY SERVICES BUDGET for 1994-95 and CITIZENS BUDGET ADVISORY COMMITTEE (CBAC) REPORT - Presented by the Appropriate Department and Budget Staff*

LOLENZO POE, HOWARD KLINK, SUSAN CLARK, KATHY TINKLE, MURIEL GOLDMAN, BILL THOMAS AND JAMES EDMONDSON PRESENTATIONS AND RESPONSE TO BOARD QUESTIONS AND DISCUSSION. STAFF TO RESPOND TO FOLLOW UP INFORMATION REQUESTS.

*Tuesday, May 3, 1994 - 11:30 AM
Multnomah County Courthouse, Room 602*

BUDGET PUBLIC HEARING

Chair Beverly Stein convened the hearing at 11:30 a.m., with Vice-Chair Tanya Collier, Commissioners Sharron Kelley, Gary Hansen and Dan Saltzman present.

PH-1 *Public Hearing and Testimony for the COMMUNITY AND FAMILY SERVICES BUDGET*

CHRISTINA GERMAIN, BILL MUIR, DIANE FELDT, JAN SAVIDGE, BOB BERNSTEIN, ERIK STEN, DEBBIE ARUENFELD, DAVID FUKS, LARRY SANCHEZ, RICHARD LUCETTI, JUDY LOW AND VIEMG KHAMVOMGSA TESTIMONY IN SUPPORT OF PROPOSED BUDGET AND ADD PACKAGES.

There being no further public testimony, the hearing was adjourned at 12:15 p.m.

*Tuesday, May 3, 1994 - 1:00 PM
Multnomah County Courthouse, Room 602*

BOARD BRIEFING

B-1 *Briefing on the City of Portland's Approved Budget. Presented by Mayor Vera Katz.*

**MAYOR VERY KATZ PRESENTED AND RESPONSE TO
BOARD QUESTIONS AND DISCUSSION REGARDING
CITY OF PORTLAND'S APPROVED BUDGET.**

*Tuesday, May 3, 1994 - 1:30 PM
Multnomah County Courthouse, Room 602*

EXECUTIVE SESSION

Chair Beverly Stein convened the meeting at 1:40 p.m., with Vice-Chair Tanya Collier, Commissioners Sharron Kelley, Gary Hansen and Dan Saltzman present.

E-1 *Multnomah County Board of Commissioners Will Meet in Executive Session Pursuant to ORS 192.660 (1)(e) for Deliberations Concerning Real Property Transactions*

**FOLLOWING THE EXECUTIVE SESSION, THE BOARD
CONVENED IN OPEN SESSION FOR DISCUSSION.**

*Wednesday, May 4, 1994 - 9:00 AM
Multnomah County Courthouse, Room 602*

BUDGET WORK SESSION

WS-2 *Work Session to Review and Discuss the HEALTH DEPARTMENT BUDGET for 1994-95 and CITIZENS BUDGET ADVISORY COMMITTEE (CBAC) REPORT - Presented by the Appropriate Department and Budget Staff*

**BILLI ODEGAARD, TOM FRONK, DR. GARY OXMAN,
MARGE JOZSA, JOANNE DeHOFF, GORDON EMPEY,
SHARI BLAKESLEE, MARY LOU HENNRICH, JAN
SINCLAIR, DATHY PAGE, DARLENE YOUNG AND
DWAYNE PRATHER PRESENTATIONS AND RESPONSE
TO BOARD QUESTIONS AND DISCUSSION. STAFF TO
RESPOND TO FOLLOW UP INFORMATION REQUESTS.**

*Wednesday, May 4, 1994 - 11:15 AM
Multnomah County Courthouse, Room 602*

BOARD BRIEFING

B-2 *Update and Presentation on the Community Strength Meetings. Presented by*

BRIEFING CANCELLED.

*Wednesday, May 4, 1994 - 11:30 AM
Multnomah County Courthouse, Room 602*

BUDGET PUBLIC HEARING

Chair Beverly Stein convened the hearing at 11:30 a.m., with Vice-Chair Tanya Collier, Commissioners Sharron Kelley, Gary Hansen and Dan Saltzman present.

PH-2 Public Hearing and Testimony for the HEALTH DEPARTMENT BUDGET

**KENNETH YEE TESTIMONY IN OPPOSITION TO
CHAIR'S ENVIRONMENTAL HEALTH DIVISION
BUDGET PROPOSAL. BOB DONOUGH TESTIMONY IN
SUPPORT OF PUBLIC SAFETY ADD PACKAGES.**

*There being no further public testimony, the hearing was adjourned at 11:35
a.m.*

*Wednesday, May 4, 1994 - 1:30 PM
Multnomah County Courthouse, Room 602*

BUDGET PUBLIC HEARING

Chair Beverly Stein convened the hearing at 1:35 p.m., with Vice-Chair Tanya Collier, Commissioners Sharron Kelley, Gary Hansen and Dan Saltzman present.

**PH-2A Public Hearing and Testimony for the COMMUNITY AND FAMILY
SERVICES DIVISION and HEALTH DEPARTMENT BUDGETS**

**MICHAEL BALTER, DR. DAVID ROSENSTEIN, ORIN
BOLSTAD, TOM TROXEL, JUDITH MAYER, VICKI
SMEAD, CHRISTINE BRUNO, DEBRA EVANS, LESLIE
HAINES, KATHY OLIVER, VALARIE FAGERBERG,
CAROL LAINE, RON HURL, JEAN WAGNER, MARY A.
MILLS, KATHY HAMMOCK, PATTI SWANSON, KINDA
DULIO, BUZZ MARRON, JANET ROSENSTEIN,
GERALDINE WILLIAMS, DIANE FELDT, LINDA
BIFANO, DON TRUE, JULIA LING, SUSIE SILVA-
STROMMER, NATALIA SANCHEZ, LUCY UBALDO,
KEVIN FITTS, MARY CLAIRE BUCKLEY, LAURIE
BENDER AND DONNA SHILTZ-MARESH TESTIMONY**

**IN SUPPORT OR PROPOSED BUDGET AND ADD
PACKAGES.**

*There being no further public testimony, the hearing was adjourned at 3:45
p.m.*

**Wednesday, May 4, 1994 - 6:00 PM
Multnomah County Central Library - Auditorium
801 SW 10th Avenue**

**BUDGET OVERVIEW & ORIENTATION and
PUBLIC HEARING**

*Overview and Orientation of Multnomah County Chair's Proposed 1994-95
Budget*

**CHAIR BEVERLY STEIN AND DAVE WARREN
PRESENTATION TO PUBLIC QUESTIONS REGARDING
THE PROPOSED 1994-1995 EXECUTIVE BUDGET.**

*Chair Beverly Stein convened the hearing at 7:00 p.m., with Vice-Chair Tanya
Collier, Commissioners Sharron Kelley, Gary Hansen and Dan Saltzman present.*

**PH-3 Public Hearing and Testimony for the Multnomah County Proposed 1994-95
Budget**

**JUDITH WILD, ARDEN BALLOU, TOMAS AMADOR,
FARM SAETERN, JENNIFER NINN, TERESA TAYLOR,
JUANITA GLASS, MELIZZA DELANEY, MARILYN
MILLER, VALENTINA CORTEZ, ROSY ORTEGA,
CHRISTINA GERMAIN, BARBARA SULEK, ELIZABETH
PERRY, TINI MATT, DIANET GOMEZ, KALE
SAETERN, JIM FRANCESCONI, JUDY LOW, TERSIA
RODRIQUEZ, SULUTASEN AMADOR, JON KART,
NICOLE RENSENBRINK, JOE NAZZARO, SHANNON
GILBERT, CINNAMON BANCROFT, KASEY SAE CHAO
AND ARMANDO MAFFIA TESTIMONY IN SUPPORT OF
PROPOSED BUDGET AND ADD PACKAGES.**

*There being no further public testimony, the hearing was adjourned at 8:20
p.m.*

**Thursday, May 5, 1994 - 9:30 AM
Multnomah County Courthouse, Room 602**

REGULAR MEETING

Chair Beverly Stein convened the meeting at 9:36 a.m., with Vice-Chair Tanya Collier, Commissioners Sharron Kelley, Gary Hansen and Dan Saltzman present.

CHAIR STEIN REQUESTED THAT C-4 BE CONSIDERED WITH THE REGULAR AGENDA. UPON MOTION OF COMMISSIONER KELLEY, SECONDED BY COMMISSIONER SALTZMAN, MOTION TO MOVE C-4 TO THE REGULAR AGENDA WAS UNANIMOUSLY APPROVED.

CONSENT CALENDAR

UPON MOTION OF COMMISSIONER KELLEY, SECONDED BY COMMISSIONER COLLIER, THE CONSENT CALENDAR (ITEMS C-1, C-2, C-3 AND C-5) WAS UNANIMOUSLY APPROVED.

SHERIFF'S OFFICE

- C-1 *Dispenser Class C/Greater Privilege Liquor License Application Submitted by Sheriff's Office with Recommendation for Approval, for CLUB GENESIS, 13639 SE POWELL, PORTLAND*

DEPARTMENT OF ENVIRONMENTAL SERVICES

- C-2 *ORDER in the Matter of the Execution of Correction Deed D940971 for Certain Tax Acquired Property to AAA STRUCTURES INC.*

ORDER 94-79.

- C-3 *ORDER in the Matter of Contract 15765 for the Sale of Certain Real Property to GREGORY V. WEIGEL, FRANCESCA W. ROSEMEYER AND JUDITH ANN DONALDSON*

ORDER 94-80.

DEPARTMENT OF HEALTH

- C-5 *Ratification of an Intergovernmental Revenue Agreement, Contract #202294, between METRO and Multnomah County, Health Department to Provide Assistance and Guidance in the Completion of a Bloodborne Pathogens Program Services, Effective May 2, 1994 through May 1, 1995*

REGULAR AGENDA

NON-DEPARTMENTAL

- R-1 *Presentation in the Matter of Employee Service Awards Honoring Multnomah County Employees with Various Years of Service.*

BOARD GREETED, ACKNOWLEDGED AND PRESENTED 5 YEAR AWARDS TO CARRIE BUNCH OF DCC; NILS BITTNER DENNIS DEXTER, NASARIO GARCIA, DEBRA LONG, MARIA MALDONADO-KILIS, MICHAEL MATTHEW, PATRICIA THOMPSON AND CAROLYN ZWASCHKA OF DES; JAN MARIE COOPER AND NATALIE SHILLING OF LDS; RITA LYNE MARTIN, MARIA ROJO DE STEFFEY, JAY TUMBAGA AND BRYAN WALDEN OF NOND; DELORES ANDERSON, LISA DAVISON, VIRGINIA JONES, KATHERINE MARTIN, JAN OLSON, CAROLYN PFAENDER, CRYSTAL ROBINSON AND NANCY WILTON OF DSS; 10 YEAR AWARDS PRESENTED TO VICKI MARCH, GERARD WELCH AND SUSAN KAESER WINTERBOURNE OF DCC; CAROL BOWNE AND MARILYN HALL OF DA'S; KATHLEEN TUNEBERG OF DES; MEGAERA JARVIS, ELAINE MORGAN AND GAIL PARKER OF DLS; LAURA JEANETTE DEAN AND J. MICHAEL DOYLE OF NOND; STEPHEN BALOG AND KATHLEEN TINKLE OF DSS; 15 YEAR AWARDS PRESENTED TO BARBARA SKILES OF DA'S; ALLAN HOVDE, CAROL HOVDEY AND MURRAY SINGLETON OF DCC; GAIL ANDERSON AND DEANNA MAYER OF DES; MARGARET KHILNANI OF DSS; 20 YEAR AWARDS PRESENTED TO JEAN GUNN OF DA'S; LUCILLE BEIGHLEY AND HAROLD STANKEY OF DES; JOHN MILLER OF DSS; 25 YEAR AWARDS PRESENTED TO GREGG LOWE OF DA'S; LAWRENCE FLETCHER, LYNN LANGLEY, SHARON HOFFMANN AND NEWCOMBE WANG OF DES; 30 YEAR AWARDS PRESENTED TO W. REESE HOOPES OF DCC; AND MANUAL MIKE OF DSS.

- R-2 *PROCLAMATION in the Matter of Proclaiming May 12, 1994 as Chronic Fatigue Syndrome Awareness Day in Multnomah County, Oregon*

COMMISSIONER KELLEY MOVED AND COMMISSIONER HANSEN SECONDED, APPROVAL OF R-2. BILLI ODEGAARD INTRODUCED DEAN FLECK WHO PRESENTED VIDEO AND EXPLANATION. PATRICIA BERGIN-GALLUP READ PROCLAMATION FOR THE RECORD. PROCLAMATION 94-81 UNANIMOUSLY APPROVED.

NON-DEPARTMENTAL

R-3 Consideration in the Matter of Setting A Hearing Date Regarding an Appeal of the Revocation of an Adult Home Care License for Charla Dinnocenzo.

PETE KASTING, DEPUTY CITY ATTORNEY FOR THE CITY OF PORTLAND, REPRESENTING THE BOARD OF COUNTY COMMISSIONERS ON THIS ITEM, PRESENTED EXPLANATION AND RESPONSE TO BOARD QUESTIONS REGARDING THE POSSIBLE DECISION TO SET A HEARING DATE TO REVIEW THE APPEAL OF CHARLA DINNOCENZO FROM THE HEARINGS OFFICER DECISION REVOKING APPELLANTS'S ADULT CARE HOME LICENSE.

CHAIR STEIN PROPOSED TO ALLOW THREE MINUTES TO EACH SIDE TO EXPLAIN IF HEARING SHOULD BE GRANTED OR NOT.

MARTIN REEVES, ATTORNEY FOR THE APPELLANT, PRESENTED AND EXPLAINED WHY HEARING WITH ADDITIONAL EVIDENCE SHOULD BE GRANTED AND SCHEDULED.

CHIP LAZENBY, ASSISTANT COUNTY COUNSEL, PRESENTED OPTIONS AND RULES AVAILABLE TO THE BOARD TO MAKE A DECISION WITHOUT GRANTING AND ADDITIONAL HEARING. THE COMPLETE HEARINGS OFFICER RECORD WILL BE ON FILE WITH THE OFFICE OF THE BOARD CLERK AND AVAILABLE FOR REVIEW. MR. LAZENBY SUGGESTED THAT THERE WAS NO NEED FOR A HEARING.

MR. KASTING LISTED POSSIBLE OPTIONS WITH PARAMETERS.

UPON MOTION OF COMMISSIONER COLLIER, TO UPHOLD THE HEARINGS OFFICERS DECISION, FAILED FOR LACK OF SECOND.

COMMISSIONER KELLEY MOVED TO LEAVE RECORD OPEN TO RECEIVE WRITTEN TESTIMONY ON THE ISSUE OF THE PSYCHOLOGICAL CONDITION OF THE APPELLANT, SECONDED BY COMMISSIONER SALTZMAN, WAS UNANIMOUSLY.

TIME LINES AGREED ON BY ALL TO ALLOW FIVE WEEKS, WITH THREE WEEKS FOR THE PURPOSE OF OBTAINING PSYCHOLOGICAL EVALUATIONS FROM EACH SIDE, AND TWO WEEKS FOR EACH SIDE TO RESPOND TO THE EVALUATIONS, THEN TO RETURN TO THE BOARD OF COUNTY COMMISSIONERS FOR CONSIDERATION.

COMMISSIONER COLLIER STATED CONCERN FOR ANYONE WHO REMAINS IN THIS FACILITY FOR CARE DURING THIS PERIOD OF TIME.

STEVE BALOG PRESENTED RESPONSE TO BOARD QUESTION AND EXPLANATION AS TO WHAT IS CURRENTLY BEING DONE AND THE CONCERNS OF THE COUNTY FOR THE WELL BEING OF ANY AND ALL RESIDENTS OF THIS FACILITY.

MR. KASTING SUGGESTED ASK MR. REEVES IF HE CAN ASSURE THAT ACCESS AS PROVIDED BY THE RULES WILL BE PROVIDED AND IF THIS IS NOT BEING DONE, IT WILL COME BACK BEFORE THE BOARD MORE EXPEDITIOUSLY.

MR. REEVES RESPONDED THAT HE WOULD MAKE THIS RECOMMENDATION TO HIS CLIENT AND EXPLAIN THAT SHE MUST COMPLY WITH THE COUNTY REGULATIONS.

MR. KASTING SUGGESTED THAT THE BOARD PROCEED AS DESCRIBED WITH THE FIVE WEEKS TO SUBMIT ADDITIONAL TESTIMONY, BUT TO MAKE THIS PROCEDURE CONTINGENT UPON THE APPELLANT COMPLYING FULLY WITH ADMINISTRATIVE STAFF AND IF APPELLANT FAILS THIS ISSUE WOULD COME BACK BEFORE THE BOARD IMMEDIATELY TO TAKE OTHER ACTION.

UPON MOTION OF COMMISSIONER COLLIER, SECONDED BY COMMISSIONER HANSEN, IF THE APPELLANT IN THIS CASE DOES NOT COMPLY WITH COUNTY RULES IN REGARDS TO PROVIDING INFORMATION AND COMPLY WITH THE PSYCHIATRIC EVALUATIONS, THAT THIS ISSUE WILL IMMEDIATELY BE BROUGHT BACK BEFORE THE BOARD OF COUNTY COMMISSIONERS FOR

IMMEDIATE ACTION. ALSO, THE DATE FOR CONSIDERATION AND POSSIBLE ACTION WILL BE DETERMINED AFTER ALL RESPONSES HAVE BEEN RECEIVED. MOTION WAS UNANIMOUSLY APPROVED.

MANAGEMENT SUPPORT

- R-4** *RESOLUTION in the Matter of the Issuance and Sale of Short-Term Promissory Notes (Tax and Revenue Anticipation Notes, Series 1994) in the Amount of \$11,000,000 for the Purpose of Meeting Current Expenses of the County for the 1994-95 Fiscal Year*

COMMISSIONER KELLEY MOVED AND COMMISSIONER SALTZMAN SECONDED, APPROVAL OF R-4. DAVE BOYER PRESENTED EXPLANATION AND RESPONDED TO BOARD QUESTIONS. RESOLUTION 94-82 UNANIMOUSLY APPROVED.

DEPARTMENT OF ENVIRONMENTAL SERVICES

- C-4** *Budget Modification DES #15 Requesting Authorization to Transfer \$16,100 from Fair Fund Contingency into Personal Services to Fully Fund the Fair Administrator Position and a Temporary Clerical Position*

COMMISSIONER COLLIER MOVED AND COMMISSIONER KELLEY SECONDED, APPROVAL OF C-4. LANCE DUNCAN PRESENTED EXPLANATION AND RESPONSE TO BOARD QUESTIONS. BUDGET MODIFICATION UNANIMOUSLY APPROVED.

SERVICE DISTRICTS

(Recess as the Board of County Commissioners and convene as the Governing Body of Dunthorpe-Riverdale Sanitary Service District No. 1)

- R-5** *PUBLIC HEARING and First Meeting of the Board of County Commissioners Sitting as the Budget Committee for Dunthorpe-Riverdale Sanitary Service District No. 1 Regarding Acceptance and Approval of Fiscal Year 1994-95 Budget*

COMMISSIONER COLLIER MOVED, AND COMMISSIONER HANSEN SECONDED, APPROVAL OF R-5. JOHN DORST PRESENTED EXPLANATION AND RESPONSE TO BOARD QUESTIONS. NO PUBLIC TESTIMONY RECEIVED. R-5 WAS UNANIMOUSLY APPROVED.

(Recess as the Governing Body of Dunthorpe-Riverdale Sanitary Service District No. 1 and convene as the Governing Body of Mid-County Street Lighting Service District No. 14)

- R-6 *PUBLIC HEARING and First Meeting of the Board of County Commissioners Sitting as the Budget Committee for Mid-County Street Lighting Service District No. 14, Regarding Acceptance and Approval of Fiscal Year 1994-95 Budget*

COMMISSIONER COLLIER MOVED, AND COMMISSIONER HANSEN SECONDED, APPROVAL OF R-6. JOHN DORST PRESENTED EXPLANATION AND RESPONSE TO BOARD QUESTIONS. NO PUBLIC TESTIMONY RECEIVED. R-6 WAS UNANIMOUSLY APPROVED.

(Recess as the Governing Body of Mid-County Street Lighting Service District No. 14 and reconvene as the Board of County Commissioners)

SHERIFF'S OFFICE

- R-7 *Ratification of an Intergovernmental Agreement, Contract #800724, between the Metropolitan Explosive Disposal Unit (MEDU) and the Multnomah County Sheriff's Office to Participate in and Fund the Activities of the MEDU, Effective Upon Completion*

COMMISSIONER KELLEY MOVED AND COMMISSIONER HANSEN SECONDED, APPROVAL OF R-7. LARRY AAB PRESENTED EXPLANATION AND RESPONSE TO BOARD QUESTIONS. R-7 WAS UNANIMOUSLY APPROVED.

DEPARTMENT OF ENVIRONMENTAL SERVICES

- R-8 *RESOLUTION in the Matter of Exempting the Multnomah County Fair from Resolution 90-2 and Allowing the Multnomah County Fair to Serve Beer and Wine and to Enter into Sponsor Partnerships with Local Microbreweries and Wineries*

COMMISSIONER SALTZMAN MOVED AND COMMISSIONER COLLIER SECONDED, APPROVAL OF R-8. BARBARA RUTHERFORD-CREST PRESENTED EXPLANATION AND RESPONSE TO BOARD QUESTIONS. COMMISSIONER KELLEY AND COMMISSIONER HANSEN PRESENTED EXPLANATION WHY THEY WOULD NOT SUPPORT THIS RESOLUTION. RESOLUTION 94-83 APPROVED, WITH

**CHAIR STEIN, VICE-CHAIR COLLIER AND
COMMISSIONER SALTZMAN VOTING AYE, AND
COMMISSIONER KELLEY AND COMMISSIONER
HANSEN VOTING NO.**

DEPARTMENT OF HEALTH

- R-9 Request for Approval of a Notice of Intent to Apply for a Grant from the
Department of Health and Human Services for Funding the Development of
Integrated Service Networks**

**COMMISSIONER HANSEN MOVED AND
COMMISSIONER KELLEY SECONDED, APPROVAL OF
R-9. TOM FRONK PRESENTED EXPLANATION AND
RESPONSE TO BOARD QUESTIONS. R-9 WAS
UNANIMOUSLY APPROVED.**

PUBLIC CONTRACT REVIEW BOARD

*(Recess as the Board of County Commissioners and convene as the Public
Contract Review Board)*

- R-10 ORDER in the Matter of Exempting from Public Bidding a Contract with
Racal-Datcom for the Provision of Modems**

**COMMISSIONER SALTZMAN MOVED AND
COMMISSIONER KELLEY SECONDED, APPROVAL OF
R-10. SUSAN KAESER PRESENTED EXPLANATION
AND RESPONSE TO BOARD QUESTIONS. ORDER 94-
84 WAS UNANIMOUSLY APPROVED.**

*(Recess as the Public Contract Review Board and reconvene as the Board of
County Commissioners)*

NON-DEPARTMENTAL

- R-11 PUBLIC HEARING and Testimony in the Matter of the Proposed Midland
Branch Library Relocation and Possible Board Decision**

**PUBLIC TESTIMONY RECEIVED FROM MARK
RUHLAND, ELMER SANKEY, KEN BRUNEAU, MAVIS
HOLD, HOWARD HOLD, LELA JOANNE HILL, MARK
CVETKO, MARIANNE FELT, LES PRATT, DENNIS
RICHEY, MICHAEL DANA AND DIANE HARR.**

PUBLIC COMMENT

R-12 *Opportunity for Public Comment on Non-Agenda Matters. Testimony Limited to Three Minutes Per Person.*

NONE.

There being no further business, the meeting was adjourned at 11:45 a.m.

**OFFICE OF THE BOARD CLERK
for MULTNOMAH COUNTY, OREGON**


Carrie A. Parkerson

*Thursday, May 5, 1994 - 11:45 AM
Multnomah County Courthouse, Room 602*

BOARD BRIEFING

B-3 *Presentation and Discussion of Recommendations made by the 1994 Multnomah County Salary Commission, Presented by Judith Clark, Chair; Ron Craig and Mary Ann Wersch of the Multnomah County Salary Commission.*

**MULTNOMAH COUNTY AUDITOR, GARY BLACKMER
INTRODUCED JUDITH CLARK, CHAIR OF THE
MULTNOMAH COUNTY SALARY COMMISSION,
PRESENTED AND EXPLAINED THE DETAILED
REPORT OF THE SALARY COMMISSION.
INFORMATION ONLY, NO BOARD ACTION TAKEN AT
THIS TIME.**



MULTNOMAH COUNTY OREGON

OFFICE OF THE BOARD CLERK
SUITE 1510, PORTLAND BUILDING
1120 S.W. FIFTH AVENUE
PORTLAND, OREGON 97204

BOARD OF COUNTY COMMISSIONERS		
BEVERLY STEIN •	CHAIR	• 248-3308
DAN SALTZMAN •	DISTRICT 1	• 248-5220
GARY HANSEN •	DISTRICT 2	• 248-5219
TANYA COLLIER •	DISTRICT 3	• 248-5217
SHARRON KELLEY •	DISTRICT 4	• 248-5213
CLERK'S OFFICE •	248-3277	• 248-5222

AGENDA

MEETINGS OF THE MULTNOMAH COUNTY BOARD OF COMMISSIONERS FOR THE WEEK OF

May 2, 1994 - May 6, 1994

Tuesday, May 3, 1994 - 9:00 AM - Budget Work Session Page 2

Tuesday, May 3, 1994 - 11:30 AM - Budget Public Hearing Page 2

Tuesday, May 3, 1994 - 1:00 PM - Board Briefing Page 2

Tuesday, May 3, 1994 - 1:30 PM - Executive Session Page 2

Wednesday, May 4, 1994 - 9:00 AM - Budget Work Session Page 3

Wednesday, May 4, 1994 - 11:15 AM - Board Briefing Page 3

Wednesday, May 4, 1994 - 11:30 AM - Budget Public Hearing Page 3

Wednesday, May 4, 1994 - 6:00 PM - Budget Orientation Page 3
& Public Hearing - at the CENTRAL LIBRARY

Thursday, May 5, 1994 - 9:30 AM - Regular Meeting Page 4

Thursday, May 5, 1994 - 11:45 AM - Board Briefing Page 6

Thursday Meetings of the Multnomah County Board of Commissioners are taped and can be seen at the following times:

Thursday, 10:00 PM, Channel 11 for East and West side subscribers

Thursday, 10:00 PM, Channel 49 for Columbia Cable (Vancouver) subscribers

Friday, 6:00 PM, Channel 30 for Paragon Cable (Multnomah East) subscribers

Saturday 12:00 Noon, Channel 21 for East Portland and East County subscribers

INDIVIDUALS WITH DISABILITIES MAY CALL THE OFFICE OF THE BOARD CLERK AT 248-3277 OR 248-5222, OR MULTNOMAH COUNTY TDD PHONE 248-5040, FOR INFORMATION ON AVAILABLE SERVICES AND ACCESSIBILITY.

Tuesday, May 3, 1994 - 9:00 AM

Multnomah County Courthouse, Room 602

BUDGET WORK SESSION

9:00 - 11:30 AM

WS-1 *Work Session to Review and Discuss the **COMMUNITY AND FAMILY SERVICES BUDGET for 1994-95 and CITIZENS BUDGET ADVISORY COMMITTEE (CBAC) REPORT** - Presented by the Appropriate Department and Budget Staff*

Tuesday, May 3, 1994 - 11:30 AM

Multnomah County Courthouse, Room 602

BUDGET PUBLIC HEARING

11:30 AM - Noon

PH-1 *Public Hearing and Testimony for the **COMMUNITY AND FAMILY SERVICES BUDGET***

Tuesday, May 3, 1994 - 1:00 PM

Multnomah County Courthouse, Room 602

BOARD BRIEFING

B-1 *Briefing on the City of Portland's Approved Budget. Presented by Mayor Vera Katz. **1:00 PM TIME CERTAIN, 30 MINUTES REQUESTED.***

Tuesday, May 3, 1994 - 1:30 PM

Multnomah County Courthouse, Room 602

EXECUTIVE SESSION

E-1 *Multnomah County Board of Commissioners Will Meet in Executive Session Pursuant to ORS 192.660 (1)(e) for Deliberations Concerning Real Property Transactions - **1:30 TIME CERTAIN, 1 HOUR REQUESTED.***

Wednesday, May 4, 1994 - 9:00 AM

Multnomah County Courthouse, Room 602

BUDGET WORK SESSION

9:00 - 11:15 AM

WS-2 **Work Session to Review and Discuss the HEALTH DEPARTMENT BUDGET for 1994-95 and CITIZENS BUDGET ADVISORY COMMITTEE (CBAC) REPORT - Presented by the Appropriate Department and Budget Staff**

Wednesday, May 4, 1994 - 11:15 AM

Multnomah County Courthouse, Room 602

BOARD BRIEFING

B-2 **Update and Presentation on the Community Strength Meetings. Presented by Jo Ann Allen, Helen Richardson and Steve Johnson. 11:15 AM TIME CERTAIN, 15 MINUTES REQUESTED.**

Wednesday, May 4, 1994 - 11:30 AM

Multnomah County Courthouse, Room 602

BUDGET PUBLIC HEARING

11:30 AM - Noon

PH-2 **Public Hearing and Testimony for the HEALTH DEPARTMENT BUDGET**

Wednesday, May 4, 1994 - 6:00 PM

**Multnomah County Central Library - Auditorium
801 SW 10th Avenue**

**BUDGET OVERVIEW & ORIENTATION and
PUBLIC HEARING**

**6:00-7:00 PM Overview and Orientation of Multnomah County Chair's
Proposed 1994-95 Budget**

PH-3 **7:00-8:00 PM Public Hearing and Testimony for the Multnomah County
Proposed 1994-95 Budget**

Thursday, May 5, 1994 - 9:30 AM

Multnomah County Courthouse, Room 602

REGULAR MEETING

CONSENT CALENDAR

SHERIFF'S OFFICE

- C-1 *Dispenser Class C/Greater Privilege Liquor License Application Submitted by Sheriff's Office with Recommendation for Approval, for CLUB GENESIS, 13639 SE POWELL, PORTLAND*

DEPARTMENT OF ENVIRONMENTAL SERVICES

- C-2 *ORDER in the Matter of the Execution of Correction Deed D940971 for Certain Tax Acquired Property to AAA STRUCTURES INC.*
- C-3 *ORDER in the Matter of Contract 15765 for the Sale of Certain Real Property to GREGORY V. WEIGEL, FRANCESCA W. ROSEMEYER AND JUDITH ANN DONALDSON*
- C-4 *Budget Modification DES #15 Requesting Authorization to Transfer \$16,100 from Fair Fund Contingency into Personal Services to Fully Fund the Fair Administrator Position and a Temporary Clerical Position*

DEPARTMENT OF HEALTH

- C-5 *Ratification of an Intergovernmental Revenue Agreement, Contract #202294, between METRO and Multnomah County, Health Department to Provide Assistance and Guidance in the Completion of a Bloodborne Pathogens Program Services, Effective May 2, 1994 through May 1, 1995*

REGULAR AGENDA

NON-DEPARTMENTAL

- R-1 *Presentation in the Matter of Employee Service Awards Honoring Multnomah County Employees with Various Years of Service. 9:30 AM TIME CERTAIN, 20 MINUTES REQUESTED.*
- R-2 *PROCLAMATION in the Matter of Proclaiming May 12, 1994 as Chronic Fatigue Syndrome Awareness Day in Multnomah County, Oregon. 9:50 AM TIME CERTAIN, 10 MINUTES REQUESTED.*

- R-3 *Consideration in the Matter of Setting A Hearing Date Regarding an Appeal of the Revocation of an Adult Home Care License for Charla Dinnocenzo. 10:00 AM TIME CERTAIN, 10 MINUTES REQUESTED.*

MANAGEMENT SUPPORT

- R-4 *RESOLUTION in the Matter of the Issuance and Sale of Short-Term Promissory Notes (Tax and Revenue Anticipation Notes, Series 1994) in the Amount of \$11,000,000 for the Purpose of Meeting Current Expenses of the County for the 1994-95 Fiscal Year*

SERVICE DISTRICTS

(Recess as the Board of County Commissioners and convene as the Governing Body of Dunthorpe-Riverdale Sanitary Service District No. 1)

- R-5 *PUBLIC HEARING and First Meeting of the Board of County Commissioners Sitting as the Budget Committee for Dunthorpe-Riverdale Sanitary Service District No. 1 Regarding Acceptance and Approval of Fiscal Year 1994-95 Budget*

(Recess as the Governing Body of Dunthorpe-Riverdale Sanitary Service District No. 1 and convene as the Governing Body of Mid-County Street Lighting Service District No. 14)

- R-6 *PUBLIC HEARING and First Meeting of the Board of County Commissioners Sitting as the Budget Committee for Mid-County Street Lighting Service District No. 14, Regarding Acceptance and Approval of Fiscal Year 1994-95 Budget*

(Recess as the Governing Body of Mid-County Street Lighting Service District No. 14 and reconvene as the Board of County Commissioners)

SHERIFF'S OFFICE

- R-7 *Ratification of an Intergovernmental Agreement, Contract #800724, between the Metropolitan Explosive Disposal Unit (MEDU) and the Multnomah County Sheriff's Office to Participate in and Fund the Activities of the MEDU, Effective Upon Completion*

DEPARTMENT OF ENVIRONMENTAL SERVICES

- R-8 *RESOLUTION in the Matter of Exempting the Multnomah County Fair from Resolution 90-2 and Allowing the Multnomah County Fair to Serve Beer and Wine and to Enter into Sponsor Partnerships with Local Microbreweries and Wineries*

DEPARTMENT OF HEALTH

- R-9 *Request for Approval of a Notice of Intent to Apply for a Grant from the Department of Health and Human Services for Funding the Development of Integrated Service Networks*

PUBLIC CONTRACT REVIEW BOARD

(Recess as the Board of County Commissioners and convene as the Public Contract Review Board)

- R-10 *ORDER in the Matter of Exempting from Public Bidding a Contract with Racal-Datcom for the Provision of Modems*

(Recess as the Public Contract Review Board and reconvene as the Board of County Commissioners)

NON-DEPARTMENTAL

- R-11 *PUBLIC HEARING and Testimony in the Matter of the Proposed Midland Branch Library Relocation and Possible Board Decision, 11:15 AM TIME CERTAIN, 30 MINUTES REQUESTED.*

PUBLIC COMMENT

- R-12 *Opportunity for Public Comment on Non-Agenda Matters. Testimony Limited to Three Minutes Per Person.*

Thursday, May 5, 1994 - 11:45 AM

Multnomah County Courthouse, Room 602

BOARD BRIEFING

- B-3 *Presentation and Discussion of Recommendations made by the 1994 Multnomah County Salary Commission, Presented by Judith Clark, Chair; Ron Craig and Mary Ann Wersch of the Multnomah County Salary Commission. 11:45 AM TIME CERTAIN, 15 MINUTES REQUESTED.*

MULTNOMAH COUNTY BUDGET MEETING SCHEDULE

(April 22, 1994 Revision)

Community & Family Services Division (CFS) Work Session	5/3/94	9:00-11:30 am - Board Room +
<u>CFS Public Testimony</u>	<u>5/3/94</u>	<u>11:30-12:00 pm - Board Room</u>
Health Department (HD) Work Session	5/4/94	9:00-11:30 am - Board Room
<u>HD Public Testimony</u>	<u>5/4/94</u>	<u>11:30-12:00 pm - Board Room</u>
<u>*CFS/HD Public Testimony</u>	<u>5/4/94</u>	<u>1:30-4:30 pm - Board Room</u>
<u>Budget 101 Orientation</u>	<u>5/4/94</u>	<u>6:00-7:00 pm - Central Library</u>
<u>Public Hearing/Budget</u>	<u>5/4/94</u>	<u>7:00-8:00 pm - Central Library</u>
		<u>Auditorium, 801 SW 10th,</u>
		<u>Portland</u>
Aging Services Division (ASD) Work Session	5/9/94	10:00-11:30 am - Board Room
<u>ASD Public Testimony</u>	<u>5/9/95</u>	<u>11:30-12:00 pm - Board Room</u>
Juvenile Justice Division (JJD) Work Session	5/9/94	1:30-3:00 pm - Board Room
<u>JJD Public Testimony</u>	<u>5/9/94</u>	<u>3:00-3:30 pm - Board Room</u>
District Attorney (DA) Work Session	5/9/94	3:30-4:30 pm - Board Room
<u>DA Public Testimony</u>	<u>5/9/94</u>	<u>4:30-5:00 pm - Board Room</u>
Multnomah County Sheriff's Office (MCSO) Work Session	5/10/94	9:00-11:30 am - Board Room
<u>MCSO Public Testimony</u>	<u>5/10/94</u>	<u>11:30-12:00 pm - Board Room</u>
<u>*ASD/JJD Public Testimony</u>	<u>5/11/94</u>	<u>1:30-3:00 pm - Board Room</u>
<u>*DA/MCSO Public Testimony</u>	<u>5/13/94</u>	<u>9:30-12:00 pm - Board Room</u>
Department of Environmental Services (DES) Work Session	5/23/94	9:00-11:30 am - Board Room
<u>DES Public Testimony</u>	<u>5/23/94</u>	<u>11:30-12:00 pm - Board Room</u>
Department of Community Corrections (DCC) Work Session	5/23/94	1:30-4:30 pm - Board Room
<u>DCC Public Testimony</u>	<u>5/23/94</u>	<u>4:30-5:00 pm - Board Room</u>
DES & Management Support Services (MSS) Work Session	5/24/94	9:00-11:30 am - Board Room
<u>DES/MSS Public Testimony</u>	<u>5/24/94</u>	<u>11:30-12:00 pm - Board Room</u>

MULTNOMAH COUNTY BUDGET MEETING SCHEDULE - continued
(April 22, 1994 Revision)

Department of Library Services (DLS) Work Session	5/31/94	9:00-11:30 am - Board Room
<u>DLS Public Testimony</u>	<u>5/31/94</u>	<u>11:30-12:00 pm - Board Room</u>
<u>*DLS/DES/DCC Public Testimony</u>	<u>5/31/94</u>	<u>1:30-4:30 pm - Board Room</u>
Independent Agencies & Other Government Support Work Session	6/1/94	9:00-11:30 am - Board Room
<u>Ind/Other Public Testimony</u>	<u>6/1/94</u>	<u>11:30-12:00 pm - Board Room</u>
<u>Public Hearing/Budget</u>	<u>6/1/94</u>	<u>7:00-9:00 pm - Council Chambers, Gresham City Hall, 1333 NW Eastman Parkway, Gresham</u>
General Work Session	6/7/94	9:30-12:00 pm - Board Room
<u>Public Hearing/Budget</u>	<u>6/7/94</u>	<u>7:00-9:00 pm - Board Room</u>
General Work Session	6/8/94	9:30-12:00 pm - Board Room
General Work Session	6/14/94	9:30-12:00 pm - Board Room
General Work Session	6/15/94	9:30-12:00 pm - Board Room
<u>Public Hearing/Adopt Budget</u>	<u>6/16/94</u>	<u>9:30-12:00 pm - Board Room</u>

(* Denotes Additional Public Testimony As Needed)

+ Board Room Address:

Multnomah County Courthouse, Room 602
1021 SW Fourth Avenue, Portland, Oregon 97204

Contact the Office of the Board Clerk, 248-3277 or 248-5222
for Further Information

Michelle Rodriguez
had to leave -

sorry -

HISPANIC ACCESS CENTER

OREGON HUMAN DEVELOPMENT CORPORATION

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- Consejos
- Interpretación
- Y Más...



SERVICES:

- Employment
- Housing
- Counseling
- Interpretation
- And More...

(503) 236-9670

✓
PLEASE PRINT LEGIBLY!

MEETING DATE May 4, 1994

NAME Kenneth Yee

ADDRESS 1922 SW Idaho St.

STREET

Portland

CITY

97201

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM # Environmental
Health Budget

SUPPORT _____ **OPPOSE** ✓

SUBMIT TO BOARD CLERK

2/

PLEASE PRINT LEGIBLY!

MEETING DATE

5-4-94

NAME

Bob Donough

ADDRESS

Tri-County Youth Services Consortium
2045 WE MLK Jr Blvd

STREET

Alt

CR

97212

CITY

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

Public Safety
Add Packages

SUPPORT

OPPOSE

SUBMIT TO BOARD CLERK

1 ✓ # 1
PLEASE PRINT LEGIBLY!

MEETING DATE

5/4/94

NAME

Michael BALTER

ADDRESS

7427 SE Reed College PL

STREET

portland

CITY

97202

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

BUDGETS
AFFORDABLE

SUPPORT

ADD PACKAGES

OPPOSE

SUBMIT TO BOARD CLERK

2/ ✓
PLEASE PRINT LEGIBLY!

Rosenstein

MEETING DATE

5-14/94

NAME

DR. DAVID ROSENSTEIN

ADDRESS

611 SW CAMPUS DR

STREET

PORTLAND

97201

CITY

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

DONTOR CTRY

SUPPORT

OPPOSE

SUBMIT TO BOARD CLERK

3 ✓

5-4-94

ORIN BOLSTAD

7423 St 32

Portman On 9-10-2

ZIP CODE

B11262

✓

SUBMIT TO BOARD CLERK

42/

PLEASE PRINT LEGIBLY!

MEETING DATE

5-4-94

NAME

Tom Troxel Troxel

ADDRESS

710 Centr St

STREET

CITY

Oruga City

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

SUPPORT

OPPOSE

SUBMIT TO BOARD CLERK

4b ✓
PLEASE PRINT LEGIBLY!

MEETING DATE

5/4-94

NAME

Judith Mayer

ADDRESS

~~21~~ 6941 N Central

STREET

Portland, OR

CITY

97206
ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

Health

SUPPORT



OPPOSE

SUBMIT TO BOARD CLERK

5 ✓
PLEASE PRINT LEGIBLY!

MEETING DATE 5-4-94

NAME Licki Smead

ADDRESS 619 S.W. 11th 234

STREET

Portland

CITY

97205

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM # 11

SUPPORT X **OPPOSE** _____

SUBMIT TO BOARD CLERK

6✓
PLEASE PRINT LEGIBLY!

MEETING DATE ~~4-25~~ 5-4-94

NAME Christine Brand

ADDRESS 8225w 29th #4

STREET

Troutdale OR

97060

CITY

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM # DD

SUPPORT ✓ **OPPOSE** _____

SUBMIT TO BOARD CLERK

7✓
PLEASE PRINT LEGIBLY!

MEETING DATE

5-4-94

NAME

Debra Evans

ADDRESS

19550 E Burnside #26

STREET

Portland Ore

97233

CITY

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

22

SUPPORT

1 **OPPOSE**

SUBMIT TO BOARD CLERK

8 ✓
PLEASE PRINT LEGIBLY!

MEETING DATE

05-04-94

NAME

Leslie Haines

ADDRESS

3025 SW 11th

STREET

Portland OR 97201

CITY

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

PH-2A

SUPPORT

✓

OPPOSE

SUBMIT TO BOARD CLERK

9 ✓

PLEASE PRINT LEGIBLY!

MEETING DATE

5/4/94

NAME

Kathy Oliver

ADDRESS

1236 SW Salmon

STREET

Portland

CITY

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

Budget

SUPPORT

OPPOSE

SUBMIT TO BOARD CLERK

10 ✓
PLEASE PRINT LEGIBLY!

MEETING DATE

5-4-94

NAME

Valaris Fagerberg

ADDRESS

25800 Eagle Creek Rd

STREET

Eagle Creek, OR

CITY

97022

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

Corrections
mental

SUPPORT

X

OPPOSE

health

SUBMIT TO BOARD CLERK

11 ✓
PLEASE PRINT LEGIBLY!

MEETING DATE

5/4/98

NAME

CAROL LAINE

ADDRESS

601 NE 183rd

STREET

Portland OR 97230

CITY

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

Health

SUPPORT

☒

OPPOSE

Budget

SUBMIT TO BOARD CLERK

12 ✓
PLEASE PRINT LEGIBLY!

MEETING DATE

5-4-94

NAME

RON HURL

ADDRESS

15610 NE STANTON

STREET

PORTLAND OR 97230

CITY

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

DD

SUPPORT

OPPOSE

SUBMIT TO BOARD CLERK

13
✓

PLEASE PRINT LEGIBLY!

MEETING DATE

May 4, 1994

NAME

Jean Wagner

ADDRESS

Mt Hood Comm. College Head Start
10100 NE Prescott

STREET

Portland

OR 97220

CITY

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

Head Start

SUPPORT

✓

OPPOSE

SUBMIT TO BOARD CLERK

M/

PLEASE PRINT LEGIBLY!

MEETING DATE

5/4/94

NAME

Mary A. Mills

ADDRESS

2016 SE. 122 Ave, #18

STREET

Portland

CITY

97233

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

Headstart

SUPPORT

✓

OPPOSE

SUBMIT TO BOARD CLERK

15/

PLEASE PRINT LEGIBLY!

MEETING DATE

5/4/94

NAME

Kathy Hammock

ADDRESS

3 225 NW Couch

STREET

CITY

Portland, OR

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

Health

SUPPORT

OPPOSE

SUBMIT TO BOARD CLERK

Dept Budget

16/ ✓
PLEASE PRINT LEGIBLY!

MEETING DATE

5-4-94

NAME

Patti Swanson

ADDRESS

135 NW First

STREET

Grasham Dr

CITY

97030

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

P14-2A
Family Support Centers

SUPPORT



OPPOSE

SUBMIT TO BOARD CLERK

20

PLEASE PRINT LEGIBLY!

Michelle Rodriguez ^{MEETING DATE} 5-4-94

NAME Hispanic Access Center

ADDRESS 1533 E Burnside

STREET Port. OR 97214

CITY ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM # ? Family Support
? School

SUPPORT X **OPPOSE** Retention Projects

SUBMIT TO BOARD CLERK \$100,000 for Hispanics

I have to leave at 2:20.

18 ✓
PLEASE PRINT LEGIBLY!

MEETING DATE

5-4-94

NAME

LINDA Duihio

ADDRESS

134 NC 125th

STREET

CITY

PORTLAND ORE 97230

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

7

SUPPORT

OPPOSE

SUBMIT TO BOARD CLERK

17
(Not here)
PLEASE PRINT LEGIBLY!

MEETING DATE

5/4/94

NAME

Laura Milligan

ADDRESS

134 W. Burnside

STREET

Portland

CITY

97209

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

29

SUPPORT

OPPOSE

SUBMIT TO BOARD CLERK

19 ✓
PLEASE PRINT LEGIBLY!

MEETING DATE

5/4/94

NAME

BUZZ MARROW

ADDRESS

4924 SW FAIRMERE CT.

STREET

PORTLAND

CITY

97221

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

PH-2A

SUPPORT

✓

OPPOSE

SUBMIT TO BOARD CLERK

21/

PLEASE PRINT LEGIBLY!

MEETING DATE May 4, 1994

NAME Janet Rosenstein

ADDRESS 3352 NE 17th DR.

STREET

GRESHAM, OR 97030-4509

CITY

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM # RESPIRE / MENTAL HEALTH HEAD START

SUPPORT X OPPOSE
SUBMIT TO BOARD CLERK

22
✓
PLEASE PRINT LEGIBLY!

MEETING DATE 4-4-94

NAME GERALDINE Williams

ADDRESS 635 NE SIMPSON
STREET

Portland OR
CITY 97211
ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM # 4

SUPPORT _____ **OPPOSE** _____
SUBMIT TO BOARD CLERK

22 ✓
PLEASE PRINT LEGIBLY!

MEETING DATE 5-3

NAME Diane Feldt

ADDRESS 7704 N. Hereford
STREET

CITY

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM # Teen Clinics

SUPPORT

☒ **OPPOSE**

SUBMIT TO BOARD CLERK

24

PLEASE PRINT LEGIBLY!

MEETING DATE 5-4-94

NAME Linda Bifano

ADDRESS 4220 SW View Point Tr #8

STREET Portland, OR 97201

CITY Portland, OR **ZIP CODE** 97201

I WISH TO SPEAK ON AGENDA ITEM #

SUPPORT **OPPOSE**

SUBMIT TO BOARD CLERK

25✓

PLEASE PRINT LEGIBLY!

NAME DON True, M.D. MEETING DATE 5-4-94

ADDRESS 2024 NE 22nd Ave
STREET
PDY, OR 97212
CITY ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM # PH-2A

SUPPORT ☒ OPPOSE
SUBMIT TO BOARD CLERK

26/

PLEASE PRINT LEGIBLY!

MEETING DATE

5/4/94

NAME

JULIA LING

ADDRESS

Emanuel Hospital 2801 N. Gantubeau

STREET

Durham, NC

CITY

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

Health Dept.
Budget

SUPPORT

OPPOSE

SUBMIT TO BOARD CLERK

27✓

PLEASE PRINT LEGIBLY!

MEETING DATE 5-4-94

NAME Susie Silva-Strommer

ADDRESS 5402 SE Taylor St.

STREET

Portland OR 97215

CITY

ZIP CODE

Hispanic Recruitment & Retention

I WISH TO SPEAK ON AGENDA ITEM #

SUPPORT

X

OPPOSE

SUBMIT TO BOARD CLERK

28 ✓

PLEASE PRINT LEGIBLY!

MEETING DATE 5/4/94

NAME NATALIA SANCHEZ

ADDRESS 155 NE KANE #28

STREET

GRESHAM OR.

CITY

97030

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM # HISPANIC RECOGNITION & RETENTION

SUPPORT X **OPPOSE**

SUBMIT TO BOARD CLERK

29 ✓

PLEASE PRINT LEGIBLY!

MEETING DATE 5-4-94

NAME LUCY LIBARDO

ADDRESS 1999 NE DIVISION #39

STREET

GRESHAM, OR 97030

CITY

ZIP CODE

Hispanic Recruitment + Retention
I WISH TO SPEAK ON AGENDA ITEM #

SUPPORT

X

OPPOSE

SUBMIT TO BOARD CLERK

30✓

PLEASE PRINT LEGIBLY!

MEETING DATE 5-4-94

NAME Kevin Fitts

ADDRESS 2514 SE Ankeny #6
STREET
Portland, OR 97214
CITY ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM # Budget

SUPPORT ✓ OPPOSE _____
SUBMIT TO BOARD CLERK

31✓

PLEASE PRINT LEGIBLY!

MEETING DATE 5/4/94

NAME MARY CLAIRE BUCKLEY

ADDRESS 620 SW 5TH SUITE 907

STREET

PORTLAND 97210

CITY

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM # CORR. MH

SUPPORT ✓ **OPPOSE**

SUBMIT TO BOARD CLERK

32 ✓

PLEASE PRINT LEGIBLY!

MEETING DATE 5-4-94

NAME Laurie Bender

ADDRESS 630 SW Fifth Ave

STREET Portland, OR 97204

CITY ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM # Corrections

SUPPORT mental OPPOSE health

SUBMIT TO BOARD CLERK

33✓

PLEASE PRINT LEGIBLY!

MEETING DATE

5/4/94

NAME

Donna Shiltz-Maresch

ADDRESS

STREET

CITY

After 330 Pm

ZIP CODE

I WISH TO SPEAK ON AGENDA ITEM #

Health

SUPPORT

✓

OPPOSE

Budget

SUBMIT TO BOARD CLERK

MEETING DATE MAY 04 1994

AGENDA NUMBER WS-2 + PH-2

AGENDA PLACEMENT FORM

SUBJECT: 1994-95 Budget, Health Department

BOARD BRIEFING: Date Requested May 4, 1994

Amount of Time Needed: 2 and 1/2 hours & 1/2 hour Public Testimony

REGULAR MEETING: Date Requested

Amount of Time Needed:

DEPARTMENT: Nondepartmental DIVISION Planning & Budget

CONTACT: Dave Warren TELEPHONE : 248-3822

BLDG/ROOM: 106/1400

PERSON(S) MAKING PRESENTATION: Department staff and budget staff

ACTION REQUESTED

☐ INFORMATIONAL ONLY ☐ POLICY DIRECTION ☒ APPROVAL ☐ OTHER

SUMMARY (Statement of rationale for action requested, personnel and fiscal/budgetary impacts, if applicable):

Work session reviewing the Health Department budget for 1994-95 &

Public Testimony for the Health Department Budget for 1994-95

BOARD OF
COUNTY COMMISSIONERS
MULTNOMAH COUNTY
OREGON
1994 APR 26 AM 11:39

SIGNATURES REQUIRED:

ELECTED OFFICIAL: Beverly Stein

OR

DEPARTMENT MANAGER:

ALL ACCOMPANYING DOCUMENTS MUST HAVE REQUIRED SIGNATURES

Any Questions: Call the Office of the Board Clerk 248-3277/248-5222

1994-95 Budget Work Session & Public Hearing

Health Department

Wednesday, May 4

9:00 - 12:00

AGENDA

- | | | |
|-------------|---|--------------|
| I. | Department Budget Overview | 9:00 |
| II. | Community Health Council Report | 9:20 |
| III. | Discussion of Issues & Opportunities | 9:30 |
| | 1. CareOregon [page 3] | |
| | 2. Dental Care Organization [page 4] | |
| | 3. Refugee Early Employment Program [page 5] | |
| | 4. Corrections Health and Corrections Mental Health
[page 6] | |
| | 5. Drug Free Babies [page 7] | |
| | 6. School Based Clinics [page 8] | |
| | 7. Immunizations [page 9] | |
| | 8. North Portland Clinic [new- see packet #2] | |
| | 9. Outreach Coordination/Training [new- see packet # 2] | |
| IV. | Division Level Questions & Answers | 10:30 |
| | 1. Director's Office [page 18] | |
| | 2. Regulatory Health [page 21] | |
| | 3. HIV Clinics [page 29] | |
| | 4. Specialty Care Clinics [page 44] | |
| | 5. Field Services [page 53] | |
| | 6. CareOregon [page 57] | |
| | 7. Primary Care Clinics [page 59] | |
| | 8. Dental Services [page 69] | |
| | 9. Services & Support [page 75] | |
| | 10. Business & Administrative Services [page 84] | |
| | 11. Corrections Health [page 93] | |
| V. | Public Testimony | 11:30 |

MEMORANDUM

TO: Board of County Commissioners

FROM: Billi Odegaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 1 - CareOregon

1. Topic

CareOregon is a Division of Multnomah County Health Department which functions as a fully capitated health plan (FCHP) providing services to Oregon Health Plan (OHP) clients throughout the state.

2. Introduction

The Oregon Health Plan, which began February 1, 1994, is changing the way health care services are provided to low income Oregonians. A number of health plans are now competing for clients who have traditionally been served in County health clinics and other "safety net" clinics. It is important for these "safety net" providers to continue to operate because they make up a large percentage of the total primary care capacity in the community and without their participation in OHP, clients would not have health care access despite having an OHP membership card. These providers also have experience providing culturally relevant health services to low income, migrant and non-English speaking patients.

3. Analysis/Alternative

Had CareOregon not been developed, Health Department Medicaid clients would have been assigned to one of the other private plans under the Oregon Health Plan until their primary care provider capacity was reached. Many clients would have been determined eligible for OHP, but there simply would not have been enough primary care providers participating in OHP to meet their needs. The success of the OHP national demonstration project would be severely threatened.

Involvement of the County as the financial agent for CareOregon exposes the County to some degree of financial risk. The County is now contractually obligated to provide services through January 31, 1995; with approval of the 1994-95 Budget the Department will be authorized to contract for the February 1995 through January 1996 period.

4. Financial Impact

The CareOregon budget assumes a statewide enrollment of 35,000 members by the end of fiscal 1995 with 15,750 choosing Multnomah County Health Department Primary Care sites. If this level can be achieved, the plan will break even fiscally on a monthly basis and the Multnomah County Primary Care Division Clinics will have the level of revenue forecasted in the 1994-95 county Budget. Should this level not be achieved, the Department will need to reduce services and expenditures to balance its operating budget during 1994-95.

In the current year the Department has implemented an after hours access (Urgency Care) clinic. The Chair's 1994-95 proposal continues that clinic through next fiscal year, at a cost of \$184,000.

Staff Report - CareOregon

5. Legal Issues

- a) Earlier this year, a controversy arose as to whether it is appropriate for Multnomah County to establish contracts with Community and Migrant Health Centers and other health care providers outside the geographic boundaries of the County. The Board of County Commissioners passed RESOLUTION 93-384 on December 9, 1993 which resolved this question.
- b) Oregon Health Sciences University has agreed to "take the risk" for inpatient care statewide and specialty and ancillary services outside of Multnomah County. The contract between Multnomah and OHSU is currently being finalized by Multnomah County Counsel's Office and the State Attorney General's office to codify these verbal understandings and agreements.

6. Controversial Issues

- a) Other OHP contracted plans grounded in the private sector may consider that CareOregon has an unfair advantage in enrolling members since many potentially eligible clients have been traditionally receiving their "unsponsored" care at Multnomah County and other "partner" clinics. Prior to OHP funding for these clients, other private providers refused to provide them service.
- b) Although the State believes that there is insufficient primary care capacity without Multnomah County's participation in OHP, some private health systems and providers dispute the private sector capacity estimates and therefore question participation by "public" providers such as Multnomah County and OHSU.

7. Link To Current County Policies

Multnomah County Health Department provides Primary Care services in high schools, drug treatment centers, community outreach locations and links primary medical care with many community social and educational service providers. Additional movement toward integrated service sites and family support centers will be enhanced by a strong health and outreach component provided by Health Department staff and supported by OHP funds.

8. Citizen Participation

The CareOregon Advisory Board is comprised of nine members representing the partner agencies. In addition, the Health Department's Community Health Council (CHC), a 51% consumer board, has been involved in the creation of CareOregon and will continue to serve as one organized way of assuring citizen input. The CareOregon Advisory Board also plans to develop a strong committee structure in the near future which will include a Member Advisory Committee.

9. Partnerships And Collaboration

CareOregon is based totally on collaboration between public and private non-profit and private for-profit health care providers. The Advisory Board membership of OHSU, Clackamas County, and Oregon Primary Care Clinic representatives demonstrates these partnerships.

MEMORANDUM

TO: Board of County Commissioners

FROM: Billi Odegaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 2 - Dental Care Organization

1. Topic

The Oregon Health Plan Medicaid demonstration project which began February 1, 1994 includes dental benefits for both adults and children. The Plan mandates the delivery of care be done through a managed dental care organization (DCO).

The Dental Division, which has been providing managed dental care to children through MultiCare PCO, applied and received certification as a dental DCO under the rules of the Oregon Health Plan. The DCO is named MultiCare Dental.

MultiCare Dental consists of the three County dental clinics and Russell Street Dental Clinic (a community health center in North Portland). In addition, MultiCare Dental has negotiated contracts with OHSU and several private practice dental specialists to provide the specialty services to enrolled plan members.

2. Introduction

MultiCare Dental will provide access to dental care for low-income Multnomah County residents. Revenues from the plan could result in expansion of the program to meet the needs of the Division's target populations.

3. Analysis/Alternatives

MultiCare Dental has been approved by OMAP to enroll as many as 20,000 Multnomah County residents in the plan. The funding for enrollees is in the form of a capitation rate which will adequately fund the care delivered to enrollees who seek care.

There are two alternatives to forming a DCO for the Dental Division:

- a. To not form a DCO and encourage other DCOs and private practice dentists in the community to enroll and care for enrollees. The Dental Clinical Program would reduce in size and see only those County residents who fall through the eligibility cracks of the Oregon Health Plan. This option would significantly reduce access to needy clients as the Dental Division would need to rely more heavily on scarce General Fund dollars to fund the program. Access for non-English speaking clients who seek us for care because of our increased use of bilingual and bicultural staff would be impacted negatively.
- b. Option 2 would be to subcontract with established DCOs operating in Multnomah County. We would then accept clients enrolled with these plans and receive fee for service revenues. The fee for service revenues offered by the other DCOs appears to be about 60% of usual fees common in our community. The capitation rate we receive as a DCO is computed to be 80% of usual fees in our area. Therefore, if we were to choose this option our revenues would be impacted negatively. The benefit of both options is that we would not be "in competition" with private sector providers and thereby encourage their participation in treating low-income patients in our community. Historically, however in our community, dentists have not provided adequate access

for care and not met the needs of low-income, minority and uncompensated patients. Even Medicaid recipients have difficulty finding dentists who will treat them.

Involvement of the County as a DCO exposes the County to some degree of financial risk. The County is now contractually obligated to provide dental services through January 31, 1995; with approval of the 1994-95 Budget the Department will be authorized to contract for the February 1995 through January 1996 period.

4. Financial Impact

It is very difficult at this point in time to predict the financial impact of the DCO because of the number of unanswered variables including number of enrollees, pent up demand, and expanded benefit package. However, early counts are very positive. The plan will not have a negative impact on the General Fund.

5. Legal Issues

N/A

6. Controversial Issues

The DCO effort is not anticipated to raise any controversy, even in the Dental Community. The Dental Division has a long standing collaborative relationship with private dentists and even though MultiCare Dental is competing for enrollees like other plans there is no feeling of competition. All seem to agree that there is a need for as much access as possible to meet the care needs of eligible residents.

7. Link To Current County Policies

N/A

8. Citizen Participation

The Health Department's Community Health Council is supportive of the plan.

9. Partnerships And Collaboration

MultiCare Dental has collaborated with Russell Street Dental Clinic to be a provider option in the plan. Russell Street is a Community and Migrant Health Center which provides care to homeless, HIV positive and other low-income groups. Russell Street is also owned and operated by OHSU School of Dentistry.

MultiCare Dental also has an agreement with another DCO operating in the County for some specialty care as well as with several private practice dental specialists, OHSU School and Dentistry, Hospital Dental Services and CDRC Dental Clinic.

MEMORANDUM

TO: Board of County Commissioners

FROM: Billi Odegaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 3 - REEP

1. Topic

REEP (Refugee Early Employment Program) health services are provided to a monthly average of 900 refugees. 100 to 125 new refugees arrive each month in Multnomah County.

2. Introduction

Newly arriving refugees have traditionally been ineligible for the state's Medicaid program and have instead been eligible for a federally funded program of health, employment training and language education called REEP. The health component has been provided through a contract with Multnomah County Health Department for nine years. Oregon's implementation of the Oregon Health Plan (OHP) has raised discussion at the federal level regarding the necessity of having a separate health program for refugees now that the eligibility criteria for medical coverage has been expanded under OHP.

3. Alternatives

The state Office of Refugee Programs and the State OHP office are two separate offices at the State level with two separate funding sources. Discussions are occurring now about keeping them separate systems or combining the programs and have refugees be eligible for the OHP. Refugees could continue to receive their care through county clinics if the refugee clients choose CareOregon as their health plan. Refugee clients would also be free to select one of the other 12 OHP participating health plans. There are both potential public health and financial impacts to Multnomah County Health Department from any of these options.

4. Financial Impact

The cost of delivering health care to newly arriving refugees is significantly higher (nearly double) the cost of serving other low income residents. This is partially due to the need for all visits to be interpreted which lengthens the time need for each visit as well as the fact that most refugees have significant health problems which have been neglected in their countries of origin. The REEP program recognized these additional costs and paid a monthly capitation rate per enrollee of \$207/client. The current rate in the metro area for general OHP enrollees is less than half this monthly amount per client. If REEP is eliminated and all refugees were to enroll with OHP and choose CareOregon, MCHD would lose approximately \$1 million which currently provides a major source of funding for the International Health Clinic (IHC).

5. Legal Issues

The current contract which runs through September 30, 1994 has a 60 day advance notice for discontinuation of funding.

6. Controversial Issues

- a) Refugee clients receive public health screening at IHC soon after their arrival. Personal health problems are also screened for. MCHD has worked diligently over the past years to become knowledgeable, culturally competent health care providers able to serve the ever changing

refugee client nationalities. If clients are eligible for OHP and can choose any participating OHP Plan, but are required to first come to MCHD for the public health screenings and treatment, they will most likely choose CareOregon as their OHP plan. The general OHP rates will be inadequate to cover

their costs however, and CareOregon will have a major "adverse selection" problem which will jeopardize its fiscal solvency.

- b) If MCHD stops the initial public health screening of all newly arriving refugees, certain diseases, e.g. TB, which are endemic in some of the countries of origin, may be inadequately diagnosed and treated, thereby endangering the community at large.
- c) The current REEP program benefits are different from OHP benefits, making possible "discrimination" claims a possibility. Efforts are underway to make the benefit packages the same.

7. Links to Current County Policy

NA

8. Citizen Participation

The Department's Community Health Council (CHC) has representatives of the refugee community involved in its actions. MCHD is also an active part of the Refugee Forum which includes refugee service agencies and refugee advocates. We also work closely with the many Mutual Assistance Associations (MAA's).

9. Partnerships and Collaboration

MCHD's Refugee Services collaborate with the Voluntary Agencies ((VOLAG's) which sponsor refugee resettlement as well as other state, city and county agencies providing health, education, housing and employment services to refugee families.

MEMORANDUM

TO: Board of County Commissioners

FROM: Billi Odegaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 4 - Corrections Mental Health

1. Topic

To develop a continuum of mental health services which would provide the assessment, stabilization and community linkage for persons in custody.

2. Introduction

A comprehensive continuum of mental health services would include the following objectives:

- a. To increase mental health assessments, which would allow early identification of the actual number of persons with mental illness that are in custody.
- b. To increase mental health treatment in jail, which will allow for continued assessments, stabilization, education and community linkage upon release.

3. Background/Alternatives/Analysis

The Corrections Mental Health Services work group was formed to review current services and recommend more effective ways of serving persons in the criminal justice system who have mental health problems. Critical concerns have been identified:

- a. With the mental health system under pressure to reduce institutional bed space, persons with mental illness who are released from jail do not receive appropriate mental health treatment in the community.
- b. Because of the sheer numbers of clients booked per year, many of the persons with mental illness who are incarcerated do not receive assessments or stabilization during their incarceration, nor are they linked with follow-up services upon release from custody.

Alternatives to adoption of this proposal would be to continue services as they are at present, the results of which are listed in 3a and b. An added risk is that unidentified clients in crisis who go untreated, may lead to a continued deterioration of their condition or suicide. Likewise, clients who are released from custody without community linkage and treatment may very soon find their way back in custody.

4. Financial Impact

This add package is included in the Chair's budget proposal. It carries a cost in 1994-95 of \$381,961. No one time only or start-up costs are required. The package funds three linkage nurses, two assessment nurses, a half time Psychiatric mid level practitioner, and clerical support. Also included are funds for consulting psychiatric consultation.

5. Evaluation

The effectiveness of the proposal will be measured by:

- a. The number of persons identified as needing mental health services.
- b. The number of persons released from custody on psychiatric medications and/or
- c. The number of persons linked to mental health services in the community upon release

from custody.

Baseline data will be collected, to allow a basis for measurement and comparison to performance in future periods.

6. Legal Issues

Provision of "basic" mental health services is required for persons in custody. Case law and Community Standards are utilized to determine "basic". This proposal has been developed in concert with representatives from the District Attorney's Office, Public Defender's Office, Courts, Oregon Advocacy Center and other agencies.

ORS 169.076, 169.077, 169.760, 169.780, 426.215, 426.175, 426.295, 427.051.

7. Controversial Issues

This proposal is not controversial. In fact, this proposal directly addresses the growing concern among stakeholders in our community regarding the increased numbers of mentally ill in custody.

8. Link to Current County Policies and Benchmarks

This proposal is specific to the Urgent Benchmark of Access to Health Care. It also addresses Benchmarks for People related to Premature Mortality linked to alcohol/drug use and suicide.

9. Citizen Participation

This proposal has been developed in concert with representatives from the District Attorney's Office, Public Defender's Office, Multnomah County Courts, Oregon Advocacy Center and other agencies.

10. Other Government Participation

This proposal was developed in collaboration with the Multnomah County Sheriff's Office, Alcohol and Drug Program, Mental and Emotional Disability Program, Department of Community Corrections, Community Mental Health Centers, and others involved with the Target Cities Project.

MEMORANDUM

TO: Board of County Commissioners

FROM: Billi Odegaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 5 - Drug Free Babies

1. Topic

According to birth certificate data for 1992, 5.6% of the Multnomah County women giving birth admitted to substance use (alcohol and/or illicit drugs) during their pregnancy. An enhanced Prenatal Substance Abuse Intervention is needed to address this problem.

2. Introduction

Improving birth outcomes and reducing substance use during pregnancy have been high priorities for the Health Department for many years. The Chair's Budget includes additional funding to begin to bridge the gaps and inadequacies in existing services by: (1) improving early identification of substance use in prenatal clients; (2) by enhancing the linkages between prenatal medical services, treatment services, and other social services; and (3) by supporting pregnant women to successfully stay in treatment and continue with aftercare services.

3. Background/Analysis

Birth certificate data is certainly an underestimate of the actual prevalence of prenatal substance use. Population based prevalence estimates put the rate of prenatal substance abuse Statewide at about 11%.

Alternative approaches to reducing substance use during pregnancy are: 1) to implement urine drug tests for all prenatal clients seen through the Health Department clinics, followed by referrals to existing drug/alcohol treatment resources for positive screens; and 2) to create a substance abuse treatment program at a Health Department clinic site that would provide substance abuse assessment, treatment and aftercare services. Using urine screens with referrals to existing treatment would be the least costly alternative, as no new services are added. However, this is also likely the least effective alternative. Urine testing provides only a narrow window on drug use and is not considered a fool proof screening method. In addition, there is limited existing treatment capacity for pregnant women, and referrals without coordination and advocacy are unlikely to result in positive outcomes. Fears of sanctions brought about by positive urine screens may cause some women to delay or forego needed prenatal care services. Developing an on-site treatment program that provides substance abuse assessment and treatment might be effective, but would be quite costly, including need for more space and personnel.

A third alternative is really a blend of the first two. This model uses existing prenatal care services and substance abuse treatment services, but adds the following: (1) a substance abuse intervention specialist at the site of prenatal care services; (2) on-going case management through a community health nurse; (3) an outreach worker knowledgeable about treatment who can provide followup and support to insure that women become engaged in treatment. This "enhanced intervention" model would work in the following way: MCHD prenatal providers screen all prenatal clients for substance use during their prenatal clinic visit. For those women with a positive or questionable history of substance use there will be a referral to an on-site Alcohol and Drug Intervention Specialist (A & D IS). A more detailed assessment will then take place with three possible outcomes: 1) admitted substance use problem, or 2) no substance use problem, or 3) probable substance use, but client denies. Women admitting to substance use will be linked with an appropriate treatment program and referred to a Community Health Nurse (CHN) and an Outreach worker. The CHN will provide on-going case management throughout the pregnancy. The Outreach worker will follow up to assure women become engaged in treatment. Women with no substance use problem will be followed in the usual manner by the Health Department prenatal providers.

Women with probable substance use (but who deny) will be referred to the CHN for follow up and will be reassessed by the A&D IS later in the pregnancy.

The A&D IS will be part of the intake system being developed by the Alcohol & Drug Program Target Cities project. They will also do on-site support groups for prenatal clients who are substance users and provide training and consultation for HD staff. The CHN will provide linkage between the Health Department prenatal providers and the treatment programs to ensure continuity of prenatal care.

4. Financial Impact

The Chair's Budget includes funding for enhanced Prenatal Substance Abuse Intervention services, at a cost of \$121,500.

5. Legal Issues

Confidentiality between the Health Department medical provider and the substance abuse treatment program can be a barrier to collaborating on the client's treatment (Code of Federal Regulations, 42 CFR Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records.") It is a legal issue and is being currently addressed in the Target Cities program development.

CSD reporting laws require providers to report substance use during pregnancy that results in an infant that is drug-affected at birth. Generally this reporting requirement falls to the hospital delivering the baby, but women's fear of CSD reporting may affect their willingness to admit substance use.

6. Controversial Issues

Medical providers sometimes fear that confronting substance use during pregnancy may cause a woman to delay beginning prenatal care services, or to avoid services. In addition, pregnant women who are using drugs/alcohol may deny use and may resist efforts to identify use. Some community members may think legal intervention and mandating women to treatment is the appropriate approach. Sensitivity to all these perceptions is necessary for successful program development.

7. Link To Current County Policies

This approach is linked to the Board of County Commissioners benchmark of reducing drug affected babies, the Health Department's initiative of reducing drug affected babies, and to the Oregon Urgent Benchmark of reducing drug affected babies. It is consistent with County programs, such as ADAPT, START, and Target Cities.

8. Citizen Participation

None

9. Other Government Participation

This proposal will be closely tied to the Target Cities project of the Alcohol and Drug Program. Target Cities will be funding one Intervention Specialist at one clinic site. The Target Cities A&D IS will be doing assessments for all clinic clients. This proposal requests an additional A&D IS for an additional clinic site. The HD A&D IS will be considered a part of the centralized intake team. Target Cities will provide training, on-going clinical consultation, computer linkage between the Health Department and the intake system and access to treatment vouchers for women who are not eligible for Medicaid. The proposal also builds on the HD Primary Care Substance Abuse Linkage grant, which provides partial funding for an A&D Intervention Specialist for Northeast Health Center.

MEMORANDUM

TO: Board of County Commissioners

FROM: Billi Odegaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 6 - School Based Health Centers

1. Topic

Expansion of School Based Health Center services into Roosevelt Cluster Middle Schools; Expanded health services for students and their families at Roosevelt High School in North Portland; improved access to Mental Health Services at School Based Clinics.

2. Introduction

Middle school students age 11-14 years are at a vulnerable stage of development where experimentation with health risking behaviors become life long habits. These are prime years for making successful health interventions with these students and their families. Expanding services at Roosevelt School-Based Health Center for families of students and adding part time on-site clinical services at George and Portsmouth Middle schools would:

- provide greater access to primary and preventive health care for students and families
- permit early identification of health problems when intervention is more likely to be successful in reducing students' risk for premature sexual activity, pregnancy, STD, HIV, substance abuse, chronic physical and mental health problems and school failure.

Current evaluation of the SBHC program indicate that sexual activity often begins in middle school as indicated by the numbers of pregnant freshmen entering high school.

Each School Based Clinic has the services of a half time Mental Health Consultant. However, the frequency of acute and chronic mental health overlays to physical problems warrants expansion of mental health services.

3. Background/Alternative Analysis

The North Portland community is among the most medically underserved in our county. The Roosevelt community, via the Leaders Roundtable process, was the first community to identify the lack of and need for health services in the middle schools. The Roosevelt Cluster Steering Committee was the first to establish a health subcommittee to address this need. The Roosevelt SBHC, the first of seven SBHCs, began operating in 1986. There is more demand than current staff can meet at this site.

This proposal greatly improves access to health care for high school and middle school students and their families.

Currently students and families may receive services from a few primary care providers in the area, Providence, Emanuel, Bess Kaiser or the North Portland Health Center, which is at capacity. The St. John's area ranks as the most medically underserved community in the Portland area according to a recent Oregon Health Division Primary Care Needs Assessment.

Strong support for this proposal exists in the community, the school district and the Health Department. The Roosevelt cluster is one of the state's integrated service sites. Our RSBHC staff currently participates

in the steering committee which includes DHR, AFS, CSD, Portland Public Schools, ESD, Multnomah County Mental Health and numerous other local service providers.

4. Financial Impact

The Chair's budget includes funding for two middle schools (\$207,000); expansion of Roosevelt High School to allow inclusion of families (\$82,000); and increasing mental health services at each current high school site to full time (\$190,000).

5. Evaluation

A baseline needs assessment and health behavior survey will be conducted prior to offering services and at periodic intervals.

Over time, this proposal should contribute to reducing teen pregnancy rates in the N.P community and contribute to goal of 100% graduation.

Other key results:

- 1) Increase the number of students/families who receive ongoing services from primary care provider in their community.
- 2) Specific health needs of the middle school students/families will be identified and appropriate health services designed to address these issues.

6. Legal Issues

We will continue to support the rights of minors in receiving health care services. Students under 15 years of age must have parental consent for medical treatment. There is no age limit for minors to receive birth control information, HIV testing or STD diagnosis and treatment.

7. Controversial Issues

The specific site selection of the Roosevelt Cluster in North Portland was made jointly with Portland Public Schools. There was strong interest expressed by school officials from other clusters, specifically Jefferson and Marshall to site SBHCs in their respective areas. Reproductive Health Services is always a controversial subject and a clear policy about this issue and of parental consent for medical treatment will be developed with the school district and parents prior to opening for services.

8. Link to Current County Policies and Benchmark

This proposal is consistent with State and County benchmarks and builds on the model of integrated service sites for families. This proposal relates to key benchmarks concerning access to primary care and prevention of teen pregnancy.

9. Citizen Participation

The Roosevelt Cluster Caring community identified lack of health care as a top concern of students and families which is a barrier to 100% graduation. Community members currently sit on the RSBHC Advisory Board and will continue to be an integral part of this proposal through the needs assessment survey and as members of the new advisory boards at the middle schools.

10. Other Government Participation

The success of this proposal requires strong collaboration and partnership with Portland Public Schools, ESD school health services, the Roosevelt Family Resource Center and local service providers. This strong model enhances the probability that the Health Department will secure Robert Wood Johnson funding to replicate this model elsewhere in the county.

MEMORANDUM

TO: Board of County Commissioners

FROM: Billi Odegaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 7 - Immunizations

1. Topic

This issue describes the activities planned for the next 12 months to improve immunization levels of all Multnomah County children up to 24 months of age.

2. Introduction

Though immunizations have been considered one of the mainstays of public health services, numerous barriers to immunizations have resulted in low immunization levels nationwide, in Oregon and Multnomah County. Factors associated with low immunization rates are 1) failure to coordinate efforts between public and private sector organizations, 2) lack of a central record-keeping systems to track childrens immunization status, 3) lack of a major effort to educate the community at a grassroots level. During the last two years, increased emphasis has been placed on immunizations with the organization of the Oregon Preschool Immunization Consortium, which has representation from more than 40 private, public, voluntary and professional organizations.

3. Analysis/Alternatives

Recent assessment has shown that only 52% of all Multnomah County children were up-to-date on their immunizations, 60% of children receiving one or more vaccines from Multnomah County Health Department are up-to-date. In Oregon, 49.9% of Oregon's two-year-olds are adequately immunized. Currently, 76% of Multnomah County's children receive immunizations from the private health care providers (including HMOs such as Kaiser) and 24% from the Health Department and our delegate agencies. About 85% of the State's children have health insurance. Medicaid and HMO type policies cover the full costs of childhood immunizations while private insurance policies cover immunization costs for between 50 and 75% of subscribers.

Alternatives

- Maintaining the current system is not likely to improve immunization levels. This system, with the school immunization law, has provided 98% immunization levels for school-age children but has had a limited effect on preschool children's immunization levels.
- Enhancing the Health Department delivery system by expanding hours, adding staff and sponsoring free community based clinics has the potential to improve immunization levels. This will require expansion of the roles of volunteers, service organizations, church groups and professional organizations to provide contact with families in need of immunizations.
- Service clubs are interested in and have been sponsoring the NW Medical Team Health Van to provide immunizations at various sites in the community as a part of their outreach. The Van can be set up at a variety of locations including housing developments, camps, churches, shopping centers, and other community centers for targeted populations. Again, this will require community-based outreach. Because of local club involvement, the Van has been successful in bringing children in for immunizations.

- Private and public providers are making a concerted effort to reduce missed opportunities to provide immunizations. This involves providing immunizations in an easily accessible manner, providing immunizations in conjunction with other services (e.g., urgency and emergency room, WIC appointments, etc).
- Improving public/private cooperation including community networking, education, improved service delivery, and developing a centralized system of immunization record-keeping and tracking, regardless of delivery site.
- Utilization of an outreach worker to follow-up on children who are behind in their immunizations could enhance the program by bringing children in for needed immunizations, and identifying barriers to families obtaining immunization services.

4. Financial Impact

Because of the availability of federal funds IAP (Immunization Action Plan) through CDC, most of the proposed alternatives are feasible and funded. IAP money is planned for three years. Changes in funding at the federal level would significantly impact the continued operation of this program.

5. Legal Issues

None

6. Controversial Issues

There is a small segment of our community who philosophically do not believe in the value of immunizations or refuse immunizations for religious reasons. Naturopathic practitioners prefer to use herbal vaccines and/or delayed immunization schedules. School Immunization law allows religious and medical exemptions for school attendance.

7. Link to Current County Policies

Immunizations have always been provided by the Health Department and are part of our integrated service delivery system. Immunization levels are a National and State Benchmark.

8. Citizen Participation

Because of efforts of OPBS Channel 10, the Oregon Preschool Immunization Consortium and the IAP funding from CDC, there is much involvement of local service clubs, churches and children's programs and facilities working together to improve immunization levels. The Multnomah County Health Department Community Health Council has been very supportive of efforts to improve service delivery and outreach to the communities to bring families in for services.

9. Partnerships and Collaboration

In conjunction with the Oregon Preschool Immunization Consortium, Multnomah County has worked collaboratively with Health Systems in Collaboration to improve immunization levels. This group consists of CEOs and representatives from the Legacy, Sisters of Providence, Kaiser, Blue Cross-Blue Shield and OHSU health systems. The group's focus is improving immunization services within the private health care sector. Efforts have focused on development of a state wide registry system for collecting immunization information on all children born after Jan 1, 1995.

MEMORANDUM

TO: Board of County Commissioners

FROM: Billi Odegaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 8 - North Portland Space

1. Topic

The North Portland Clinic is currently housed in six duplex units. The North Portland Field Team is housed at a separate site. North Portland is the smallest general purpose Primary Care Clinic. It has no dental care on site. It is strategically the most attractive site for its local residents who will be choosing a health care provider under the Oregon Health Plan.

2. Introduction

The lead time necessary to allow renovation of the North Portland site will over a year. There are several steps that may be taken to begin the process. Examples include researching federal regulations regarding the use of the Villa space for this purpose, securing required zoning variances, and developing a proposal for exchanging the Villa property for tax foreclosed property.

The goal of the project is to increase the clinic's primary care space capacity, to allow the addition of dental services in response to rapidly rising DCO enrollment, and to co-locate the Field Team, which is currently renting space elsewhere.

3. Analysis/Alternatives

The Department is requesting that the Board approve policy of renovating the North Portland Clinic site. This would:

- 1) Allow the County to begin the process of securing a conditional use permit to allow clinical expansion;
- 2) Put together a package of tax foreclosed properties to replace the housing units that the County is using, leading to an intergovernmental agreement allowing transfer of title;
- 3) Authorize the Finance Manager a COP ceiling which would include the North Portland Clinic.

This will allow the Department to shorten the time between final project approval and the completion of the project.

There will be future decision points. The agreement with HAP for a property exchange will require Board approval. The Finance Director will seek Board approval before borrowing project funds.

4. Financial Impact

The Chair's 1994-95 Budget includes \$1.5 million in COP proceeds for renovation or replacement of the North Portland site, an estimate based on the 1992 cost of this project. There is no payment budgeted, as payments would begin in 1995-96.

The current estimate of the cost of this project is \$1.8 to \$2.0 million. The annual debt retirement cost would be approximately \$155,000 to \$172,000, assuming 6% as the cost of the COP and a twenty year amortization.

5. Legal Issues

There are several legal issues around the use of HUD subsidized housing for this purpose. Board approval at this time would start the process of resolving these issues.

6. Controversial Issues

N/A

7. Link To Current County Policies

The County is a major participant in the Oregon Health Plan as a provider of medical and dental services. These improvements in the North Portland site would better position the County as a provider of these services to citizens of North Portland.

8. Citizen Participation

The Health Department's Community Health Council is supportive of the plan.

9. Partnerships And Collaboration

The Housing Authority will be assisting in the development of this project, including taking the lead with HUD to move a transfer agreement through the federal government.

TO: Board of County Commissioners

FROM: Billi Odegaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 9 - **Outreach Workers**

1. Topic

This proposal requests funding for the development and implementation of a coordinated orientation and training program for all county outreach workers. Once developed and piloted in the County, this program will be available to other community agencies and volunteers to strengthen the linkages between existing programs and referral resources.

2. Introduction

The concept of more intensive "outreach" and developing one-on-one connections to people is gaining favor in many programs. Plans are underway to coordinate the many different outreach components of existing county programs. This orientation and training curriculum will consolidate and enhance the knowledge, skills and abilities of all workers involved in outreach and provide consistent orientation for new employees assigned to the increasing outreach efforts throughout the county. The outcome will be a highly skilled and knowledgeable group of community specialists in outreach and community organizing with both basic competencies and specific programmatic knowledge and abilities.

3. Background/Alternative/Analysis

The Health Department has significantly increased its capacity to provide outreach services to county residents through specific outreach programs and outreach workers in general health programs. Other County Departments also have similar community specialists who are responsible for seeking out individuals in target populations to provide education and referrals to existing resources. The new Family Support Initiative contains a strong outreach component. Currently, each program recruits, orients and provides ongoing inservice to its own outreach workers. Programmatic benefit could be gained by developing a core curriculum for all such employees and making the same training available to other agencies and community organizations for staff and volunteers.

The Program Development Specialist funded in this proposal will assess the current orientation and training programs for outreach staff, identify any gaps in training, identify in-house resources, evaluate appropriate external resources such as local trainers or community college programs, and design a comprehensive training program. The training will build on the unique talents and life experiences of people who are successful in providing outreach services to different communities. The training plan will include a core of basic competencies relevant for all outreach workers, plus optional modules to address program specific needs. Basic skills may include specific communication techniques for interviewing and educating people from different target populations, community organizing and leadership skills, recognition and reporting requirements for child abuse, knowledge of the existing Information and Referral system. Each program or Department will have specific training needs related to the content of the program, the setting, the community, and the target population. In collaboration with those programs, the PDS will design different modules that will enhance the core training program to meet those programmatic needs.

Once the curriculum is developed, the PDS will work with the County's District Coordinators or program managers to implement the orientation and training program. Ultimately, the Health Department will make the course available to other organizations with similar staff such as "community agents", "gatekeepers", "resource specialists," and other positions. Immediate possibilities include outreach programs at Coalition

of Community Health Clinics like Neighborhood Health Centers or Portland Public Schools, and City of Portland Neighborhood Associations.

4. Financial Impact

This proposal will reduce the general fund by approximately \$60,200.

5. Evaluation

Methodology for evaluating this program would need to be developed. Possible indicators include: satisfactory completion of training program by current county employees; satisfactory completion of training program by new county employees; satisfactory performance evaluation of training participants by program managers; participation and satisfactory completion of training by staff from other organizations; participation and satisfactory completion of training by volunteers from the County and other organizations.

Client feedback regarding quality, availability, and appropriateness of services will be obtained.

6. Legal Issues

None.

7. Controversial Issues

This proposal is not controversial. It will provide a mechanism for several interested agencies with similar outreach needs to work together and develop a corps of skilled community outreach workers to maximize the effectiveness of existing resources.

8. Link to Current County Policies and Benchmarks

Success in achieving many County, City and State benchmarks will depend on the effectiveness and initiative of outreach workers in connecting with individuals and encouraging them to use the resources available to them. Outreach workers have already demonstrated what they can do to link pregnant women to prenatal care or drug users to treatment programs. Individual employees and outreach teams have developed innovative methods and techniques, often through trial and error. Sharing what they have learned with each other across county organizational lines and with new employees will expand the capabilities of all the programs. Finally, we know that many problems we face in the Health Department are in fact complex societal problems with a medical consequence. To be effective, outreach workers and community specialists must be able to bring to bear a range of resources regardless of governmental jurisdictions and organizational boundaries.

9. Citizen Participation

The Multnomah County Community Health Council supports such intergovernmental arrangements to more fully address health-related issues in the community. Also, community members of the Council have often requested assistance from the Health Department in training their staff along with County employees. Whenever space permits, we have accommodated those requests with mutually beneficial results.

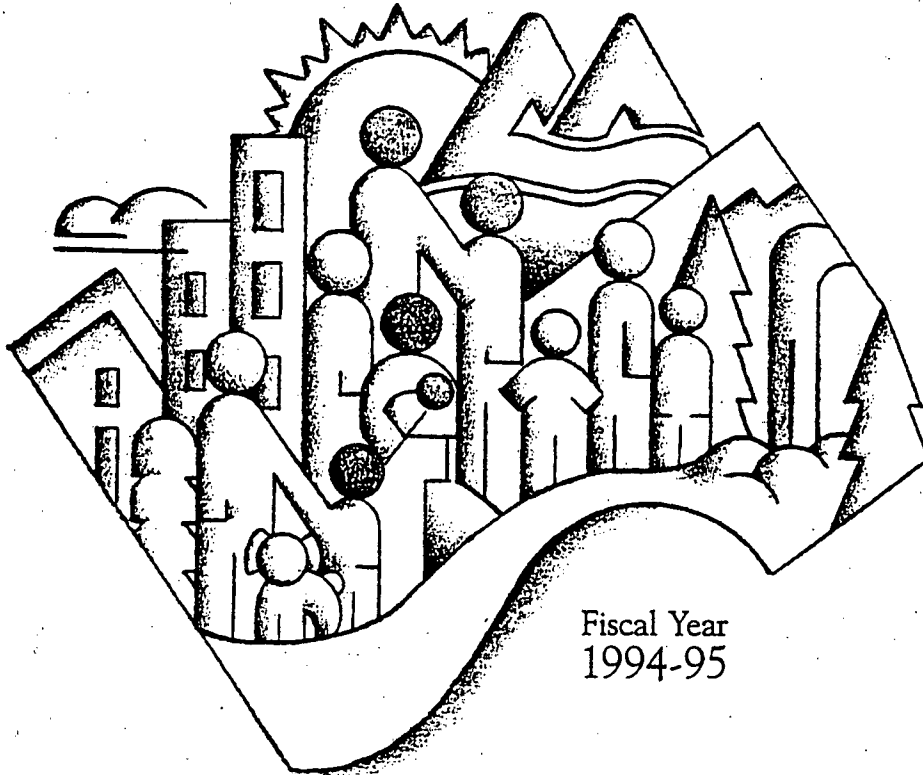
10. Other Government Participation

We expect the Community and Family Services Department will be interested in collaborating in the development and implementation of this proposal. Other county possibilities include the Libraries, Aging Services programs, and Animal Control. We believe Portland Public Schools and City of Portland Office of Neighborhood Associations will also be interested in collaborating in a joint training initiative. The PDS will explore all these possibilities as part of the initial needs assessment and design of the training plan.

*Budget Work Session
5-4-94*

Multnomah County Budget

Supplemental Information



Packet # 2

Health Department
Issues & Opportunities Reports

MEMORANDUM

TO: Board of County Commissioners

FROM: Bill Odgaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 1 - CareOregon

1. Topic

CareOregon is a Division of Multnomah County Health Department which functions as a fully capitated health plan (FCHP) providing services to Oregon Health Plan (OHP) clients throughout the state.

2. Introduction

The Oregon Health Plan, which began February 1, 1994, is changing the way health care services are provided to low income Oregonians. A number of health plans are now competing for clients who have traditionally been served in County health clinics and other "safety net" clinics. It is important for these "safety net" providers to continue to operate because they make up a large percentage of the total primary care capacity in the community and without their participation in OHP, clients would not have health care access despite having an OHP membership card. These providers also have experience providing culturally relevant health services to low income, migrant and non-English speaking patients.

3. Analysis/Alternative

Had CareOregon not been developed, Health Department Medicaid clients would have been assigned to one of the other private plans under the Oregon Health Plan until their primary care provider capacity was reached. Many clients would have been determined eligible for OHP, but there simply would not have been enough primary care providers participating in OHP to meet their needs. The success of the OHP national demonstration project would be severely threatened.

Involvement of the County as the financial agent for CareOregon exposes the County to some degree of financial risk. The County is now contractually obligated to provide services through January 31, 1995; with approval of the 1994-95 Budget the Department will be authorized to contract for the February 1995 through January 1996 period.

4. Financial Impact

The CareOregon budget assumes a statewide enrollment of 35,000 members by the end of fiscal 1995 with 15,750 choosing Multnomah County Health Department Primary Care sites. If this level can be achieved, the plan will break even fiscally on a monthly basis and the Multnomah County Primary Care Division Clinics will have the level of revenue forecasted in the 1994-95 county Budget. Should this level not be achieved, the Department will need to reduce services and expenditures to balance its operating budget during 1994-95.

In the current year the Department has implemented an after hours access (Urgency Care) clinic. The Chair's 1994-95 proposal continues that clinic through next fiscal year, at a cost of \$184,000.

Staff Report - CareOregon

5. Legal Issues

- a) Earlier this year, a controversy arose as to whether it is appropriate for Multnomah County to establish contracts with Community and Migrant Health Centers and other health care providers outside the geographic boundaries of the County. The Board of County Commissioners passed

RESOLUTION 93-384 on December 9, 1993 which resolved this question.

b) Oregon Health Sciences University has agreed to "take the risk" for inpatient care statewide and specialty and ancillary services outside of Multnomah County. The contract between Multnomah and OHSU is currently being finalized by Multnomah County Counsel's Office and the State Attorney General's office to codify these verbal understandings and agreements.

6. Controversial Issues

a) Other OHP contracted plans grounded in the private sector may consider that CareOregon has an unfair advantage in enrolling members since many potentially eligible clients have been traditionally receiving their "unsponsored" care at Multnomah County and other "partner" clinics. Prior to OHP funding for these clients, other private providers refused to provide them service.

b) Although the State believes that there is insufficient primary care capacity without Multnomah County's participation in OHP, some private health systems and providers dispute the private sector capacity estimates and therefore question participation by "public" providers such as Multnomah County and OHSU.

7. Link To Current County Policies

Multnomah County Health Department provides Primary Care services in high schools, drug treatment centers, community outreach locations and links primary medical care with many community social and educational service providers. Additional movement toward integrated service sites and family support centers will be enhanced by a strong health and outreach component provided by Health Department staff and supported by OHP funds.

8. Citizen Participation

The CareOregon Advisory Board is comprised of nine members representing the partner agencies. In addition, the Health Department's Community Health Council (CHC), a 51% consumer board, has been involved in the creation of CareOregon and will continue to serve as one organized way of assuring citizen input. The CareOregon Advisory Board also plans to develop a strong committee structure in the near future which will include a Member Advisory Committee.

9. Partnerships And Collaboration

CareOregon is based totally on collaboration between public and private non-profit and private for-profit health care providers. The Advisory Board membership of OHSU, Clackamas County, and Oregon Primary Care Clinic representatives demonstrates these partnerships.

MEMORANDUM

TO: Board of County Commissioners

FROM: 
Bill Odegaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 2 - Dental Care Organization

1. Topic

The Oregon Health Plan Medicaid demonstration project which began February 1, 1994 includes dental benefits for both adults and children. The Plan mandates the delivery of care be done through a managed dental care organization (DCO).

The Dental Division, which has been providing managed dental care to children through MultiCare PCO, applied and received certification as a dental DCO under the rules of the Oregon Health Plan. The DCO is named MultiCare Dental.

MultiCare Dental consists of the three County dental clinics and Russell Street Dental Clinic (a community health center in North Portland). In addition, MultiCare Dental has negotiated contracts with OHSU and several private practice dental specialists to provide the specialty services to enrolled plan members.

2. Introduction

MultiCare Dental will provide access to dental care for low-income Multnomah County residents. Revenues from the plan could result in expansion of the program to meet the needs of the Division's target populations.

3. Analysis/Alternatives

MultiCare Dental has been approved by OMAP to enroll as many as 20,000 Multnomah County residents in the plan. The funding for enrollees is in the form of a capitation rate which will adequately fund the care delivered to enrollees who seek care.

There are two alternatives to forming a DCO for the Dental Division:

- a. To not form a DCO and encourage other DCOs and private practice dentists in the community to enroll and care for enrollees. The Dental Clinical Program would reduce in size and see only those County residents who fall through the eligibility cracks of the Oregon Health Plan. This option would significantly reduce access to needy clients as the Dental Division would need to rely more heavily on scarce General Fund dollars to fund the program. Access for non-English speaking clients who seek us for care because of our increased use of bilingual and bicultural staff would be impacted negatively.
- b. Option 2 would be to subcontract with established DCOs operating in Multnomah County. We would then accept clients enrolled with these plans and receive fee for service revenues. The fee for service revenues offered by the other DCOs appears to be about 60% of usual fees common in our community. The capitation rate we receive as a DCO is computed to be 80% of usual fees in our area. Therefore, if we were to choose this option our revenues would be impacted negatively. The benefit of both options is that we would not be "in competition" with private sector providers and thereby encourage their participation in treating low-income patients in our community. Historically, however in our community, dentists have not provided adequate access for care and not met the needs of low-income, minority and uncompensated patients. Even Medicaid recipients have difficulty finding dentists who will treat them.

Involvement of the County as a DCO exposes the County to some degree of financial risk. The County is now contractually obligated to provide dental services through January 31, 1995; with approval of the 1994-95 Budget the Department will be authorized to contract for the February 1995 through January 1996 period.

4. Financial Impact

It is very difficult at this point in time to predict the financial impact of the DCO because of the number of unanswered variables including number of enrollees, pent up demand, and expanded benefit package. However, early counts are very positive. The plan will not have a negative impact on the General Fund.

5. Legal Issues

N/A

6. Controversial Issues

The DCO effort is not anticipated to raise any controversy, even in the Dental Community. The Dental Division has a long standing collaborative relationship with private dentists and even though MultiCare Dental is competing for enrollees like other plans there is no feeling of competition. All seem to agree that there is a need for as much access as possible to meet the care needs of eligible residents.

7. Link To Current County Policies

N/A

8. Citizen Participation

The Health Department's Community Health Council is supportive of the plan.

9. Partnerships And Collaboration

MultiCare Dental has collaborated with Russell Street Dental Clinic to be a provider option in the plan. Russell Street is a Community and Migrant Health Center which provides care to homeless, HIV positive and other low-income groups. Russell Street is also owned and operated by OHSU School of Dentistry.

MultiCare Dental also has an agreement with another DCO operating in the County for some specialty care as well as with several private practice dental specialists, OHSU School and Dentistry, Hospital Dental Services and CDRC Dental Clinic.

MEMORANDUM

TO: Board of County Commissioners

FROM: Bill Odgaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 3 - REEP

1. Topic

REEP (Refugee Early Employment Program) health services are provided to a monthly average of 900 refugees. 100 to 125 new refugees arrive each month in Multnomah County.

2. Introduction

Newly arriving refugees have traditionally been ineligible for the state's Medicaid program and have instead been eligible for a federally funded program of health, employment training and language education called REEP. The health component has been provided through a contract with Multnomah County Health Department for nine years. Oregon's implementation of the Oregon Health Plan (OHP) has raised discussion at the federal level regarding the necessity of having a separate health program for refugees now that the eligibility criteria for medical coverage has been expanded under OHP.

3. Alternatives

The state Office of Refugee Programs and the State OHP office are two separate offices at the State level with two separate funding sources. Discussions are occurring now about keeping them separate systems or combining the programs and have refugees be eligible for the OHP. Refugees could continue to receive their care through county clinics if the refugee clients choose CareOregon as their health plan. Refugee clients would also be free to select one of the other 12 OHP participating health plans. There are both potential public health and financial impacts to Multnomah County Health Department from any of these options.

4. Financial Impact

The cost of delivering health care to newly arriving refugees is significantly higher (nearly double) the cost of serving other low income residents. This is partially due to the need for all visits to be interpreted which lengthens the time need for each visit as well as the fact that most refugees have significant health problems which have been neglected in their countries of origin. The REEP program recognized these additional costs and paid a monthly capitation rate per enrollee of \$207/client. The current rate in the metro area for general OHP enrollees is less than half this monthly amount per client. If REEP is eliminated and all refugees were to enroll with OHP and choose CareOregon, MCHD would lose approximately \$1 million which currently provides a major source of funding for the International Health Clinic (IHC).

5. Legal Issues

The current contract which runs through September 30, 1994 has a 60 day advance notice for discontinuation of funding.

6. Controversial Issues

- a) Refugee clients receive public health screening at IHC soon after their arrival. Personal health problems are also screened for. MCHD has worked diligently over the past years to become knowledgeable, culturally competent health care providers able to serve the ever changing refugee client nationalities. If clients are eligible for OHP and can choose any participating OHP Plan, but are required to first come to MCHD for the public health screenings and treatment, they will most likely choose CareOregon as their OHP plan. The general OHP rates will be inadequate to cover

their costs however, and CareOregon will have a major "adverse selection" problem which will jeopardize its fiscal solvency.

- b) If MCHD stops the initial public health screening of all newly arriving refugees, certain diseases, e.g. TB, which are endemic in some of the countries of origin, may be inadequately diagnosed and treated, thereby endangering the community at large.
- c) The current REEP program benefits are different from OHP benefits, making possible "discrimination" claims a possibility. Efforts are underway to make the benefit packages the same.

7. Links to Current County Policy

NA

8. Citizen Participation

The Department's Community Health Council (CHC) has representatives of the refugee community involved in its actions. MCHD is also an active part of the Refugee Forum which includes refugee service agencies and refugee advocates. We also work closely with the many Mutual Assistance Associations (MAA's).

9. Partnerships and Collaboration

MCHD's Refugee Services collaborate with the Voluntary Agencies (VOLAG's) which sponsor refugee resettlement as well as other state, city and county agencies providing health, education, housing and employment services to refugee families.

MEMORANDUM

TO: Board of County Commissioners

FROM:  B. Odegaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 4 - Corrections Mental Health

1. Topic

To develop a continuum of mental health services which would provide the assessment, stabilization and community linkage for persons in custody.

2. Introduction

A comprehensive continuum of mental health services would include the following objectives:

- a. To increase mental health assessments, which would allow early identification of the actual number of persons with mental illness that are in custody.
- b. To increase mental health treatment in jail, which will allow for continued assessments, stabilization, education and community linkage upon release.

3. Background/Alternatives/Analysis

The Corrections Mental Health Services work group was formed to review current services and recommend more effective ways of serving persons in the criminal justice system who have mental health problems. Critical concerns have been identified:

- a. With the mental health system under pressure to reduce institutional bed space, persons with mental illness who are released from jail do not receive appropriate mental health treatment in the community.
- b. Because of the sheer numbers of clients booked per year, many of the persons with mental illness who are incarcerated do not receive assessments or stabilization during their incarceration, nor are they linked with follow-up services upon release from custody.

Alternatives to adoption of this proposal would be to continue services as they are at present, the results of which are listed in 3a and b. An added risk is that unidentified clients in crisis who go untreated, may lead to a continued deterioration of their condition or suicide. Likewise, clients who are released from custody without community linkage and treatment may very soon find their way back in custody.

4. Financial Impact

This add package is included in the Chair's budget proposal. It carries a cost in 1994-95 of \$381,961. No one time only or start-up costs are required. The package funds three linkage nurses, two assessment nurses, a half time Psychiatric mid level practitioner, and clerical support. Also included are funds for consulting psychiatric consultation.

5. Evaluation

The effectiveness of the proposal will be measured by:

- a. The number of persons identified as needing mental health services.
- b. The number of persons released from custody on psychiatric medications and/or
- c. The number of persons linked to mental health services in the community upon release from custody.

Baseline data will be collected, to allow a basis for measurement and comparison to performance in future periods.

6. Legal Issues

Provision of "basic" mental health services is required for persons in custody. Case law and Community Standards are utilized to determine "basic". This proposal has been developed in concert with representatives from the District Attorney's Office, Public Defender's Office, Courts, Oregon Advocacy Center and other agencies.

ORS 169.076, 169.077, 169.760, 169.780, 426.215, 426.175, 426.295, 427.051.

7. Controversial Issues

This proposal is not controversial. In fact, this proposal directly addresses the growing concern among stakeholders in our community regarding the increased numbers of mentally ill in custody.

8. Link to Current County Policies and Benchmarks

This proposal is specific to the Urgent Benchmark of Access to Health Care. It also addresses Benchmarks for People related to Premature Mortality linked to alcohol/drug use and suicide.

9. Citizen Participation

This proposal has been developed in concert with representatives from the District Attorney's Office, Public Defender's Office, Multnomah County Courts, Oregon Advocacy Center and other agencies.

10. Other Government Participation

This proposal was developed in collaboration with the Multnomah County Sheriff's Office, Alcohol and Drug Program, Mental and Emotional Disability Program, Department of Community Corrections, Community Mental Health Centers, and others involved with the Target Cities Project.

MEMORANDUM

TO: Board of County Commissioners

FROM: Billi Odegaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 5 - Drug Free Babies

1. Topic

According to birth certificate data for 1992, 5.6% of the Multnomah County women giving birth admitted to substance use (alcohol and/or illicit drugs) during their pregnancy. An enhanced Prenatal Substance Abuse Intervention is needed to address this problem.

2. Introduction

Improving birth outcomes and reducing substance use during pregnancy have been high priorities for the Health Department for many years. The Chair's Budget includes additional funding to begin to bridge the gaps and inadequacies in existing services by: (1) improving early identification of substance use in prenatal clients; (2) by enhancing the linkages between prenatal medical services, treatment services, and other social services; and (3) by supporting pregnant women to successfully stay in treatment and continue with aftercare services.

3. Background/Analysis

Birth certificate data is certainly an underestimate of the actual prevalence of prenatal substance use. Population based prevalence estimates put the rate of prenatal substance abuse Statewide at about 11%.

Alternative approaches to reducing substance use during pregnancy are: 1) to implement urine drug tests for all prenatal clients seen through the Health Department clinics, followed by referrals to existing drug/alcohol treatment resources for positive screens; and 2) to create a substance abuse treatment program at a Health Department clinic site that would provide substance abuse assessment, treatment and aftercare services. Using urine screens with referrals to existing treatment would be the least costly alternative, as no new services are added. However, this is also likely the least effective alternative. Urine testing provides only a narrow window on drug use and is not considered a fool proof screening method. In addition, there is limited existing treatment capacity for pregnant women, and referrals without coordination and advocacy are unlikely to result in positive outcomes. Fears of sanctions brought about by positive urine screens may cause some women to delay or forego needed prenatal care services. Developing an on-site treatment program that provides substance abuse assessment and treatment might be effective, but would be quite costly, including need for more space and personnel.

A third alternative is really a blend of the first two. This model uses existing prenatal care services and substance abuse treatment services, but adds the following: (1) a substance abuse intervention specialist at the site of prenatal care services; (2) on-going case management through a community health nurse; (3) an outreach worker knowledgeable about treatment who can provide followup and support to insure that women become engaged in treatment. This "enhanced intervention" model would work in the following way: MCHD prenatal providers screen all prenatal clients for substance use during their prenatal clinic visit. For those women with a positive or questionable history of substance use there will be a referral to an on-site Alcohol and Drug Intervention Specialist (A & D IS). A more detailed assessment will then take place with three possible outcomes: 1) admitted substance use problem, or 2) no substance use problem, or 3) probable substance use, but client denies. Women admitting to substance use will be linked with an appropriate treatment program and referred to a Community Health Nurse (CHN) and an Outreach worker. The CHN will provide on-going case management throughout the pregnancy. The Outreach worker will follow up to assure women become engaged in treatment. Women with no substance use problem will be followed in the usual manner by the Health Department prenatal providers. Women with probable substance use (but who deny) will be referred to the CHN for follow up and will be reassessed by the A&D IS later in the pregnancy.

The A&D IS will be part of the intake system being developed by the Alcohol & Drug Program Target Cities project. They will also do on-site support groups for prenatal clients who are substance users and provide training and consultation for HD staff. The CHN will provide linkage between the Health Department prenatal providers and the treatment programs to ensure continuity of prenatal care.

4. Financial Impact

The Chair's Budget includes funding for enhanced Prenatal Substance Abuse Intervention services, at a cost of \$121,500.

5. Legal Issues

Confidentiality between the Health Department medical provider and the substance abuse treatment program can be a barrier to collaborating on the client's treatment (Code of Federal Regulations, 42 CFR Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records.") It is a legal issue and is being currently addressed in the Target Cities program development.

CSD reporting laws require providers to report substance use during pregnancy that results in an infant that is drug-affected at birth. Generally this reporting requirement falls to the hospital delivering the baby, but women's fear of CSD reporting may affect their willingness to admit substance use.

6. Controversial Issues

Medical providers sometimes fear that confronting substance use during pregnancy may cause a woman to delay beginning prenatal care services, or to avoid services. In addition, pregnant women who are using drugs/alcohol may deny use and may resist efforts to identify use. Some community members may think legal intervention and mandating women to treatment is the appropriate approach. Sensitivity to all these perceptions is necessary for successful program development.

7. Link To Current County Policies

This approach is linked to the Board of County Commissioners benchmark of reducing drug affected babies, the Health Department's initiative of reducing drug affected babies, and to the Oregon Urgent Benchmark of reducing drug affected babies. It is consistent with County programs, such as ADAPT, START, and Target Cities.

8. Citizen Participation

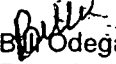
None

9. Other Government Participation

This proposal will be closely tied to the Target Cities project of the Alcohol and Drug Program. Target Cities will be funding one Intervention Specialist at one clinic site. The Target Cities A&D IS will be doing assessments for all clinic clients. This proposal requests an additional A&D IS for an additional clinic site. The HD A&D IS will be considered a part of the centralized intake team. Target Cities will provide training, on-going clinical consultation, computer linkage between the Health Department and the intake system and access to treatment vouchers for women who are not eligible for Medicaid. The proposal also builds on the HD Primary Care Substance Abuse Linkage grant, which provides partial funding for an A&D Intervention Specialist for Northeast Health Center.

MEMORANDUM

TO: Board of County Commissioners

FROM:  Bill Odegaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 6 - School Based Health Centers

1. Topic

Expansion of School Based Health Center services into Roosevelt Cluster Middle Schools; Expanded health services for students and their families at Roosevelt High School in North Portland; improved access to Mental Health Services at School Based Clinics.

2. Introduction

Middle school students age 11-14 years are at a vulnerable stage of development where experimentation with health risking behaviors become life long habits. These are prime years for making successful health interventions with these students and their families. Expanding services at Roosevelt School-Based Health Center for families of students and adding part time on-site clinical services at George and Portsmouth Middle schools would:

- provide greater access to primary and preventive health care for students and families
- permit early identification of health problems when intervention is more likely to be successful in reducing students' risk for premature sexual activity, pregnancy, STD, HIV, substance abuse, chronic physical and mental health problems and school failure.

Current evaluation of the SBHC program indicate that sexual activity often begins in middle school as indicated by the numbers of pregnant freshmen entering high school.

Each School Based Clinic has the services of a half time Mental Health Consultant. However, the frequency of acute and chronic mental health overlays to physical problems warrants expansion of mental health services.

3. Background/Alternative Analysis

The North Portland community is among the most medically underserved in our county. The Roosevelt community, via the Leaders Roundtable process, was the first community to identify the lack of and need for health services in the middle schools. The Roosevelt Cluster Steering Committee was the first to establish a health subcommittee to address this need. The Roosevelt SBHC, the first of seven SBHCs, began operating in 1986. There is more demand than current staff can meet at this site.

This proposal greatly improves access to health care for high school and middle school students and their families.

Currently students and families may receive services from a few primary care providers in the area, Providence, Emanuel, Bess Kaiser or the North Portland Health Center, which is at capacity. The St. John's area ranks as the most medically underserved community in the Portland area according to a recent Oregon Health Division Primary Care Needs Assessment.

Strong support for this proposal exists in the community, the school district and the Health Department. The Roosevelt cluster is one of the state's integrated service sites. Our RSBHC staff currently participates in the steering committee which includes DHR, AFS, CSD, Portland Public Schools, ESD, Multnomah County Mental Health and numerous other local service providers.

4. Financial Impact

The Chair's budget includes funding for two middle schools (\$207,000); expansion of Roosevelt High School to allow inclusion of families (\$82,000); and increasing mental health services at each current high school site to full time (\$190,000).

5. Evaluation

A baseline needs assessment and health behavior survey will be conducted prior to offering services and at periodic intervals.

Over time, this proposal should contribute to reducing teen pregnancy rates in the N.P community and contribute to goal of 100% graduation.

Other key results:

- 1) Increase the number of students/families who receive ongoing services from primary care provider in their community.
- 2) Specific health needs of the middle school students/families will be identified and appropriate health services designed to address these issues.

6. Legal Issues

We will continue to support the rights of minors in receiving health care services. Students under 15 years of age must have parental consent for medical treatment. There is no age limit for minors to receive birth control information, HIV testing or STD diagnosis and treatment.

7. Controversial Issues

The specific site selection of the Roosevelt Cluster in North Portland was made jointly with Portland Public Schools. There was strong interest expressed by school officials from other clusters, specifically Jefferson and Marshall to site SBHCs in their respective areas. Reproductive Health Services is always a controversial subject and a clear policy about this issue and of parental consent for medical treatment will be developed with the school district and parents prior to opening for services.

8. Link to Current County Policies and Benchmark

This proposal is consistent with State and County benchmarks and builds on the model of integrated service sites for families. This proposal relates to key benchmarks concerning access to primary care and prevention of teen pregnancy.

9. Citizen Participation

The Roosevelt Cluster Caring community identified lack of health care as a top concern of students and families which is a barrier to 100% graduation. Community members currently sit on the RSBHC Advisory Board and will continue to be an integral part of this proposal through the needs assessment survey and as members of the new advisory boards at the middle schools.

10. Other Government Participation

The success of this proposal requires strong collaboration and partnership with Portland Public Schools, ESD school health services, the Roosevelt Family Resource Center and local service providers. This strong model enhances the probability that the Health Department will secure Robert Wood Johnson funding to replicate this model elsewhere in the county.

MEMORANDUM

TO: Board of County Commissioners

FROM:  Bill Odegaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 7 - Immunizations

1. Topic

This issue describes the activities planned for the next 12 months to improve immunization levels of all Multnomah County children up to 24 months of age.

2. Introduction

Though immunizations have been considered one of the mainstays of public health services, numerous barriers to immunizations have resulted in low immunization levels nationwide, in Oregon and Multnomah County. Factors associated with low immunization rates are 1) failure to coordinate efforts between public and private sector organizations, 2) lack of a central record-keeping systems to track childrens immunization status, 3) lack of a major effort to educate the community at a grassroots level. During the last two years, increased emphasis has been placed on immunizations with the organization of the Oregon Preschool Immunization Consortium, which has representation from more than 40 private, public, voluntary and professional organizations.

3. Analysis/Alternatives

Recent assessment has shown that only 52% of all Multnomah County children were up-to-date on their immunizations, 60% of children receiving one or more vaccines from Multnomah County Health Department are up-to-date. In Oregon, 49.9% of Oregon's two-year-olds are adequately immunized. Currently, 76% of Multnomah County's children receive immunizations from the private health care providers (including HMOs such as Kaiser) and 24% from the Health Department and our delegate agencies. About 85% of the State's children have health insurance. Medicaid and HMO type policies cover the full costs of childhood immunizations while private insurance policies cover immunization costs for between 50 and 75% of subscribers.

Alternatives

- Maintaining the current system is not likely to improve immunization levels. This system, with the school immunization law, has provided 98% immunization levels for school-age children but has had a limited effect on preschool children's immunization levels.
- Enhancing the Health Department delivery system by expanding hours, adding staff and sponsoring free community based clinics has the potential to improve immunization levels. This will require expansion of the roles of volunteers, service organizations, church groups and professional organizations to provide contact with families in need of immunizations.
- Service clubs are interested in and have been sponsoring the NW Medical Team Health Van to provide immunizations at various sites in the community as a part of their outreach. The Van can be set up at a variety of locations including housing developments, camps, churches, shopping centers, and other community centers for targeted populations. Again, this will require community-based outreach. Because of local club involvement, the Van has been successful in bringing children in for immunizations.
- Private and public providers are making a concerted effort to reduce missed opportunities to provide immunizations. This involves providing immunizations in an easily accessible manner, providing immunizations in conjunction with other services (e.g., urgency and emergency room, WIC appointments, etc).

- Improving public/private cooperation including community networking, education, improved service delivery, and developing a centralized system of immunization record-keeping and tracking, regardless of delivery site.
- Utilization of an outreach worker to follow-up on children who are behind in their immunizations could enhance the program by bringing children in for needed immunizations, and identifying barriers to families obtaining immunization services.

4. Financial Impact

Because of the availability of federal funds IAP (Immunization Action Plan) through CDC, most of the proposed alternatives are feasible and funded. IAP money is planned for three years. Changes in funding at the federal level would significantly impact the continued operation of this program.

5. Legal Issues

None

6. Controversial Issues

There is a small segment of our community who philosophically do not believe in the value of immunizations or refuse immunizations for religious reasons. Naturopathic practitioners prefer to use herbal vaccines and/or delayed immunization schedules. School Immunization law allows religious and medical exemptions for school attendance.

7. Link to Current County Policies

Immunizations have always been provided by the Health Department and are part of our integrated service delivery system. Immunization levels are a National and State Benchmark.

8. Citizen Participation

Because of efforts of OPBS Channel 10, the Oregon Preschool Immunization Consortium and the IAP funding from CDC, there is much involvement of local service clubs, churches and children's programs and facilities working together to improve immunization levels. The Multnomah County Health Department Community Health Council has been very supportive of efforts to improve service delivery and outreach to the communities to bring families in for services.

9. Partnerships and Collaboration

In conjunction with the Oregon Preschool Immunization Consortium, Multnomah County has worked collaboratively with Health Systems in Collaboration to improve immunization levels. This group consists of CEOs and representatives from the Legacy, Sisters of Providence, Kaiser, Blue Cross-Blue Shield and OHSU health systems. The group's focus is improving immunization services within the private health care sector. Efforts have focused on development of a state wide registry system for collecting immunization information on all children born after Jan 1, 1995.

MEMORANDUM

TO: Board of County Commissioners

FROM: Billi Odeggaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 8 - North Portland Space

1. Topic

The North Portland Clinic is currently housed in six duplex units. The North Portland Field Team is housed at a separate site. North Portland is the smallest general purpose Primary Care Clinic. It has no dental care on site. It is strategically the most attractive site for its local residents who will be choosing a health care provider under the Oregon Health Plan.

2. Introduction

The lead time necessary to allow renovation of the North Portland site will over a year. There are several steps that may be taken to begin the process. Examples include researching federal regulations regarding the use of the Villa space for this purpose, securing required zoning variances, and developing a proposal for exchanging the Villa property for tax foreclosed property.

The goal of the project is to increase the clinic's primary care space capacity, to allow the addition of dental services in response to rapidly rising DCO enrollment, and to co-locate the Field Team, which is currently renting space elsewhere.

3. Analysis/Alternatives

The Department is requesting that the Board approve policy of renovating the North Portland Clinic site. This would:

- 1) Allow the County to begin the process of securing a conditional use permit to allow clinical expansion;
- 2) Put together a package of tax foreclosed properties to replace the housing units that the County is using, leading to an intergovernmental agreement allowing transfer of title;
- 3) Authorize the Finance Manager a COP ceiling which would include the North Portland Clinic.

This will allow the Department to shorten the time between final project approval and the completion of the project.

There will be future decision points. The agreement with HAP for a property exchange will require Board approval. The Finance Director will seek Board approval before borrowing project funds.

4. Financial Impact

The Chair's 1994-95 Budget includes \$1.5 million in COP proceeds for renovation or replacement of the North Portland site, an estimate based on the 1992 cost of this project. There is no payment budgeted, as payments would begin in 1995-96.

The current estimate of the cost of this project is \$1.8 to \$2.0 million. The annual debt retirement cost would be approximately \$155,000 to \$172,000, assuming 6% as the cost of the COP and a twenty year amortization.

5. Legal Issues

There are several legal issues around the use of HUD subsidized housing for this purpose. Board approval at this time would start the process of resolving these issues.

6. Controversial Issues

N/A

7. Link To Current County Policies

The County is a major participant in the Oregon Health Plan as a provider of medical and dental services. These improvements in the North Portland site would better position the County as a provider of these services to citizens of North Portland.

8. Citizen Participation

The Health Department's Community Health Council is supportive of the plan.

9. Partnerships And Collaboration

The Housing Authority will be assisting in the development of this project, including taking the lead with HUD to move a transfer agreement through the federal government.

TO: Board of County Commissioners

FROM:  Odgaard, Director
Department of Health

DATE: May 2, 1994

SUBJECT: STAFF REPORT - HEALTH DEPARTMENT ISSUE 9 - Outreach Workers

1. Topic

This proposal requests funding for the development and implementation of a coordinated orientation and training program for all county outreach workers. Once developed and piloted in the County, this program will be available to other community agencies and volunteers to strengthen the linkages between existing programs and referral resources.

2. Introduction

The concept of more intensive "outreach" and developing one-on-one connections to people is gaining favor in many programs. Plans are underway to coordinate the many different outreach components of existing county programs. This orientation and training curriculum will consolidate and enhance the knowledge, skills and abilities of all workers involved in outreach and provide consistent orientation for new employees assigned to the increasing outreach efforts throughout the county. The outcome will be a highly skilled and knowledgeable group of community specialists in outreach and community organizing with both basic competencies and specific programmatic knowledge and abilities.

3. Background/Alternative/Analysis

The Health Department has significantly increased its capacity to provide outreach services to county residents through specific outreach programs and outreach workers in general health programs. Other County Departments also have similar community specialists who are responsible for seeking out individuals in target populations to provide education and referrals to existing resources. The new Family Support Initiative contains a strong outreach component. Currently, each program recruits, orients and provides ongoing inservice to its own outreach workers. Programmatic benefit could be gained by developing a core curriculum for all such employees and making the same training available to other agencies and community organizations for staff and volunteers.

The Program Development Specialist funded in this proposal will assess the current orientation and training programs for outreach staff, identify any gaps in training, identify in-house resources, evaluate appropriate external resources such as local trainers or community college programs, and design a comprehensive training program. The training will build on the unique talents and life experiences of people who are successful in providing outreach services to different communities. The training plan will include a core of basic competencies relevant for all outreach workers, plus optional modules to address program specific needs. Basic skills may include specific communication techniques for interviewing and educating people from different target populations, community organizing and leadership skills, recognition and reporting requirements for child abuse, knowledge of the existing Information and Referral system. Each program or Department will have specific training needs related to the content of the program, the setting, the community, and the target population. In collaboration with those programs, the PDS will design different modules that will enhance the core training program to meet those programmatic needs.

Once the curriculum is developed, the PDS will work with the County's District Coordinators or program managers to implement the orientation and training program. Ultimately, the Health Department will make the course available to other organizations with similar staff such as "community agents", "gatekeepers", "resource specialists," and other positions. Immediate possibilities include outreach programs at Coalition of Community Health Clinics like Neighborhood Health Centers or Portland Public Schools, and City of Portland Neighborhood Associations.

4. Financial Impact

This proposal will reduce the general fund by approximately \$60,200.

5. Evaluation

Methodology for evaluating this program would need to be developed. Possible indicators include: satisfactory completion of training program by current county employees; satisfactory completion of training program by new county employees; satisfactory performance evaluation of training participants by program managers; participation and satisfactory completion of training by staff from other organizations; participation and satisfactory completion of training by volunteers from the County and other organizations. Client feedback regarding quality, availability, and appropriateness of services will be obtained.

6. Legal Issues

None.

7. Controversial Issues

This proposal is not controversial. It will provide a mechanism for several interested agencies with similar outreach needs to work together and develop a corps of skilled community outreach workers to maximize the effectiveness of existing resources.

8. Link to Current County Policies and Benchmarks

Success in achieving many County, City and State benchmarks will depend on the effectiveness and initiative of outreach workers in connecting with individuals and encouraging them to use the resources available to them. Outreach workers have already demonstrated what they can do to link pregnant women to prenatal care or drug users to treatment programs. Individual employees and outreach teams have developed innovative methods and techniques, often through trial and error. Sharing what they have learned with each other across county organizational lines and with new employees will expand the capabilities of all the programs. Finally, we know that many problems we face in the Health Department are in fact complex societal problems with a medical consequence. To be effective, outreach workers and community specialists must be able to bring to bear a range of resources regardless of governmental jurisdictions and organizational boundaries.

9. Citizen Participation

The Multnomah County Community Health Council supports such intergovernmental arrangements to more fully address health-related issues in the community. Also, community members of the Council have often requested assistance from the Health Department in training their staff along with County employees. Whenever space permits, we have accommodated those requests with mutually beneficial results.

10. Other Government Participation

We expect the Community and Family Services Department will be interested in collaborating in the development and implementation of this proposal. Other county possibilities include the Libraries, Aging Services programs, and Animal Control. We believe Portland Public Schools and City of Portland Office of Neighborhood Associations will also be interested in collaborating in a joint training initiative. The PDS will explore all these possibilities as part of the initial needs assessment and design of the training plan.

Health Department Supplemental Budget Information

May 4, 1994

Board Work Session

**MULTNOMAH COUNTY HEALTH DEPARTMENT
1994-1995**

MISSION

The mission of the Health Department is to assure, promote and protect the health of the people of Multnomah County through:

- *Promotion of a healthy community through active participation in the development and enactment of public policy affecting health;*
- *Prevention of serious health problems through early intervention and promotion of positive health behaviors;*
- *Protection of the public against health hazards, trauma, and the spread of disease; and*
- *Provision of health services to low income and high risk residents.*

LEAD BENCHMARKS

- *Maintain or decrease levels of reportable diseases.*
- *Improve access to health care (including dental care) services for medically underserved residents.*
- *Contribute to a reduction in the percent of babies born drug-affected.*
- *Contribute to a reduction in the teen pregnancy rate.*
- *Increase percentage of adequately immunized two-year olds against vaccine preventable diseases.*
- *Contribute to a reduction in the number of children abused or neglected.*

2020 VISION FOR MULTNOMAH COUNTY HEALTH DEPARTMENT

In the year 2020, county citizens and leaders look back with pride on the accomplishments of the community in improving its health since the mid-1990s. In the broadest sense of the word, the health of our citizens has improved.

-over-

Most of the problems our citizens faced in accessing basic medical care have resolved as a result of state and national reforms, and continued county advocacy and service delivery. The role of the Health Department in direct medical care delivery has gradually evolved. Beyond its role in medical care service delivery, the Department has assumed greater responsibility for both assuring and providing special services for populations at risk of identified priority health problems. The Department has also assumed a stronger role in the community of health providers as convener, partner, and participant in comprehensive community-wide efforts emphasizing health promotion, prevention and early intervention.

Objective measures of our community's health status have improved markedly.

The first wave of the AIDS epidemic has passed, leaving a legacy of a human and public health tragedy met with compassionate care and effective prevention. Thanks to the lessons of the first wave, the impact of the second wave of the epidemic continues to be mild compared with that of other communities.

Rates of low birth weight and infant mortality have dropped significantly, largely as the result of reducing the discrepancies in birth outcomes among rich and poor, and among our diverse racial and ethnic populations. Teen pregnancy rates have also dropped, as have rates of abortion. Overwhelmingly, babies are born healthy and into homes where they are wanted, loved, and well cared for.

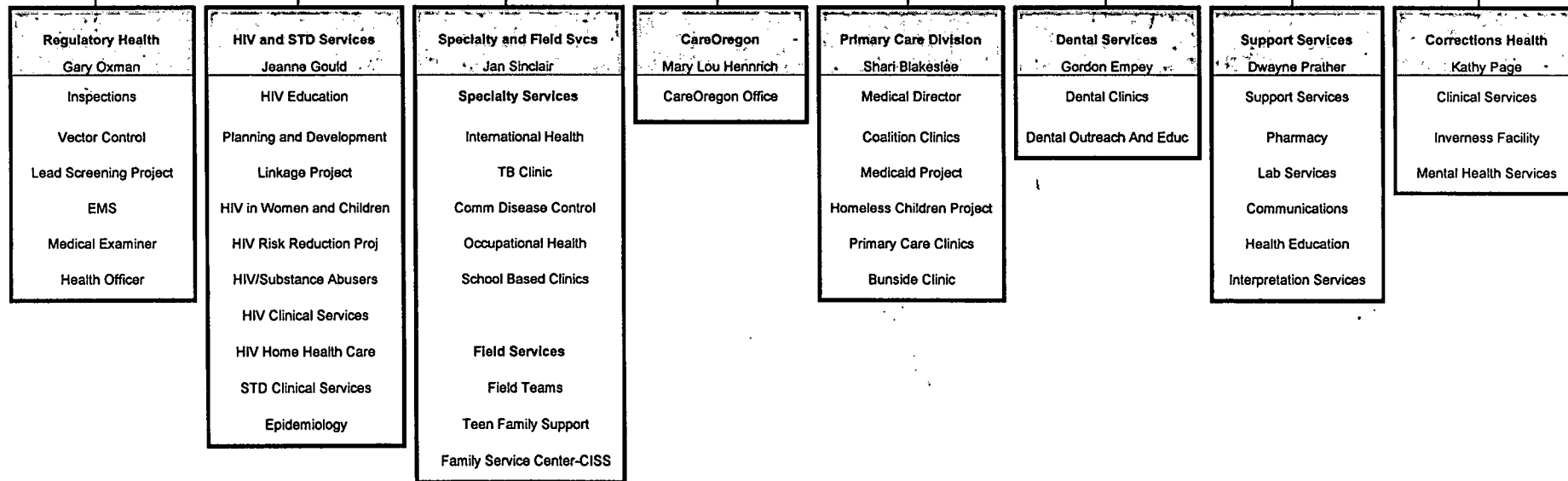
The Health Department has also grown in becoming better connected with consumers, citizens in general, and the range of health and social service providers in the community. The Department continues to carry out activities and provide services that it is uniquely positioned and qualified to do. It also fills a broader leadership role. In partnership with citizens, other governmental agencies, the private sector, and many others, the Department actively helps to identify priority community health concerns, shapes sensible policy responses, assures that efficiently and culturally competent services are available to address priority concerns, and analyzes the effectiveness of the community's policies and responses.

HEALTH DEPARTMENT 1995 STRUCTURE

Office of the Director
Billi Odegaard
Office of the Director

Business Services
Tom Fronk
Business Services
Health Information System
Medical Payables/Rec
Grant Accounting
Human Resources

Page 4



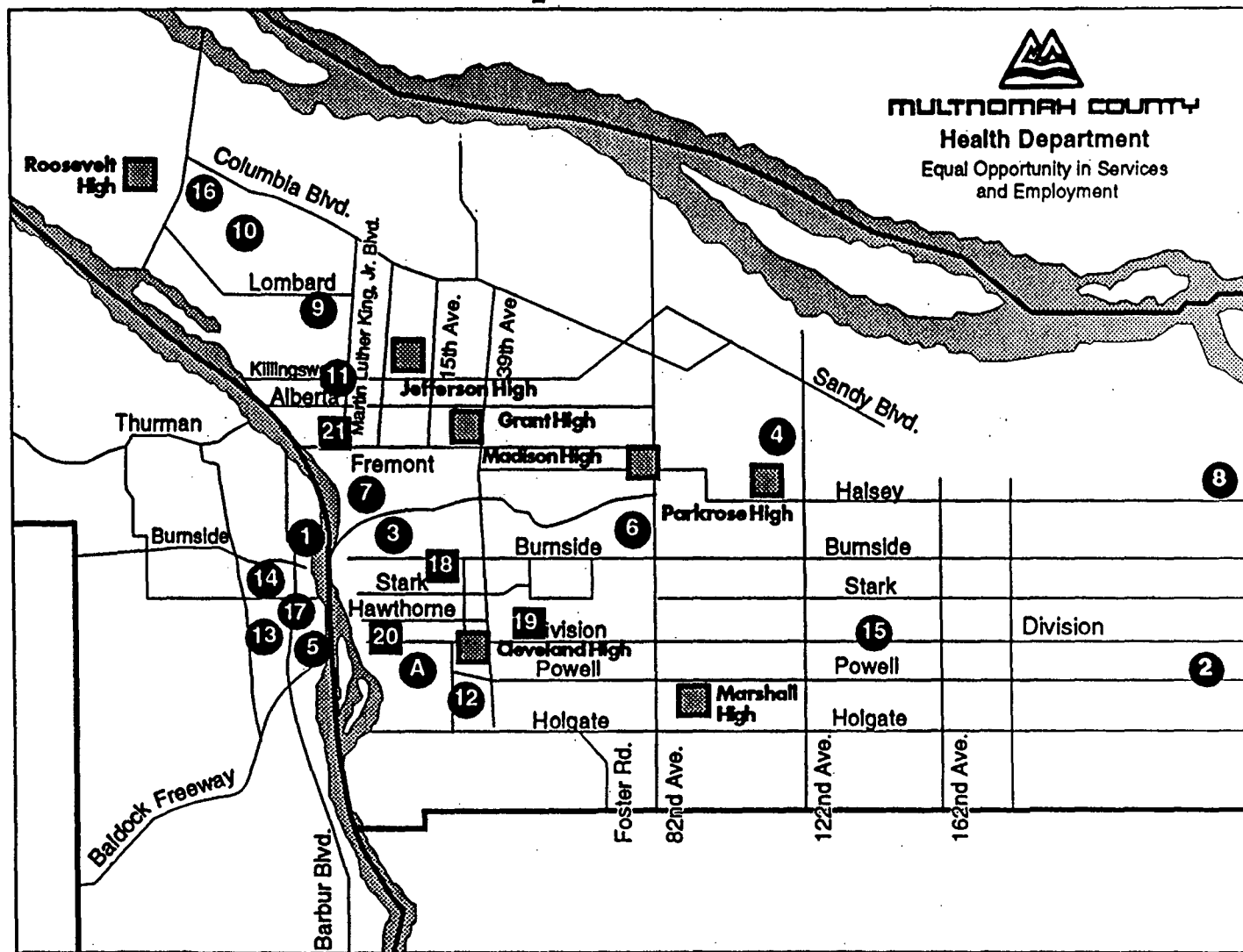
Multnomah County Health Service Sites



MULTNOMAH COUNTY

Health Department

Equal Opportunity in Services
and Employment



- 1 Burnside Health Clinic**
618 NW Davis
248-3678
- 2 East County Health Center**
620 NE 2nd Avenue, Gresham
Medical: 248-5155 / Field: 248-5157
- 3 HIV Outreach Project**
20 NE 10th Avenue
248-3030
- 4 Inverness Jail**
11540 NE Inverness Drive
248-5080
- 5 Justice Center**
1130 SW 3rd Avenue
248-3978
- 6 Juvenile Detention Center**
1401 NE 68th Avenue
248-3530
- 7 Medical Examiners Office**
301 NE Knott
248-3748
- 8 Multnomah Cty. Correction Facility**
Rt. Box 58, Troutdale
248-3480
- 9 North Portland Field Team**
1622A N. Lombard
248-3368
- 10 North Portland Health Center**
8918 N. Woolsey
248-5304
- 11 Northeast Health Center**
5329 NE Martin Luther King, Jr. Blvd.
Medical: 248-5183 / Dental: 248-3664
Field: 248-5055
- 12 Southeast Health Center**
3653 SE 34th (Powell)
Medical: 248-3500 / Dental: 248-3513
Field: 248-3520
- 13 Restitution Center**
1115 SW 11th Avenue
248-5141
- 14 Westside Health Center**
426 SW Stark
4th floor: 248-5140
STD Clinic
4th floor: 248-3700
TB Clinic
3rd floor: 248-3417
Communicable Disease Clinic
2nd floor: 248-3408
- 15 Mid-County Health Center**
12710 SE Division
Medical: 248-3801 / Dental: 248-3410
International Health: 248-3149
- 16 Vector Control**
5325 N Columbia Blvd.
248-3484
- 17 Courthouse Jail**
1021 SW 4th
248-3025

18 CODA Primary Care
306 NE 20th Ave.
239-8400

19 Mainstream Primary Care
4531 SE Belmont
234-3400

20 NARA Primary Care
1438 SE Division
231-2641

21 PCR Primary Care
3525 NE MLK, Jr. Blvd.
281-2804

Cleveland High School-Based Health Ctr.
3400 SE 26th Avenue
248-3350

Grant High School-Based Health Ctr.
2245 NE 36th Avenue
248-3372

Jefferson High School-Based Health Ctr.
5210 N Kerby
248-3380

Madison High School-Based Health Ctr.
2735 NE 82nd Avenue
248-3382

Marshall High School-Based Health Ctr.
Marshall High School
3905 SE 91st Avenue
248-3370

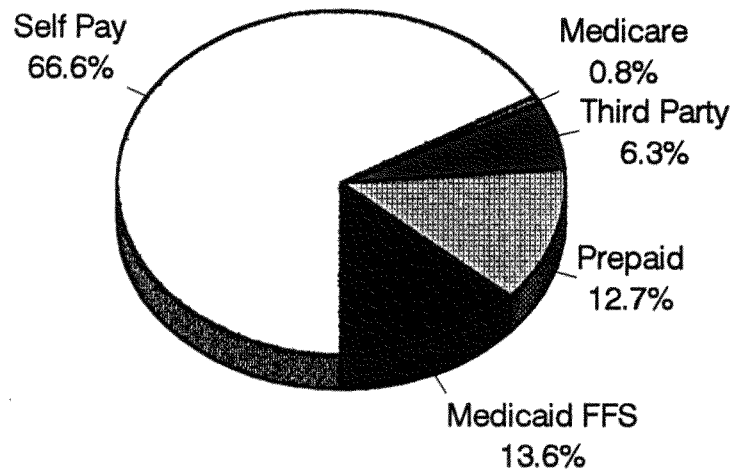
Parkrose High School-Based Health Ctr.
11717 NE Shaver
248-3392

Roosevelt High School-Based Health Ctr.
6941 N Central
248-3111

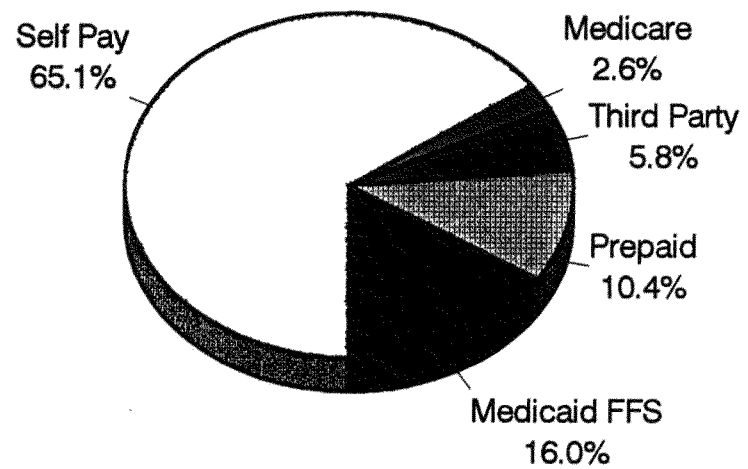
A Health Supply
2505 SE 11th Ave.
2nd floor
248-3696

School Dental Health
2505 SE 11th Ave.
2nd floor
248-3905

Our Clients Are . . .



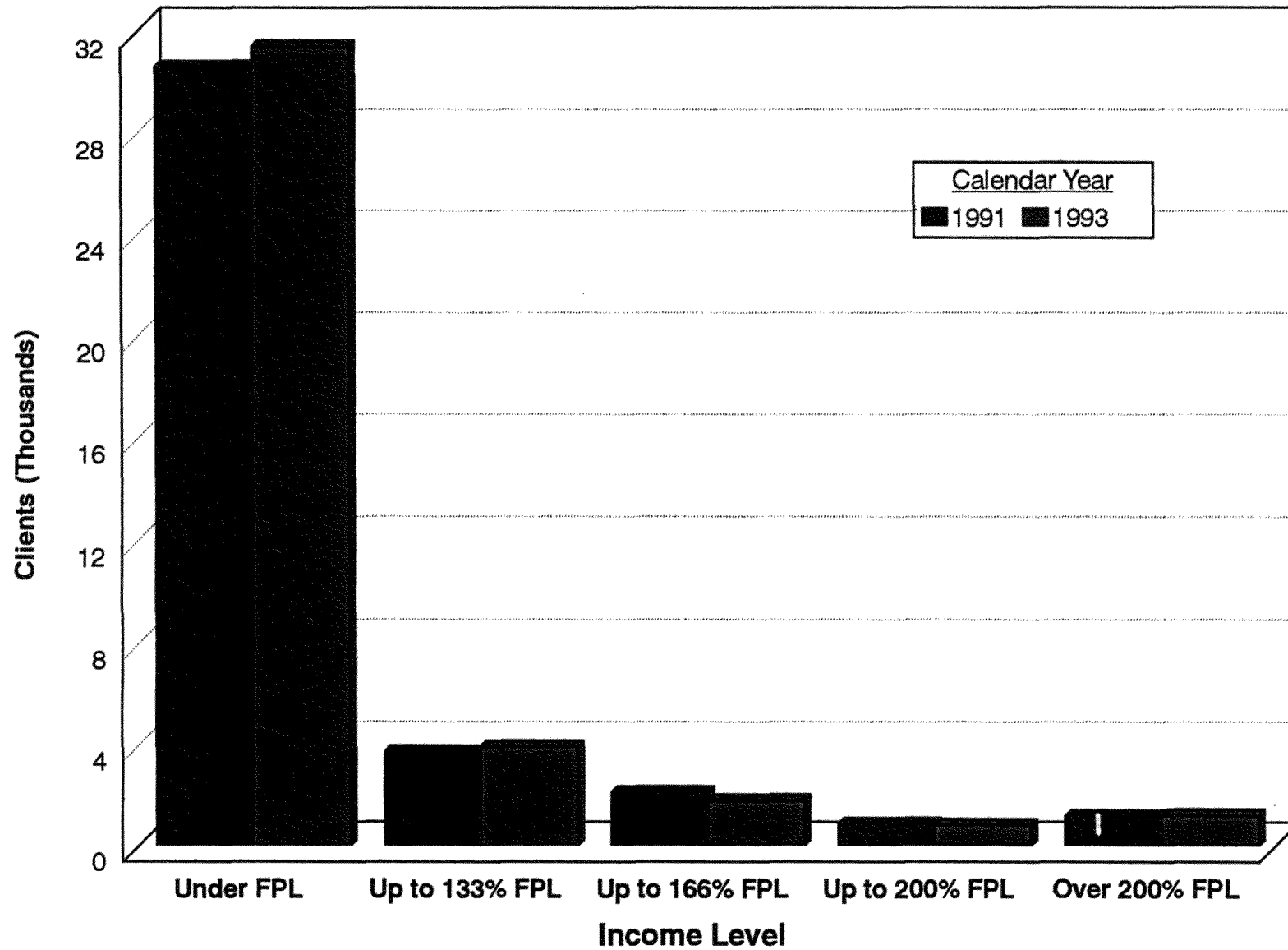
Calendar 1991



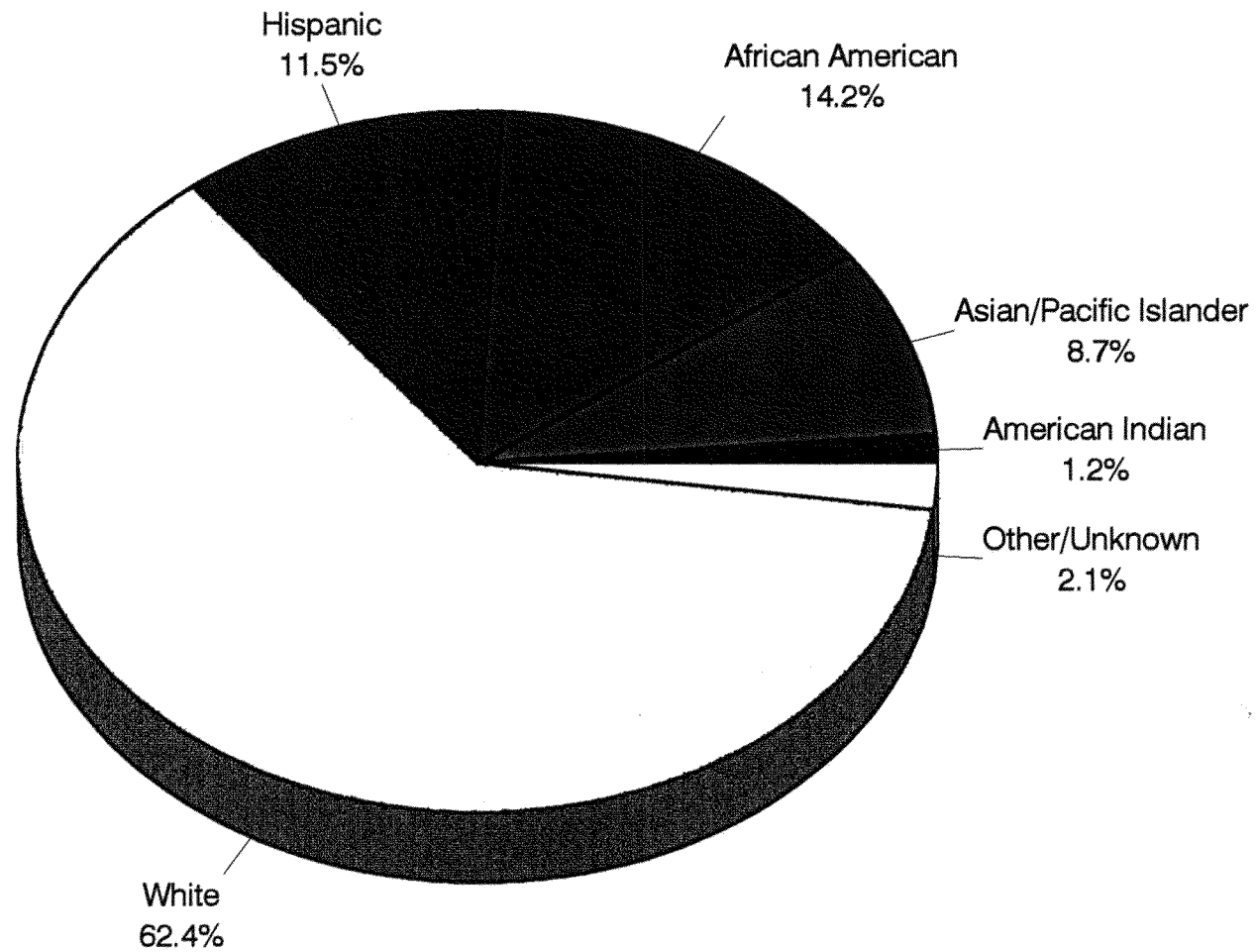
Calendar 1993

Our Clients Are . . .

Page 7

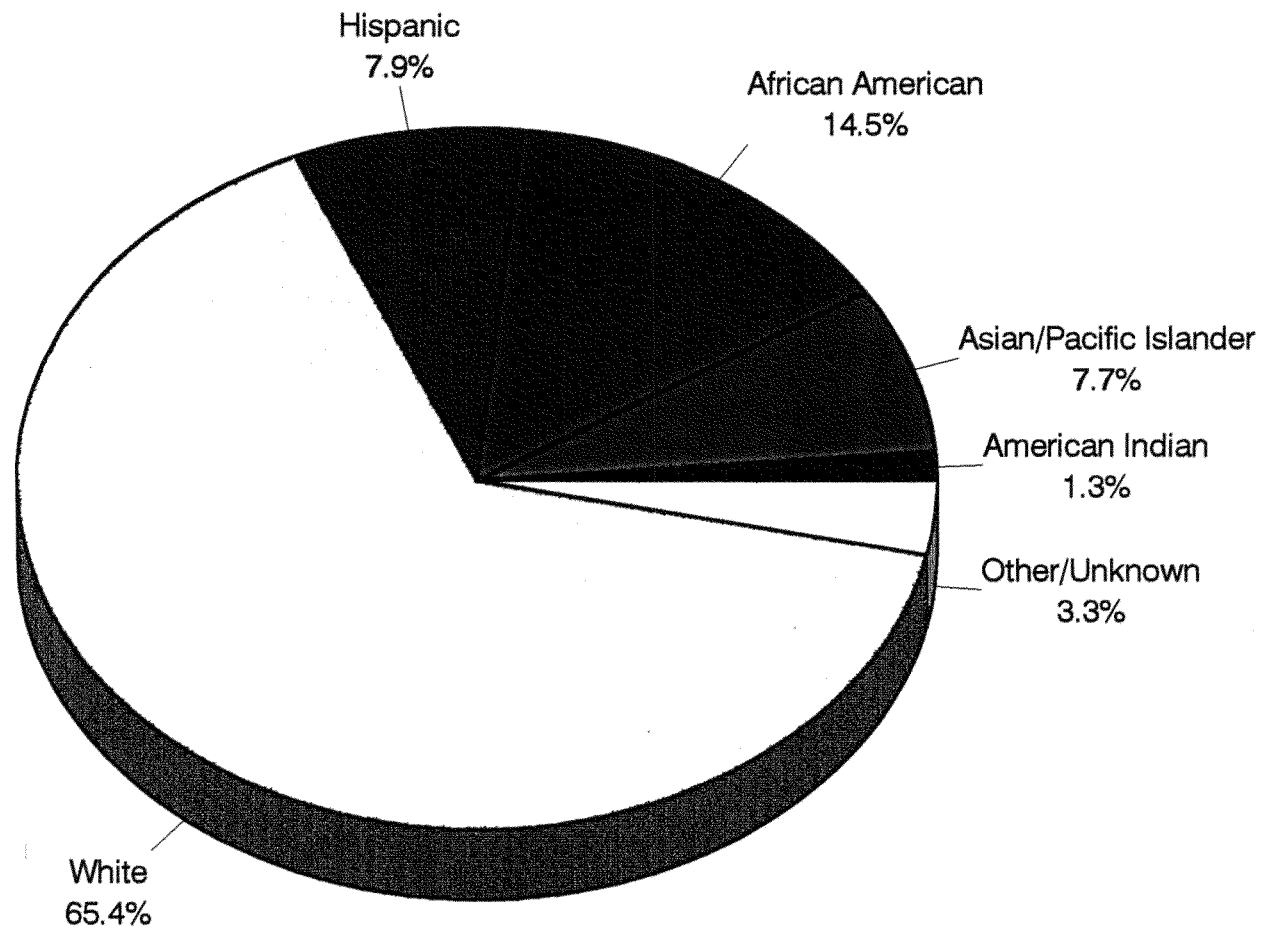


Our Clients Are . . .



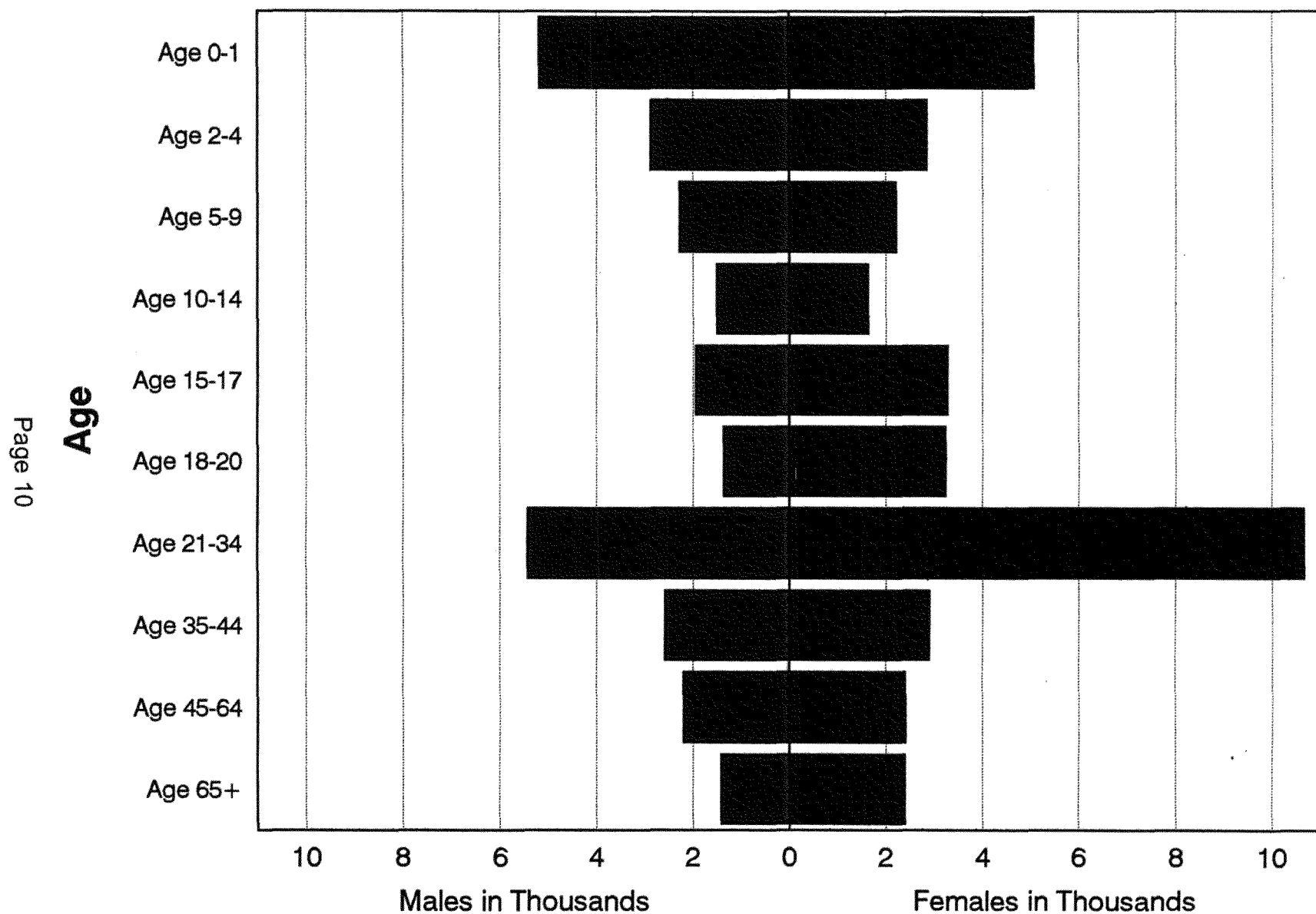
Calendar 1993

Our Clients Are . . .



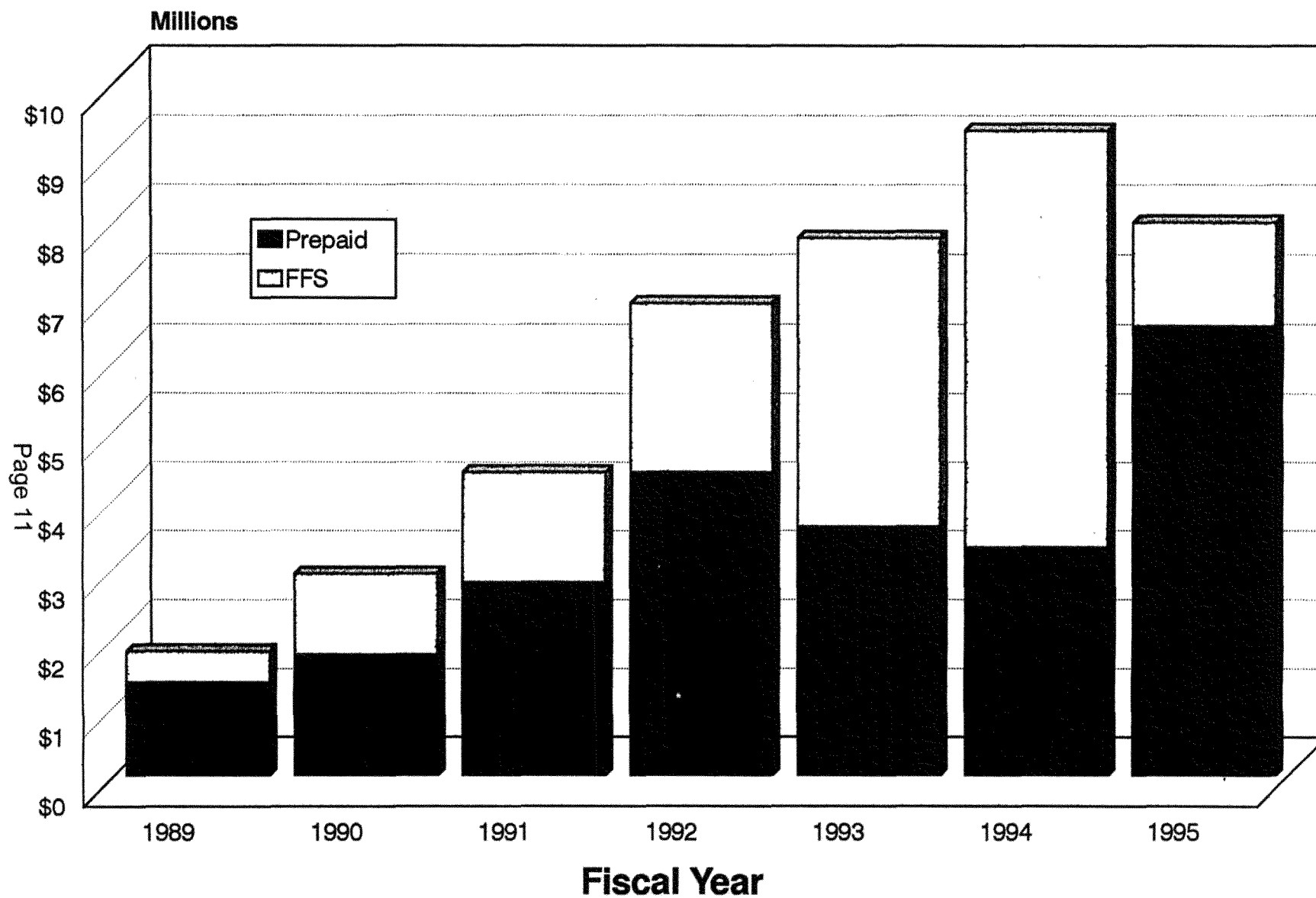
Calendar 1991

Our Clients Are . . .



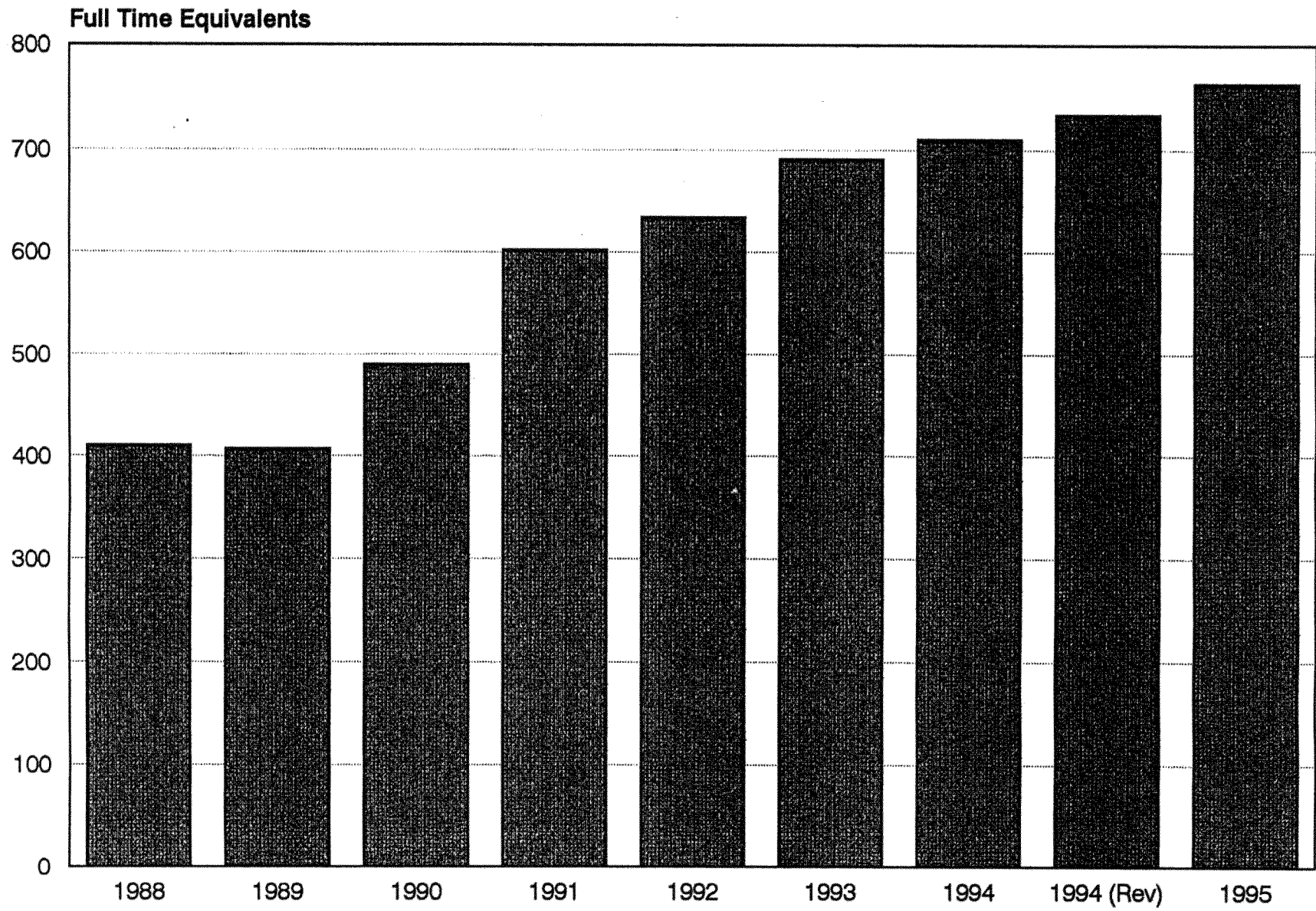
Age and Sex, Calendar 1993

Our Clients Are . . .



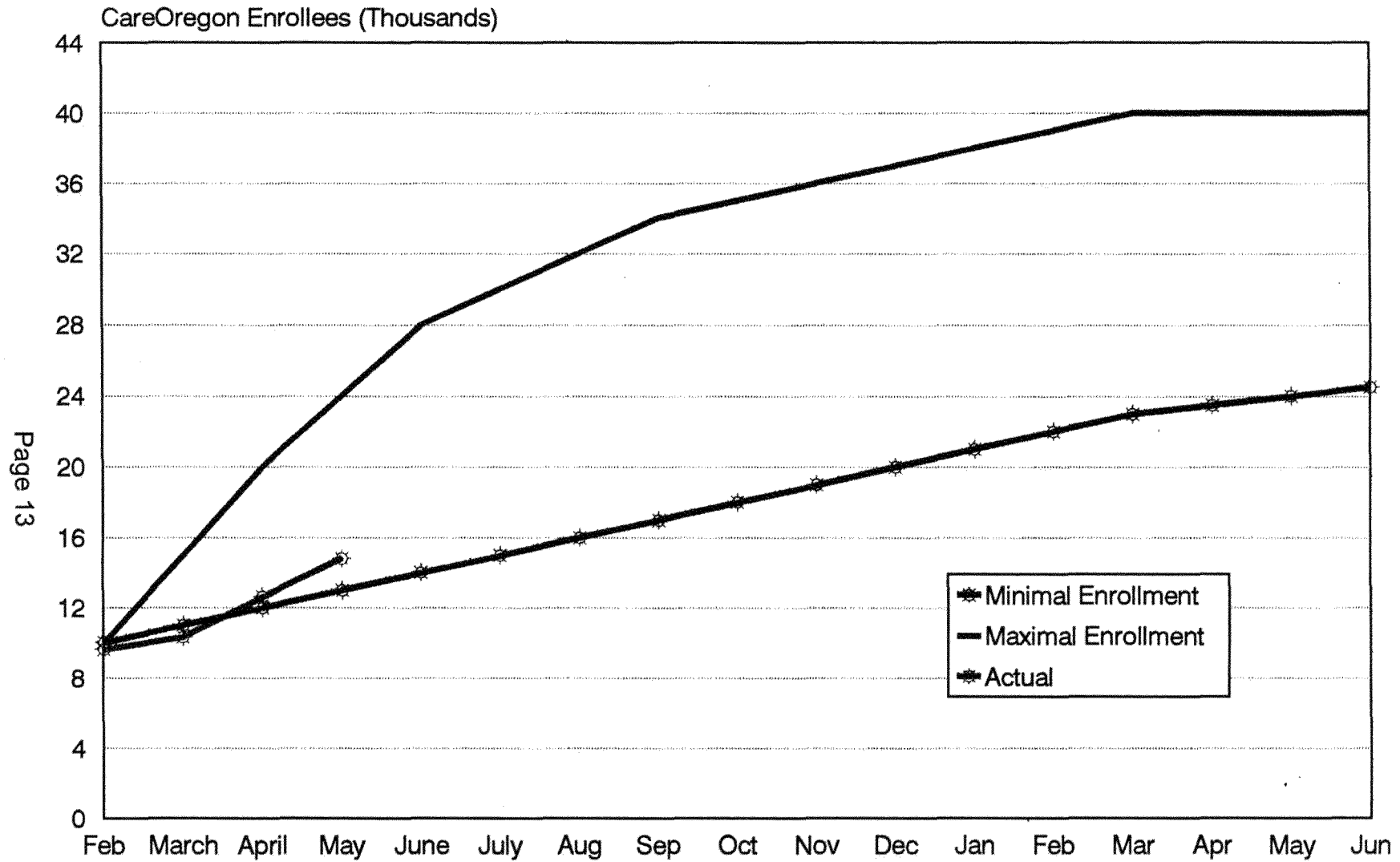
Medicaid Revenues shifting from Fee for Service

Our Clients Are . . .



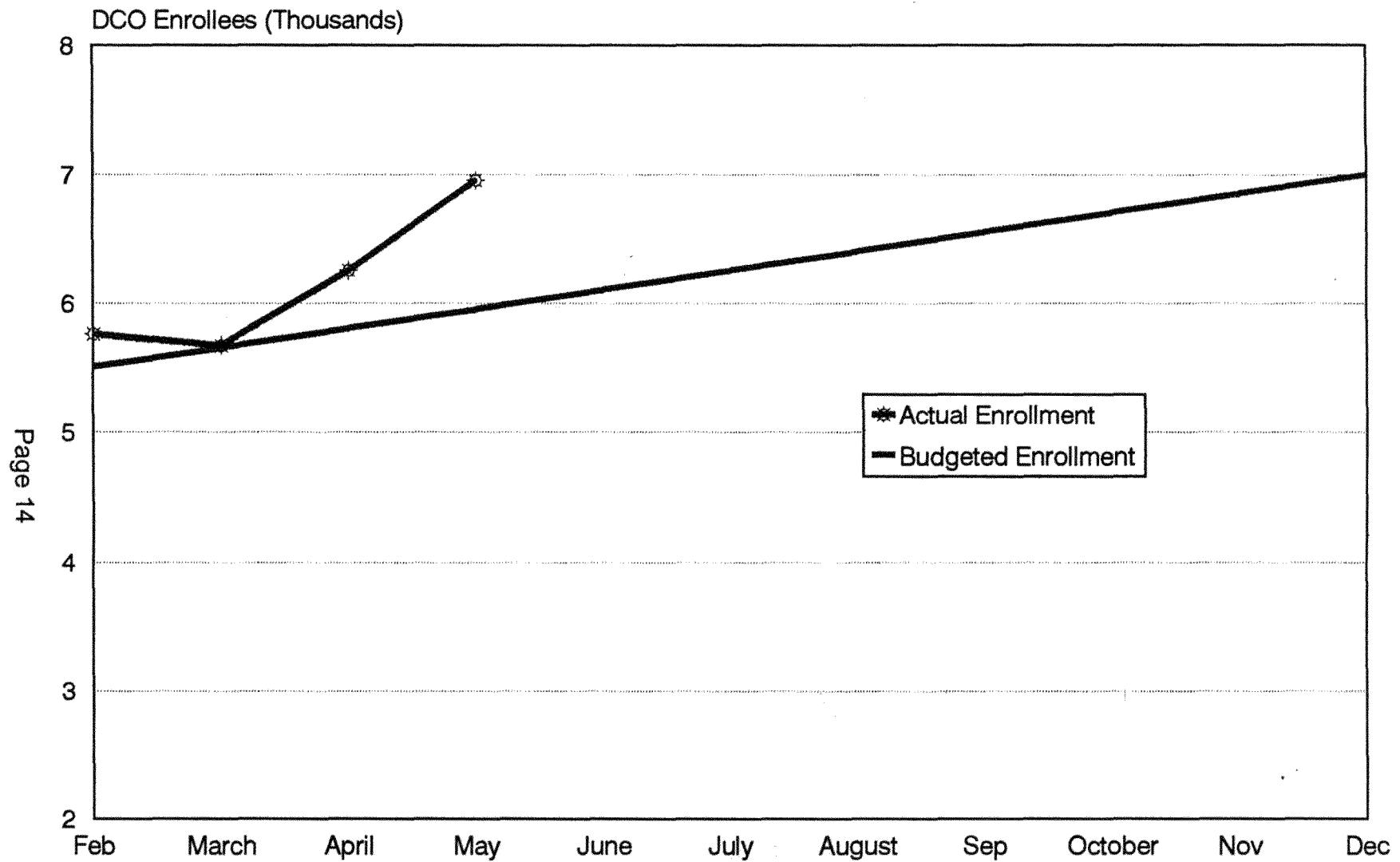
Increases in FTEs over Time

Our Clients Are . . .



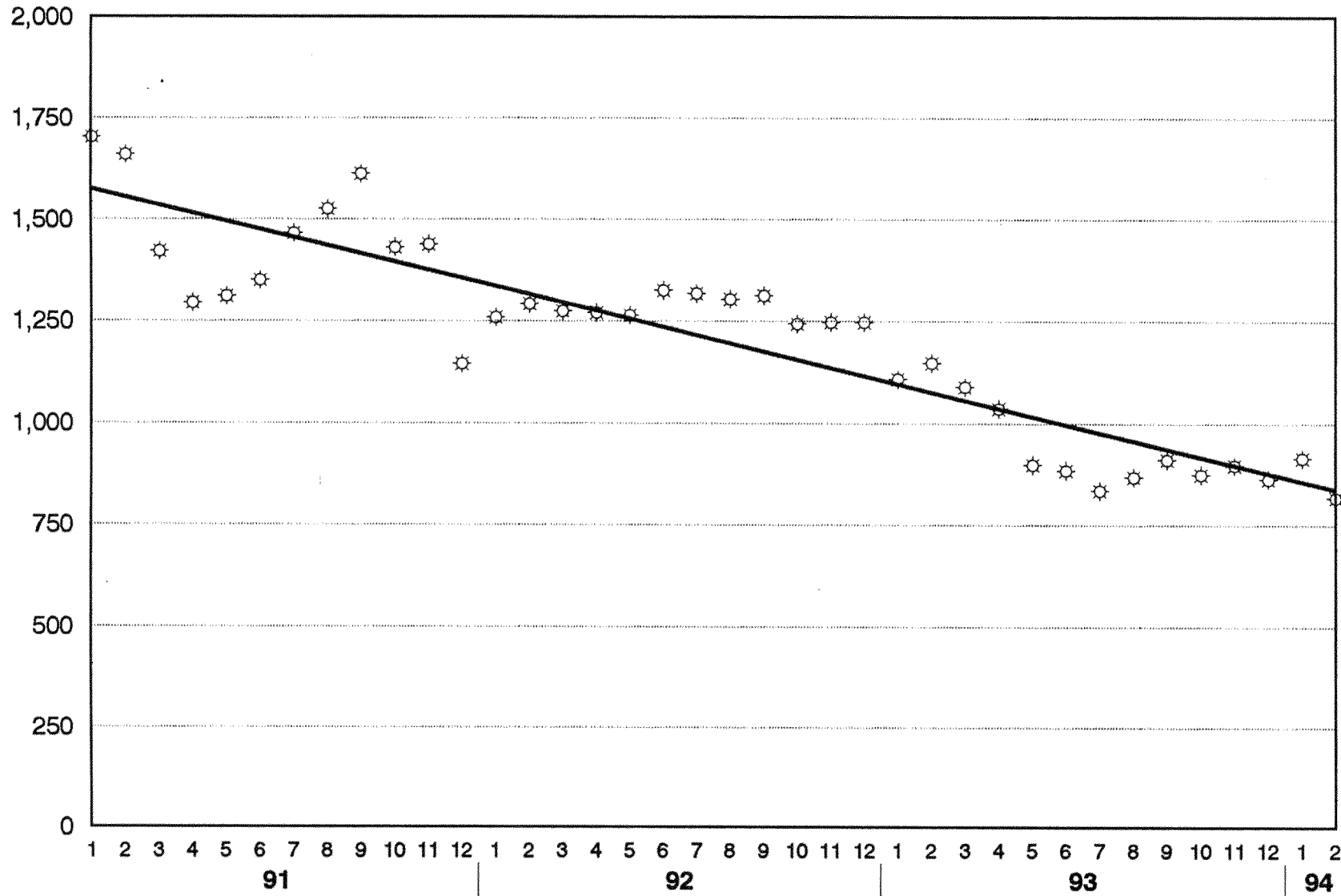
CareOregon - Optimistic Projections

Our Clients Are . . .



DCO Enrollees - Growing faster than Projected

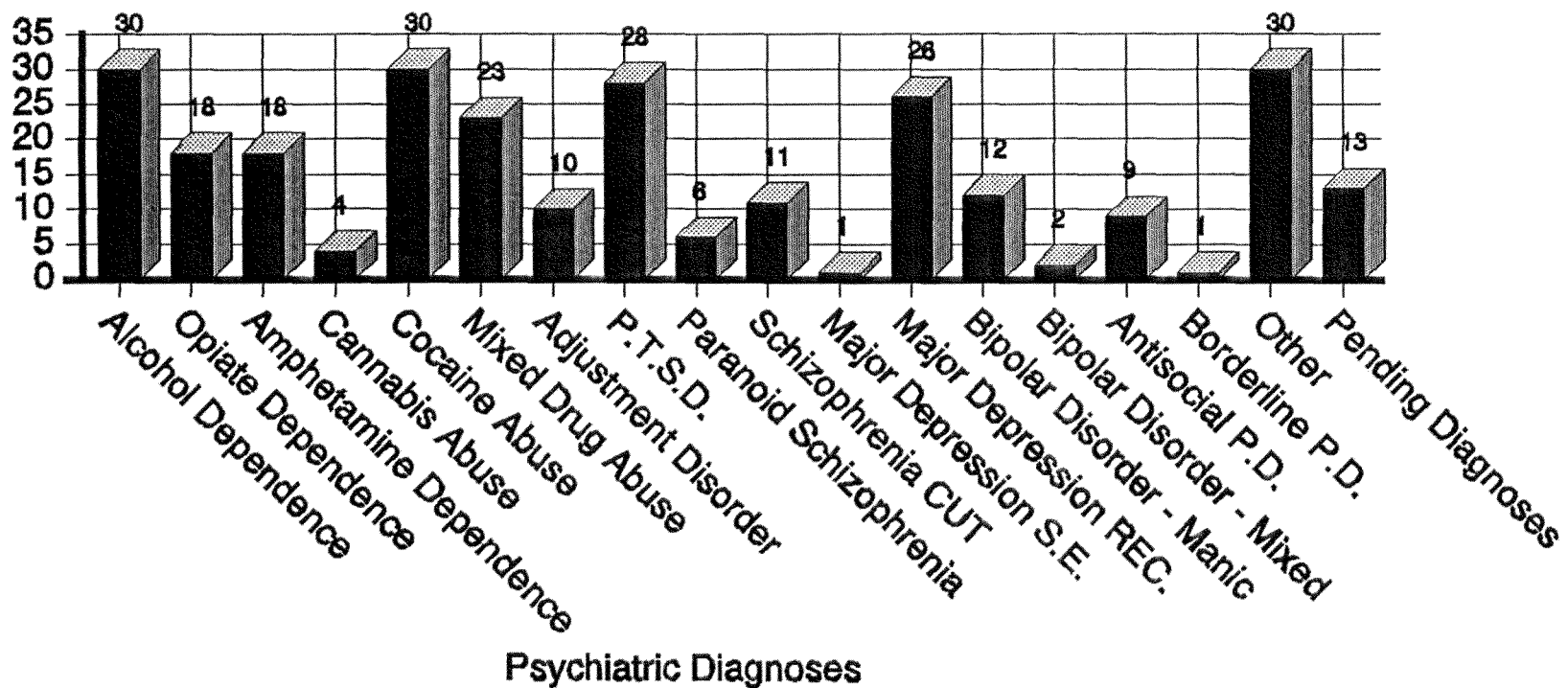
Our Clients Are . . .



Corrections Mental Health Caseload

May 3, 1994

n = 136

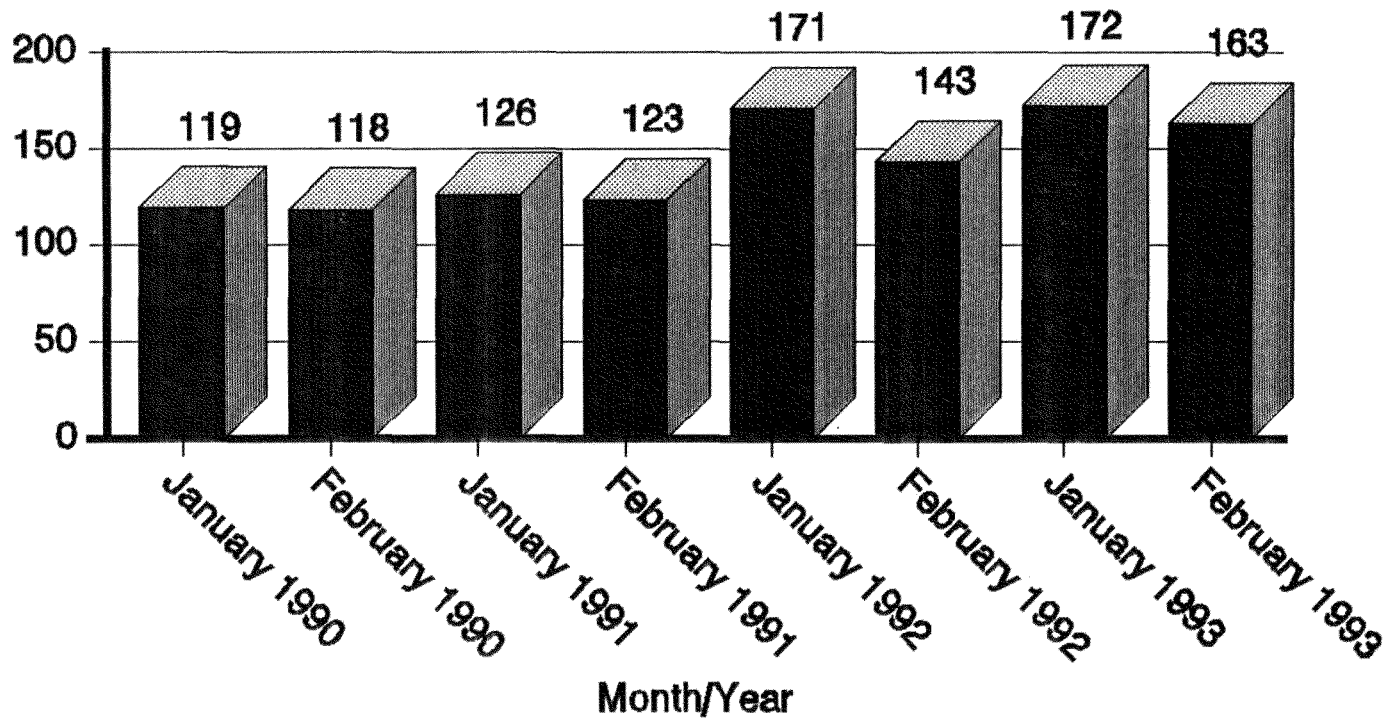


- This graph represents the Corrections Mental Health Caseload for May 3, 1994.
- Of the 497 inmates housed at MCDC on 5/3/94, 136 have been diagnosed with at least one Axis I psychiatric disorder. (27% of the jail population)
- These are not simply substance abusers; of the 136 mentally ill inmates, only 30 carry only one psychiatric diagnosis. (22%)
- 106 (78%) have at least two psychiatric diagnoses, most commonly a major mental illness coexisting with an addictive disorder.
- Our figures are consistent with national studies of corrections populations.

Corrections Mental Health Caseload

Selected Months/Years

Persons Active

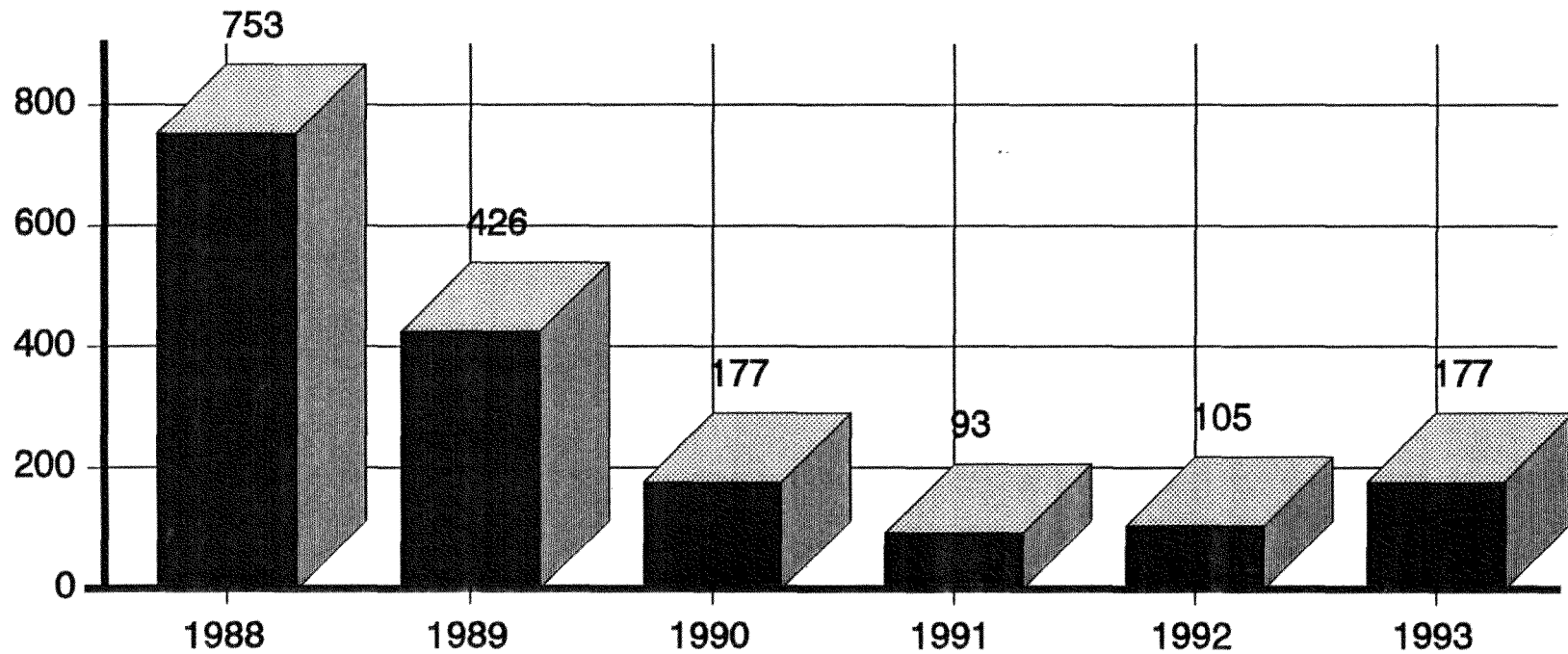


Corrections Mental Health

Corrections Mental Health Caseload

Psychiatrist Visits

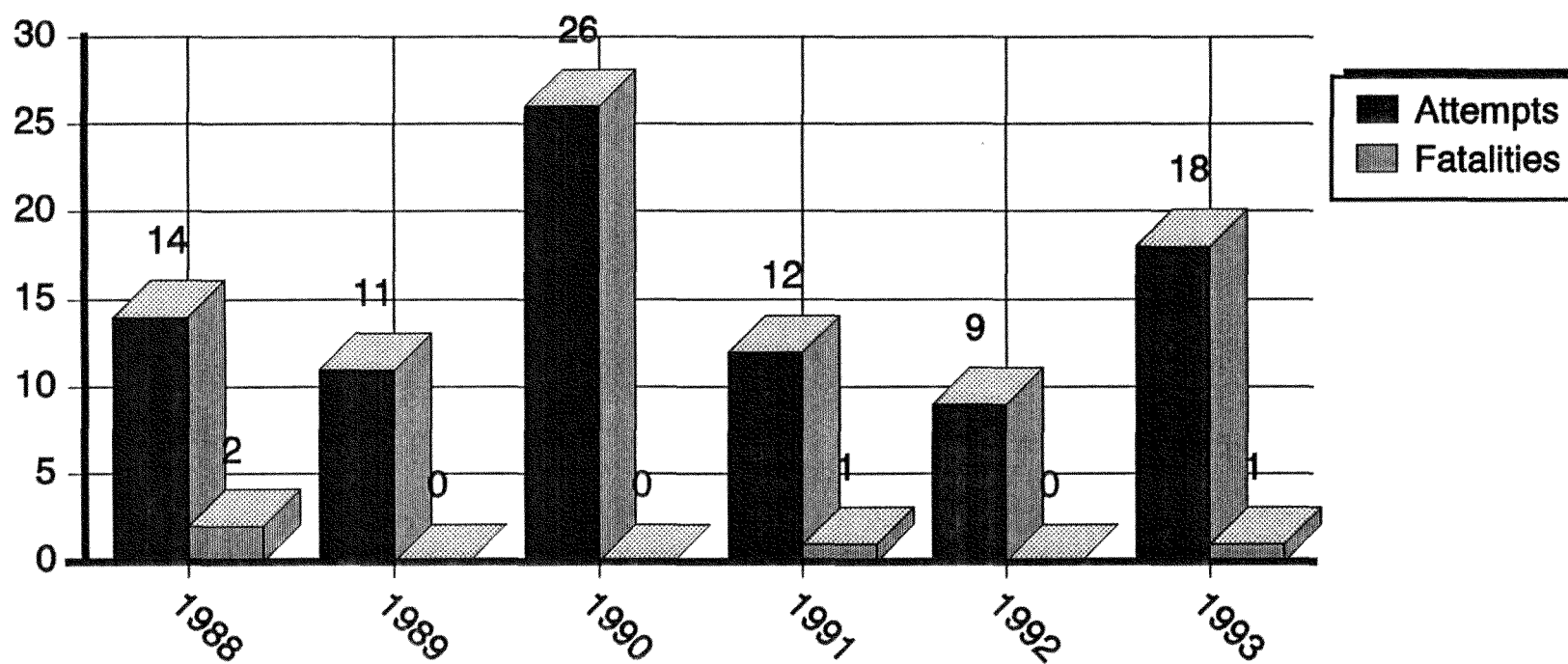
Number of client visits



Corrections Mental Health

Suicide Attempts / Fatalities

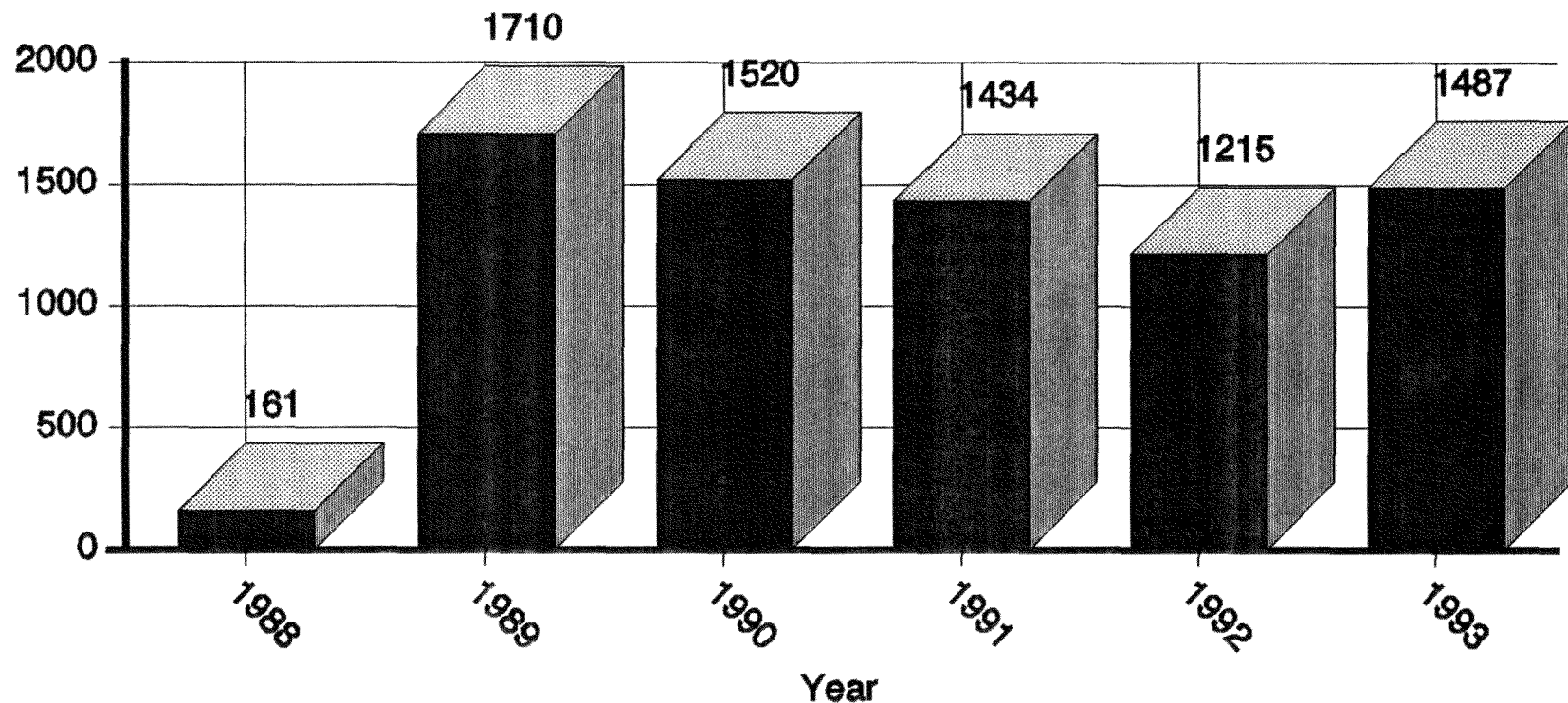
Suicide Attempts / Fatalities



Corrections Mental Health Caseload

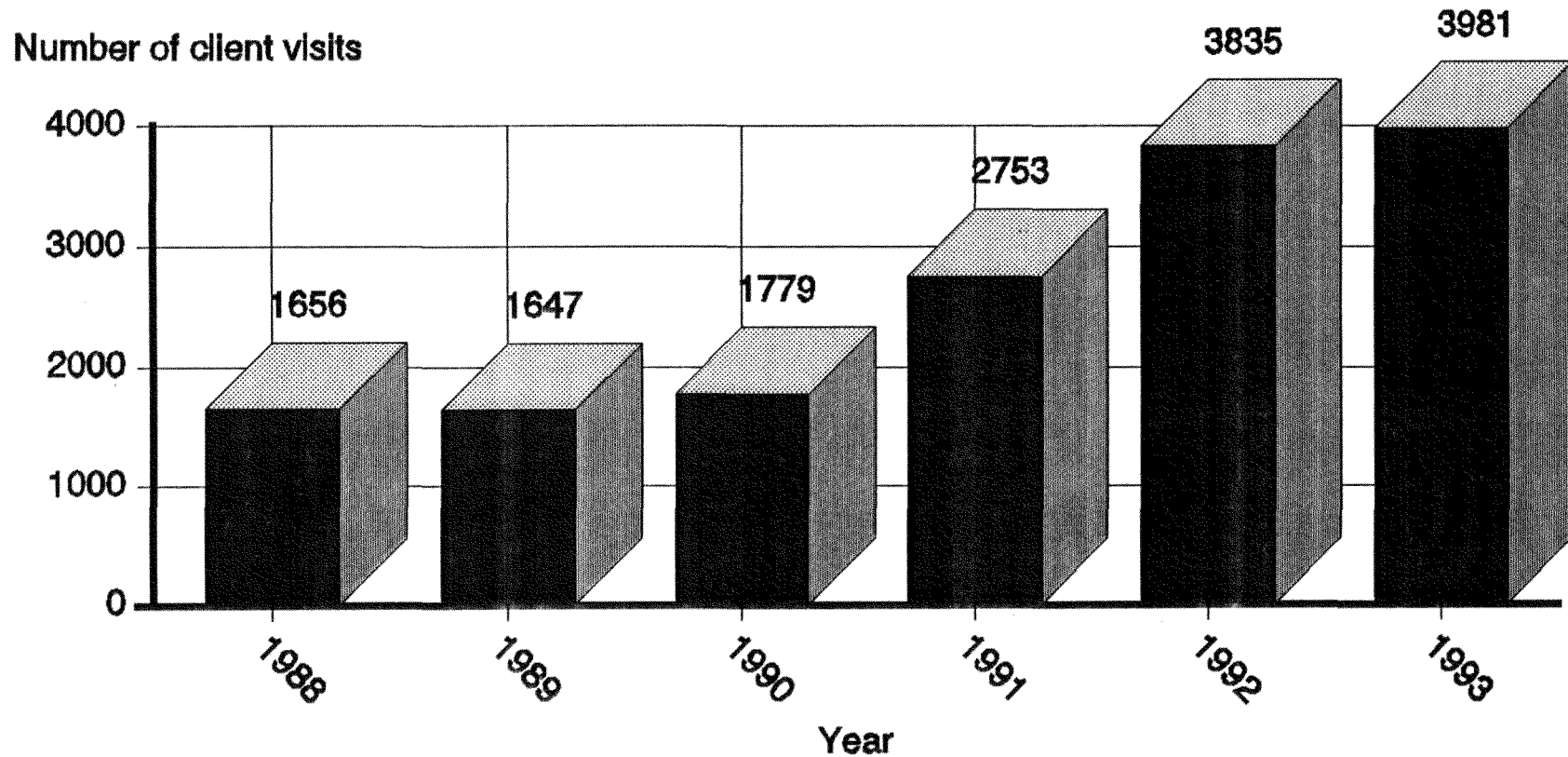
Psychiatric Nurse Practitioner

Number of client visits



Corrections Mental Health Caseload

Psychiatric Nurse





**HEALTH DEPARTMENT
MULTNOMAH COUNTY**

Budget Work Session
5-4-94
Handout #3
CareOregon

Count on us to care

MultiCare Dental ...

SUPPORT SERVICES
426 SW STARK ST., 8TH FLOOR
PORTLAND, OREGON 97204
(503) 248-3674 FAX (503) 248-3676

BEV STEIN, CHAIR OF THE BOARD

M E M O R A N D U M

TO: BEVERLY STEIN, CHAIR
COMMISSIONER TANYA COLLIER
COMMISSIONER GARY HANSEN
COMMISSIONER SHARRON KELLEY
COMMISSIONER DAN SALTZMAN

FROM: DWAYNE PRATHER, DIRECTOR, SUPPORT SERVICES DIVISION

SUBJECT: LONG RANGE PLAN FOR INCREASED CAPACITY
NORTH PORTLAND HEALTH CLINIC

DATE: April 19, 1994

FULL CULTURAL COMPETENCE IN SERVICE DELIVERY IS OUR DESTINATION

STEPS TO THE GOAL

STEP ONE - REVIEW

- ☛ Need - Although it is too early to know the trends for new patients in North Portland's CareOregon, it is important to note two things; 1) patients are choosing North Portland Clinic, and 2) North Portland is one of our smallest sites, yet it has the second largest population of singles and childless couples applying. Upon reflection, this would make sense from the data on household income. (See attachment #1.)
- ☛ Location - In cooperation with property management, other sites have been sought in the North Portland/St John's area. No other suitable site has been found. This siting process was originally initiated when other county departments were looking for space. Within the last three months this problem was reviewed again by property management.
- ☛ Conclusion - Expansion at the current site is our best option. When looking at a map of addresses of our current patients, the current site looks perfectly acceptable. (See the attached map.) The map shows patients coming to our current site from all over the North Portland/St John area.

STEP TWO - CITY PLANNING BUREAU

- ☛ Discussions with the planning bureau around growth, parking and traffic flow have discovered the need a conditional use permit as the next step in the process.
- ☛ The Housing Authority of Portland (HAP) has conditional use permits of

buildings on the north and south of our clinic that date back to the original construction (1941). There is no reason to believe that conditional use permits for the Health Clinic, upon the proper application, would not be approved.

- ☛ No further planning barriers are anticipated at this time.
- ☛ This step will take four months.

STEP THREE - REQUEST FOR PROPERTY TRANSFER

- ☛ The Intergovernmental Agreement (IGA) is the process where Multnomah County would bring tax foreclosed property through HAP to HUD and request an exchange for clinic property in Columbia Villa.
- ☛ The proposed funding mechanism for the remodeling is the Certificate of Participation (COP). This type of mechanism requires that Multnomah County have title to the property.
- ☛ The proposal is that parcels of county tax foreclosed property be exchanged for the North Portland Clinic property. An assessor has set the value of land and buildings at \$150,000.
- ☛ Both HAP and County Property Management see no problem in finding suitable property and effecting this transaction - pending Board and HUD approval.
- ☛ The decision to accept this proposal by HUD will be made in Washington, D.C.. HAP Director, Denny West, believes this is best done in property transfer rather than in cash purchase. He has agreed to help us in working with authorities in HUD to gain approval.
- ☛ This step will take nine months.

STEP FOUR - FUNDING APPROVAL

- ☛ Facilities Management and the Health Department will prepare a funding proposal. It will have the detail and estimates of the costs for remodeling.
- ☛ The funding proposal will be presented to the Board for approval and issuance of COPs.
- ☛ This step will take three months.

STEP FIVE - CONSTRUCTION

- ☛ Architectural work will begin and bid prepared.
- ☛ Construction will take 120 days.
- ☛ This step will take ten months.

STEP SIX - MOVE IN

- ☛ Range of time 24-26 months.

TIME LINE REVIEW

STEPS	INDIVIDUAL STEP TIME	TOTAL TIME
1- Review	-0-	-0-
2- City Planning	4 months	4 months
3- Property Transfer	9 months	13 months
4- Funding Approval	3 months	16 months
5- Construction	10 months	26 months
6- Moving In	1 month	(August '96)

DECISION

We are requesting approval for the whole plan.

Specific decisions by the Board will be required for the IGA approval in four months, and COP approval in 16 months.

However, our request is that the decision points for the IGA and COP are looked at as formalizing a previous decision.

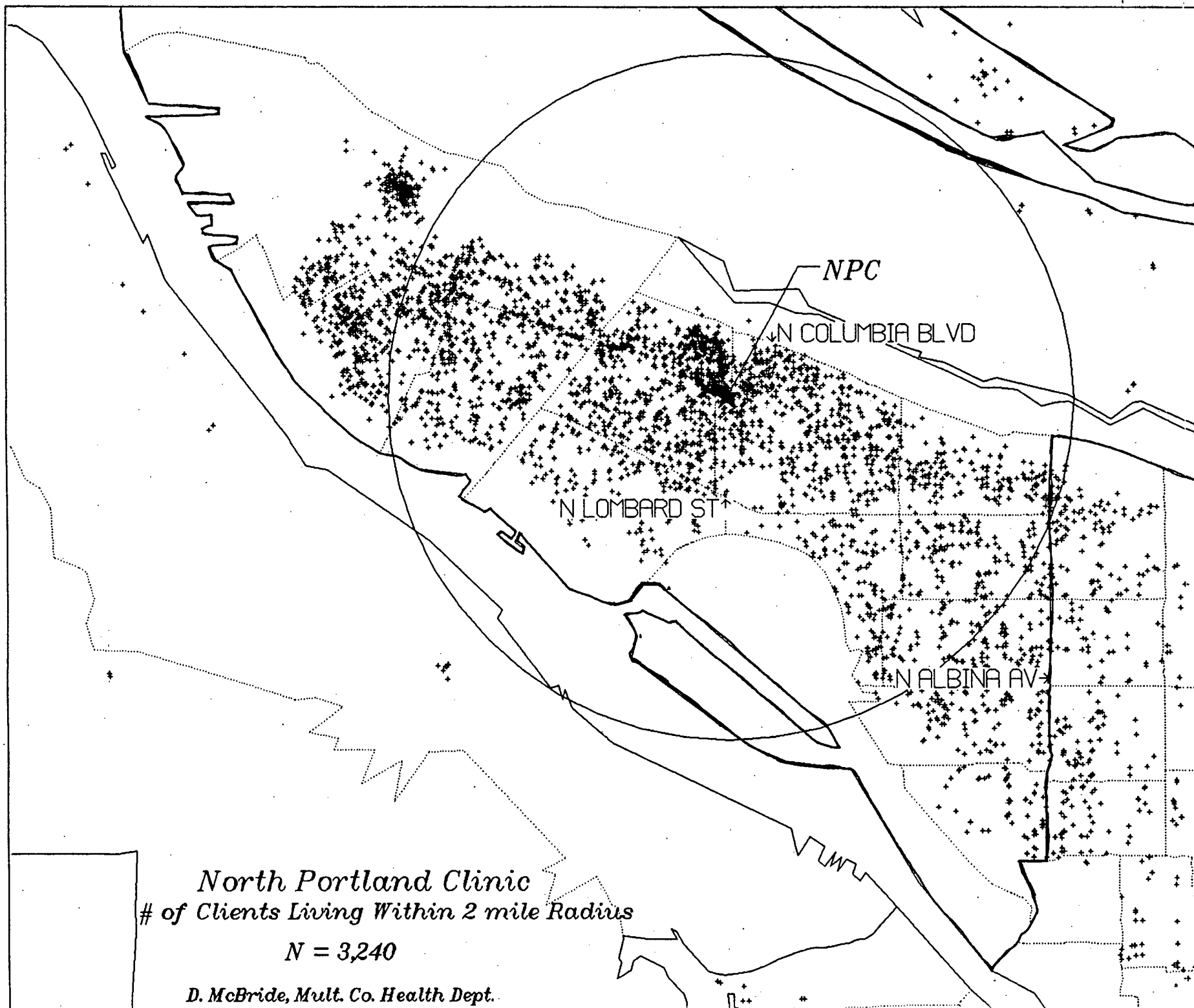
Our hope would be that concerns are raised now and resolved rather than 16 months into the project after expenses have mounted.

Attachments:

Graph - Household Income Levels

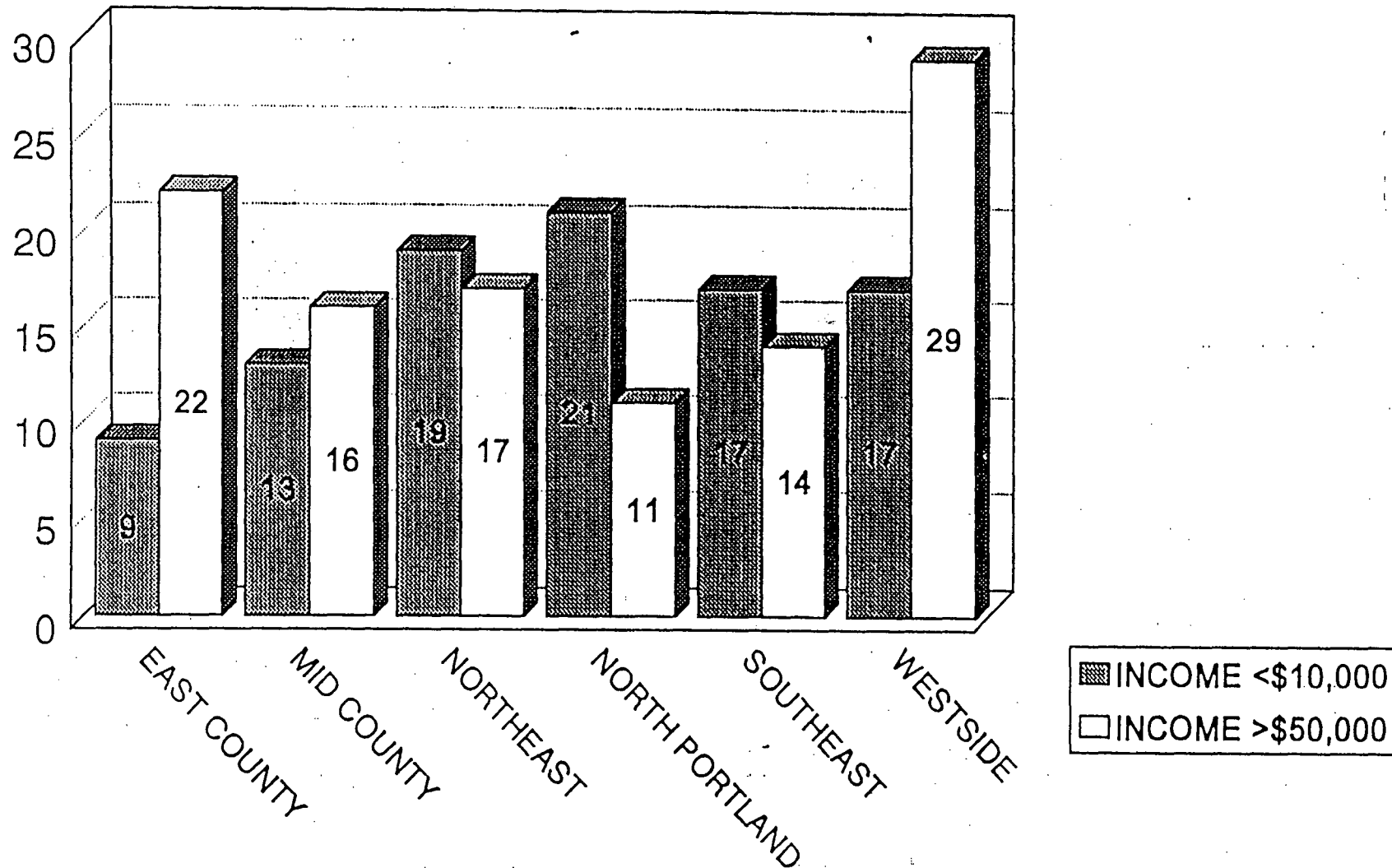
Chart - Locations of Current Patients

cc Billi Odegaard, Director, Health Department



PERCENT OF HOUSEHOLDS WITH INCOMES LESS THAN \$10,000 AND GREATER THAN \$50,000 : MCHD SERVICE AREAS

FROM 1990 CENSUS DATA



WESTSIDE INCLUDES BURNSIDE AREA CENSUS TRACTS

#4



MULTNOMAH COUNTY, OREGON

BOARD OF COUNTY COMMISSIONERS

BEVERLY STEIN
DAN SALTZMAN
GARY HANSEN
TANYA COLLIER
SHARRON KELLEY

PLANNING & BUDGET

PORTLAND BUILDING
1120 S.W. FIFTH - ROOM 1400
P. O. BOX 14700
PORTLAND, OR 97214
PHONE (503)248-3883

TO: Lorenzo Poe, Community and Family Services Director
Billi Odegaard, Health Department Director

FROM: Dave Warren

DATE: May 5, 1994

SUBJECT: Follow Up Items from the Work Sessions on May 4 and May 5

Attached is a list of items about which the Board of Commissioners would like additional information.

Please prepare a memo answering the Board's questions. I suggest that the responses state the question, and then state the response. The response may be a reference to an attached document.

I have two requests to make about the responses:

1. Please respond to all the questions by Wednesday, May 11. I realize that answers to several of the requests on the list will not be available by May 11. However, you will probably have a reasonable idea of when the answers will be available. The response to these items could be to say when the research is expected to be complete.
2. Please help us keep track of the responses. Send them to the Budget Office. We will copy them, attach a sequentially numbered cover sheet that will help the Board be sure that they are getting all the packets of information, and distribute them to the Commissioners and the Clerk of the Board.

Let me know if you have further suggestions.

c Board of County Commissioners
Larry Aab
Kelly Bacon
Susan Clark
Ginnie Cooper
Marie Eighmey
Margaret Epting
Bill Farver
Tom Fronk
Kathy Gillette
Tamara Holden
Susan Kaeser

Jim McConnell
Hal Ogburn
Mike Oswald
District Attorney Mike Schrunk
Sheriff Bob Skipper
Tom Simpson
Meganne Steele
Kathy Tinkle
Betsy Williams
CIC
Patrol

CHILDREN AND FAMILY SERVICES

Follow Up Items from the May 3 budget work session:

1. Family Support Network:

Describe the plan for this network more clearly and in a coordinated way including discussion of the following:

- collocation of service components
- client access
- service locations
- potential parallel efforts by other jurisdictions and agencies and how they relate to our plan
- outreach functions

Provide a one page description of each of the six districts, listing the services that are provided and the anticipated service location for next year.

2. Diversion:

- Describe the relation of the CFS diversion service contracts to the Juvenile Justice program
- Explain the services in CFS and the anticipated size of the caseloads
- Provide a "flow chart" of referrals and capacity by geographic area.

3. Homeless Family Case Management - explain the effect of the outstanding receivable for this program on the 1994-95 General Fund, and explain any offsets that may still be available that will improve this outlook.

4. Level 7 - Explain the potential to use Title IV A revenue to support Level 7 programs

5. Level 7:

- Describe the contracting plan for Level 7 services
- Explain the links to the Family Network and other County programs
- Address the issue of what outcome measurements will be included in the contracts

6. Regional Acute Care System - Explore, both for 1994-95 and for future years, opportunities to remove General Fund support from the crisis / commitment / emergency holds programs.

7. Managed Care for Children - Explain what risks the County may be running in moving toward the managed care model for children.

8. Hispanic student retention - How do we intend to address the geographic equity issue so that all school districts receive comparable levels of support?

9. Acculturation - Explain alternatives to an acculturation center that we could use to accomplish the same goal. Research other jurisdictions that provide publicly funded ethnic acculturation centers.

10. Respite Care

During citizen testimony on May 4 a mother discussed the difficulties she has had in locating respite providers to handle her foster children who are emotionally disturbed. The Board would like a discussion of the availability of respite care providers and the kinds of training required for such providers and its availability.

HEALTH DEPARTMENT

Follow up items from the May 4 work session

1. CareOregon

Suggest policies and strategies to deal with those who are not eligible for Care Oregon but have no other health coverage.

2. Interpretive Service

Report on how the strategies for interpretive services are working this year.

3. Drug Free Babies

Provide supplemental information about training for nurses to recognize substance abuse in prenatal clients.

4. Drug Free Babies

Provide information about any research relating to the impact of routine urinalysis on the number of pregnant women willing to contact clinics for prenatal care.

5. Immunization

Provide the Board a schedule of immunization opportunities

6. Columbia Villa Clinic

Discuss potential for collocation of County and other services at the Columbia Villa Clinic.

7. Environmental Health

Provide the Board with an overview of the inspection program including both restaurant inspection and other activities, show the revenue sources connected to the activities, and include information about the relative effectiveness of various inspection processes and the value of issuing food handler licenses.

8. Laboratory

Report on the advantages of providing lab services for Planned Parenthood.

9. Business Services

Analyze Health Department support services that parallel centrally provided support services.

10. Entrepreneurial activities

Report on marketing of blood borne pathogen training.

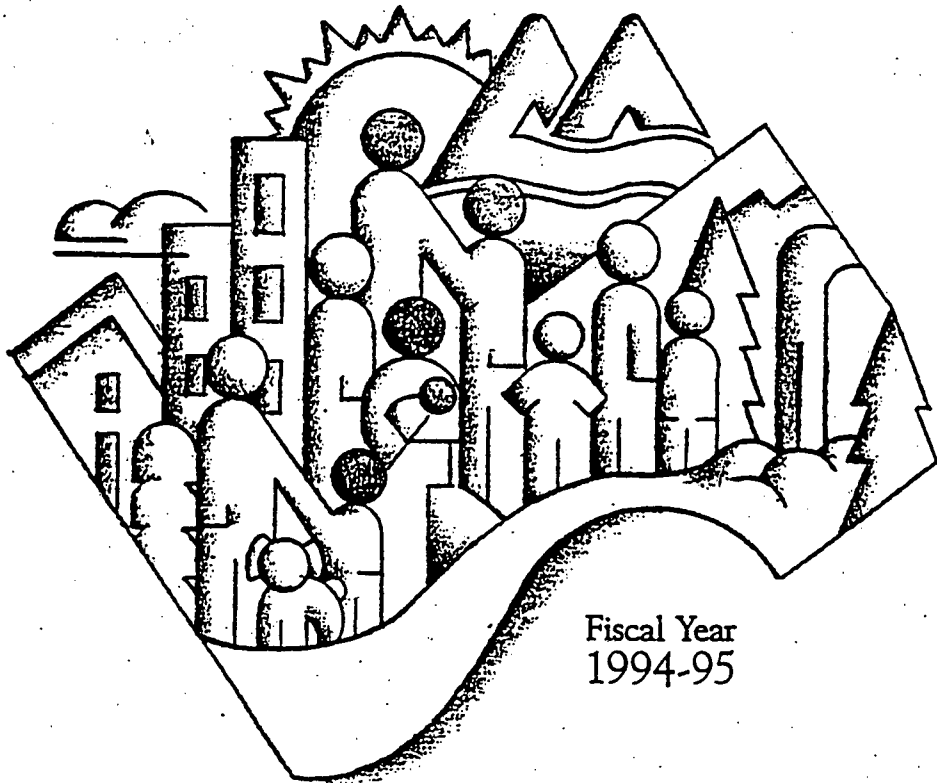
OTHER

1. Specialized contracts

At the afternoon work session on May 4, the Board requested that protocols be developed for specialized professional services that would establish norms for securing and monitoring contracts that departments might budget for and issue.

Multnomah County Budget

Supplemental Information

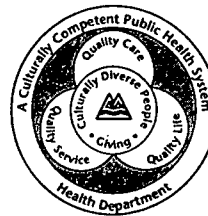


Packet #16
Health Department

Follow-up Information



MULTNOMAH COUNTY OREGON



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BOARD OF COUNTY COMMISSIONERS
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MEMORANDUM

TO: Bev Stein, Multnomah County Chair
Commissioner Dan Saltzman
Commissioner Gary Hansen
Commissioner Tanya Collier
Commissioner Sharron Kelley

FROM: Bill Odegaard, Director
Health Department

DATE: May 24, 1994

SUBJECT: QUESTIONS ARISING FROM WORK SESSIONS

Following you will find our first responses to questions that have arisen during budgetary work sessions.

Most of the questions have responses. Some will need more time, and we will forward them as soon as we are able.

If you have any questions, call either myself or Tom Fronk at 248-3674. While we may not be able to answer directly, we will direct your questions appropriately.

QUESTION (Health No. 1): CareOregon Suggest policies and strategies to deal with those who are not eligible for CareOregon but have no other health coverage.

- The Health Department entered into CareOregon and the Oregon Health Plan with the express interest of maintaining the Primary Care clinic system at a size that allows us to care for clients who are in need of subsidized health care, but ineligible for the Oregon Health Plan.
- We are investigating via client and staff input and management review the concept of enrolling clients ineligible for the OHP who need primary care. The details for this system such as eligible clients, benefit packages, access care and the enrollment process are yet to be determined.
- It is vital for us to maintain the non Medicaid funding for the Primary Care Division. Funds such as WIC (\$1.6 million), Primary Care - CHC (\$2.5), Family Planning (\$0.3), Homeless Health Care (\$0.6), MCH (\$0.5), and General Fund (\$5.4) are critical to the continued support of non Medicaid eligible patients.
- The Coalition clinics offer additional services to this population.
- We are working with OHSU to increase the amount of specialty care offered to the uninsured by coordinating our efforts.
- Health Source dollars (\$178,000) will continue to be used to support referrals and specialty care for the uninsured.
- Public Health, Field Service and Specialty clinics will continue to be available to the community and special population, examples are: Immunizations, Communicable Disease, STD, HIV, School Based Health Centers, Family Planning, WIC, Community Health Nursing
- New funds are being sought to assist the uninsured. We are currently applying to the Federal Government to add prenatal resources to the Northeast community.
- New ways of doing business are being explored and implemented, examples are: Extended hours, access/urgency services, coordination with drug and alcohol services and bilingual services.

QUESTION (OTHER No. 2): Indirect Costs Explain what is included in Indirect Costs and how these overhead charges are computed. Explain differences between 1993-94 and 1994-95.

WHAT'S INCLUDED

There are two basic types of costs associated with running a program: Direct and Indirect Costs.

Direct costs are those costs which may be assigned to specific programs with a reasonable amount of accounting ease and accuracy. For example, the Health Department operates a HIV Treatment Clinic. A nurse practicing in that clinic is a direct cost of the HIV Treatment Program.

Indirect Costs are costs incurred in supporting a wide range of programs. By their nature, these costs may not easily be linked to specific programs. For example, the Health Department employs a grant accountant. This person supports dozens of individually funded programs. As it would not be reasonable to attempt to divide employee's time into all of the programs he supports, his time is allocated to all programs as an Indirect Cost.

Indirect Costs are allocated through an Indirect Cost Allocation Plan. The development of this plan is governed by federal OMB Circular A-87, which defines cost accounting rules for states and local governments. Indirect Costs have two sources:

Central Service Costs are those arising from central County support agencies. For example, costs from the Auditor, Budget and Planning, Employee Services, and Finance are spread to Departments using allocation methodologies.

The allocations must be made using a reasonable basis, which varies based on the type of central service. For example, Employee Services costs are spread to Departments based on the number of employees each Department has, the Finance Division is spread based on the number of payment vouchers generated, and so on.

Not all central service costs are included. Some central services use accounting systems that allow direct charges to programs. Fleet and Telephones are examples of central services with enough accounting detail to allow their costs to be considered direct, rather than indirect.

Other central services are disallowed by A-87. For example, as A-87 does not allow general governmental costs to be charged to federally funded grants, activities of the Chair's Office may not be included.

Departmental Services also contribute to Indirect Costs. Each department incurs costs in support of the various programs that make up that department. Examples may include the department directors, training units, central clerical support, division managers, accounting or grants management office, planning offices, etc.

Indirect Costs are expressed as rates. The rate is established by summing Indirect Costs from these two sources, Central Service and Departmental, which together make up the Department's Indirect Cost Pool. The Indirect Cost Pool is then divided into the total dollar volume of the direct services the Department provides. For example, assume that the ABC Department has a total budget of \$10,000,000. Their Central Service allocation is \$450,000, and their Departmental Service cost is \$550,000 (45% and 55% respectively of a \$1 million total Indirect Pool). Their Indirect Rate is 10%.

The split between Departmental and Central Services as sources of Indirect Costs is important when a grant that allows Indirect Cost recovery changes. For example, assume that ABC Department receives a \$500,000 grant to do good. The grant will provide \$454,546 for services, and will pay \$45,454 in Indirect Costs (10% of \$454,546 is \$45,454; \$45,454 + \$454,546 is \$500,000).

Of the total \$45,454 of Indirect that this grant pays, 45% (\$20,454) results from Central Services and 55% (\$25,000) results from Departmental Services. Normally, if this grant award came to the Board in a budget modification the Central Service portion would increase the Contingency Account, while the Department would fund administrative support with the Departmental Services portion.

THREE INDIRECT COST RATES

In practice, three Indirect rates are established. Each Department has its own **Full Rate**, which applies to most expenditures. In 1993-94, the Health Department full rate is 12.67%, of which 4.74% originates with Central Services and 7.93% originates with Departmental Services.

In addition, the County establishes a **Pass Through Rate**. This rate, set at 0.7% County wide, applies to Pass Through contracts and County Supplements. It is based on the assumption that certain types of financial transactions require little if any County overhead. Examples of when the Pass Through rate is applied in the Health Department include the contract with Russell Street Dental (pass through of federal funds) or the subcontract with OHSU hospital care for CareOregon clients.

The third rate, applying to **Capital Purchases** only, is 0%.

DOES IT REALLY MATTER?

Indirect Costs are important for two reasons. Financially, if a funding source allows Indirect Cost Recovery, it is to the County's advantage to recover. This is true for both grant revenues, and operational revenues (fee collections, contracts, etc.).

From an accounting perspective, Indirect Cost allocation represents a convenient tool to use in showing the full cost of doing business. This is the reason that we go through the effort of transferring General Funds to grant programs who do not allow Indirect Recovery from grant funds. The transfer allows full budgeting and charging of Indirect Costs.

For both of these reasons, it is important to be as accurate as possible in identifying all overhead costs and including them in the Indirect Cost Pool.

WHY DO RATES VARY SO?

Rates vary for three reasons:

- 1) Departments are motivated to differing degrees to identify and include Departmental costs into its Indirect Pool.

Departments are organized differently. Support services in highly centralized Departments are easier to identify and include in an Indirect Pool.

Historically, the nature of a Department's funding impacts how much effort goes into identifying Departmental Indirect costs. Contrast the Health Department, with large cost based contracts and many grants that allow recovery, with the Sheriff, an agency almost wholly funded with General Funds, with Children and Family Services, a grant funded agency whose grantors have not historically paid Indirect Costs. The amount of return makes it financially rewarding to the County for the Health Department to identify to the last dollar its overhead costs.

- 2) When an Indirect Rate is established, all of the dollar figures come from the most recently completed fiscal year. For example, the rate for 1994-95 is established using dollar figures from 1992-93. This is necessary, as we are only nine months through 1993-94. Because the rate is established using one year's financial information to estimate what a future year will look like, it is called a **Prospective Rate**.

The rate, once established, is used for all of 1994-95. However, at some point an adjustment has to be made. This is necessary to account for the difference between the Prospective Rate for 1994-95 and the actual rate for 1994-95. As the actual rate for 1994-95 won't be available until the winter of 1995-96, after the books have closed on 1994-95. The adjustment is made in the rate for 1996-97. This continual multi-year adjustment process is called the Roll Forward.

How does this cause variation in rates? The Roll Forward is intended to handle the small variations that are expected annually between estimates and actuals. However, changes occur in the County that have huge impacts on this estimate and adjustment process.

The largest recent example is the establishment of Health as a separate Department. Health had no history to establish its allocations of central services, therefore, historical data for the Department of Human Services had to be assigned to Health using the information at hand. The assignments turned out to be too low, and the Roll Forward is adjusting for it by adding to Health's central service allocation and reducing Social Services. This affect is adding about 2% to the Health Department's rate, while reducing the DSS rate by 3%. In a future fiscal year this affect will wash out, and the Health rate will drop and the DSS rate will increase.

- 3) County budget practices can affect Indirect Rates. For example, the Health Department Indirect Pool includes \$814,000 of Data Processing charges, adding another 2% to our rate. For most other County agencies the service reimbursement for Data Processing is included in Non-Departmental.

QUESTION (Health No. 2): Interpretive Services Report on how the strategies for interpretive services are working this year.

FY 92-93

- Limited English encounter volume averaged 4,384 visits/month as of June 1993.
- The estimated interpreter cost per visit for the fiscal year was \$22.97.

FY 93-94, FIRST 9 MONTHS

- Limited English encounter volume has increased 15% to an average of 5,050 visits/month. Annualized growth rate is 20%.
- Interpreter cost per visit was reduced by \$4.21 to \$18.76. This is a 18% reduction.

APPROACHES TO SERVICE DELIVERY, FIRST 9 MONTHS

Bilingual Hiring

- 20 bilingual employees were hired into job classes ranging from physician to Office Assistant II. This does not include Health Assistants hired principally as interpreters.
- Local 88 has expressed serious concern with bilingual requirements and language skill assessment for potential transfers from within the Department. The Language Services manager has begun informal discussions involving Jim Smith and a small group of Local 88 members on this issue.

Spanish Language Training

- Region X eight day Spanish immersion training completed for 14 staff in October. Follow up training is being provided through Intercom language school on a limited basis.

Contracts

- Renegotiated lower rates and tight monitoring have reduced IRCO and Andalex contract interpreter expenditures from an average of \$2,083 last FY to \$559.
- AT&T Language Line contracted through the State to get volume discount rate. Initially intended to support after hours advice nurses. This service is now being used by CareOregon office and soon will be used by After Hours Clinic as a back up.
- Reduced hourly rate from approximately \$40 to \$32 per hour for sign language interpreters by contracting through the Oregon Disabilities Commission. Expenditures averaged \$1,068 per month.

Centralized Interpretation Pilot Project

Pilot Project to centralize triage interpretation and Health Information & Referral in Russian and Vietnamese languages.

6 month pilot period starting February 1994 involving Mid County and Southeast Health Centers.

Early direct client surveys indicate a major improvement in response time, and relatively good satisfaction with the new method of delivering interpretation for telephone triage and appointment service.

Volunteer Bilingual Trainees

- Steps to Success recently approved the contract language, and placed their first voluntary work experience client at Mid-County Health Center in April '94.

After Hours Clinic Telephone Interpretation

- After Hours Clinic uses speaker phone technology in exam rooms, using a telephone connection to local interpreters to handle the visit.
- A client survey will ask clients about this method of interpretation.
- Speaker phones may have potential in other clinical services where the content of the visit may be less sensitive (e.g. immunizations or on-site triage).

EXPENDITURES AND PROJECTIONS FOR THIS FISCAL YEAR

- Interpreter related expenditures for the first 9 months totaled \$820,600. Projected total for the fiscal year is \$1,114,200, which will put expenditures \$154,500 over the budgeted amount. This over expenditure is driven by the rapid growth in services to limited English speakers. Marked improvement in cost per visit has been offset by increased demand for services.

PLANS FOR NEXT FISCAL YEAR

- Decentralize budget for both permanent and temporary interpreter staff to Divisions for distribution to work units. This will increase on-site responsibility and control of interpreter related expenditures, encouraging teams to continually review site based operational decisions to minimize costs.
- Continue hiring of bilingual staff into appropriate direct service positions.
- If pilot project demonstrates success, recommend moving to permanent application.
- Build on data/experience using speaker phones in After Hours Clinic as a possible springboard for similar technology in other service areas.
- Develop and implement improved interpreter training program for temporary interpreters.
- Shift funds from selected permanent interpreter positions to other support categories.

DISCUSSION

The Department is undergoing a major change in the way it delivers services in one quarter of its encounters. Efficiency is clearly improving, but not without negative impact on some of our staff. Many are fearful of losing their options, if not their job, because of our bilingual hiring and screening policies.

Cost per visit figures indicate that the Department has made good progress in reducing interpreter expenditures, but significant growth in demand has prevented the Department from meeting the budgeted amount in the first year. Now that bilingual Civil Service exams are in place, testing and certifying processes are streamlined and many bilingual positions filled, we should see continued improvement in interpreter cost per visit figures.

The Department is now moving into the Total Quality Management/Continuous Quality Improvement (TQM/CQI) model which emphasizes the customer and moves decision making out and down in the organizational structure. Decentralized interpreter budget responsibilities will complement this approach and allow site staff to look at all aspects of their service delivery and how that impacts interpreter costs.

In addition to scheduling temporary interpreters on a daily basis and developing translated materials, Language Services will continue to track and distribute language usage data, survey clients, enhance hiring processes and improve training of temporary and permanent interpreter staff.

New approaches like the centralized telephone interpretation pilot project and speaker phone interpretation in the After Hours Clinic should lead to further efficiencies while maintaining our high level of service to our limited English speaking clients.

QUESTION (Health No. 3): Provide supplemental information about training for nurses to recognize substance abuse in prenatal clients.

Multnomah County Health Department has instituted as a part of its on-going employee orientation a two day **Substance Abuse Training**. This training is available to both new employees as well as any employee in need of continued training in chemical dependency. Our employees also have the option of attending additional community sponsored alcohol and drug prevention/treatment workshops or trainings. The **Adapt, Start and Primary Health Care Substance Abuse Programs** are recognized as programs through which Community Health Nurses become specialist in working with perinatal substance abuse clients both in clinic and field services. Attached to this report are two of the perinatal forms used by our perinatal providers in assessing alcohol and drug use during pregnancy. In an effort to address additional supplemental education for Multnomah County Community Health Nurses in recognizing substance abuse in perinatal clients, the Health Department plans to work in collaboration with Multnomah County's Alcohol and Drug Office to sponsor a Community Health Nurse Forum on Perinatal Substance Abuse.

QUESTION (Health No. 4): Research concerning the impact of routine urine testing pregnant women willing to contact clinics for prenatal care.

Substance use among pregnant women has placed an increasing number of infants in this country at risk for prematurity, low birth weight, infant mortality, mental retardation, and severe malformations. According to national surveys, somewhere between 59% and 73% of women, 12 to 34 years of age, drink alcohol during their pregnancy. ^(1, 2) It is also estimated that of the reproductive aged women in the United States (15 to 44 years of age) approximately 6% use marijuana and 1% use cocaine. According the US Department of Health and Human Services, approximately 25% of women smoke during their pregnancy.

Prenatal care plays a key role in improving birth outcomes. Unfortunately in the general population of the United States, one out of every 18 women does not receive prenatal care or receives inadequate prenatal care. Known barriers to prenatal care are financial constraints, attitudes, beliefs, transportation, child care, disruptive family situations, immigration status, and substance use.

Pregnant substance users typically seek prenatal care late in their pregnancy or not at all. For example in New York, 33% of the women giving birth to cocaine/crack affected infants received no prenatal care; while 5% of non-drug using women received no prenatal care.

Substance use typically does not occur in isolation. Pregnant substance users are more likely to have other infections (i.e., STDs, hepatitis) and can have reduced weight gain associated with their heavy drug use. Many pregnant substance using women not only have problems with drug addiction(s), but are dealing with poverty, violence, abuse, mental illness, low self-esteem, and prostitution. As a result poor birth outcomes are not solely due to prenatal substance use. To the contrary, predictors of poor birth outcomes are substance use, poor nutrition, inadequate prenatal care, and violence. ^(4, 5, 6)

With this in mind, how can we improve birth outcomes for substance using pregnant women? One solution is to require universal urine testing for drugs of all pregnant clients coming to the Multnomah County Health Department for prenatal care.

There are many limitations to urine testing for prenatal substance use, though. A well known fact is that reporting discrepancies for drug use during pregnancy exist throughout this country. In one study they found that despite similar substance use rates, women of color were 10 times more likely to be reported for substance use compared to Caucasian women. ⁽¹⁰⁾

Another limitation is the testing and reporting bias toward poor women. Poor women have been shown to be more likely identified and reported for substance use during their pregnancy than other pregnant women. This is despite findings that private and public health clients entering prenatal care were equally likely to be using drugs during their pregnancy. ⁽¹⁰⁾ According to Zellman, et al ⁽¹¹⁾, private providers are reluctant to screen their prenatal patients for drug use for fear of losing their patients.

One important limitation with the technique of urine testing is that it only detects recent drug use. Marijuana use is detected one week before testing; while cocaine use is detected only within the last few days.

A major limitation of drug testing is the potential impact on the unborn child. Many experts in the field warn that "because of the punitive laws in many states, women fear losing their children if they seek prenatal care or substance abuse treatment". ⁽⁸⁾ One study found that "pregnant women's fear of detection of drug use was the most salient barrier" to seeking prenatal care. ⁽³⁾

Before universal urine testing for drug use during pregnancy is implemented, consistent data must exist to

show that such testing improves birth outcomes and does not cause serious adverse consequences to the unborn child. To our knowledge, "there is no empirical evidence that such legislation either deters maternal substance use or improves infant mortality or morbidity."⁽⁹⁾

According to many experts in the field, the system is already overwhelmed and not adequately addressed by the number of pregnant drug using women identified through providers. For example, in New York City during 1990 substance use treatment centers were surveyed, and 54% refused to take in pregnant women; while only 13% accepted pregnant crack addicted women on Medicaid.⁽⁷⁾ What is the point of testing pregnant women for drug use during their pregnancy if we do not have the resources available to treat them?

We should not make prenatal substance use a legal or punitive issue. Testing for the presence of drugs during a woman's pregnancy is counter-productive. Instead, we need to get them into prenatal care as soon as possible and get them into the most appropriate treatment program available. By doing this we will provide the best care to the woman and to the unborn child.

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QUESTION (Health No. 5): Immunization opportunities.

Done

QUESTION (Health No. 7): Inspection Program Overview.

Program Issues

While recent events such as the *E. coli* 0157:H7 in Washington state point out the critical importance of proper food handling in restaurants and other food service establishments, there is lack of consensus on how to further improve the safety of these establishments.

One difficulty is that most local food service establishments are safe to eat in. Multnomah County has approximately 2,000 restaurants and other food service establishments currently licensed. If each establishment serves an average of 100 meals per day (a conservative estimate), the public consumes more than 60 *million* meals in the county's restaurants each year. In a typical year, the Health Department receives about 150 complaints of illness *possibly* related to consumption of food in restaurants. A small minority of these complaints are justify detailed investigation. Only in rare instances is there compelling evidence that the complainant's illness was the result of consuming food in a restaurant.

The other major difficulty is that it is not clear that current public health interventions are optimally effective in improving food safety. Public health departments have traditionally relied primarily on inspection programs to ensure the safety of establishments that serve food. This reliance is largely based on historical evidence that inspection programs were effective in putting grossly inadequate restaurants out of business, and promoting compliance with a minimum set of standards in the others. Inspection programs operate on two key assumptions. First, they assume that the food handling practices observed during two to three hours of inspection per year are representative of practices throughout the thousands of hours that a typical restaurant operates each year. Second, they assume that inadequate practices identified in the inspection are reliably corrected on a long-term basis as the result of the inspection and the guidance given by the inspecting sanitarian. These assumptions are probably reasonable in dealing with food service establishments that have consistent, simple, and fairly obvious problems. They are probably less valid for establishments that have intermittent, complex, or subtle problems. A growing body of public health literature is questioning the effectiveness of traditional inspection programs in identifying and correcting deficiencies that create a well-defined risk to the health of the public. A local example is the study carried out by Dr. Alan Melnick, Health Officer for Washington County. This study which found a relatively poor correlation between inspection scores and the risk of food-born illness.

Many alternative approaches to food safety have been proposed in recent years. These have included modified inspection programs, self-inspection, food handler and food service manager training, and utilizing market incentives to improve food handling practices. Formal evaluation of these approaches is ongoing. There is evidence in the literature to suggest that some of these are effective (e.g., food handler training and other approaches that create internalized systems for assuring food hygiene).

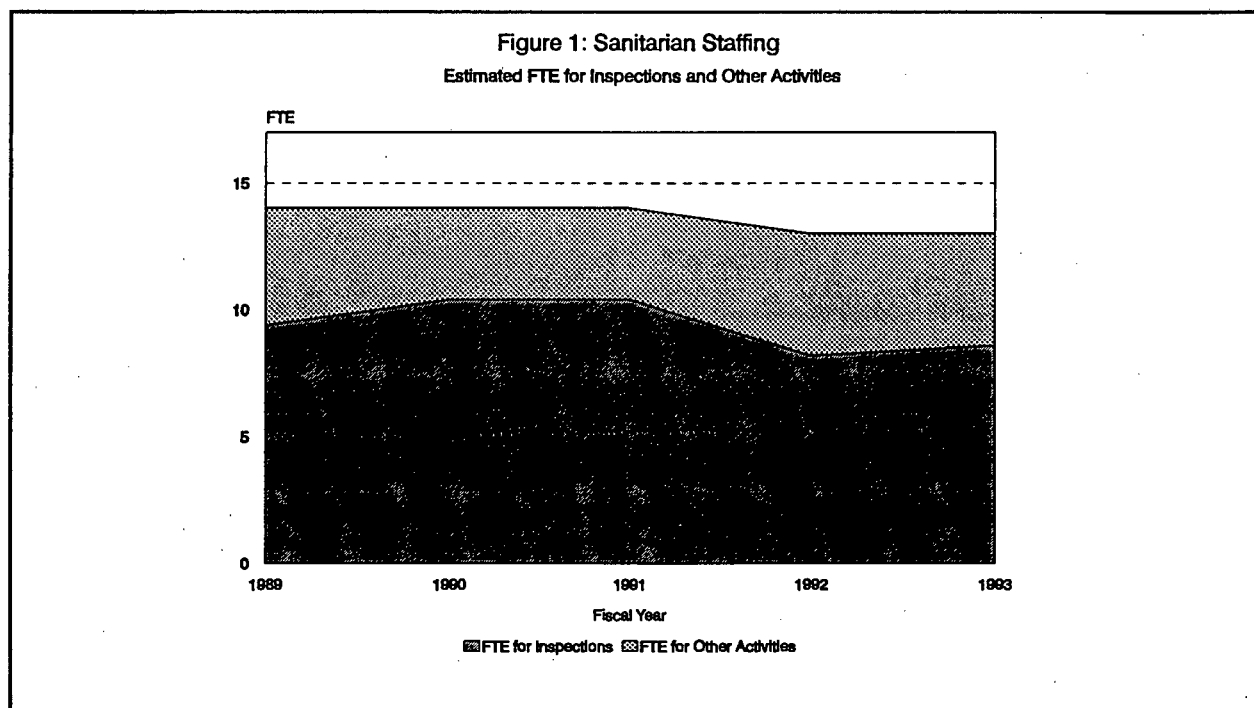
Multnomah County Health Department carries out food service licensing and regulation as a delegated program of the Oregon Health Division. The Department operates in an environment largely defined by food sanitation, inspection, and programmatic rules promulgated by the state. The state is currently re-examining some aspects of its approach to food sanitation. The emerging direction appears to be positive, but it is unclear when or to what degree these changes will be formally adopted by the state. For the time being, the most appropriate programmatic course is to 1) continue to work with the state in

evaluating and modifying the current approach to inspections and other aspects of food sanitation; 2) evaluate and modify existing local programs (e.g., food handler certification); and 3) explore new programs (e.g., awards and food manager training) to ensure that our local program is optimally effective in protecting the public health.

Sanitarian Workload

During the Budget Hearing, there was testimony that the current sanitarian staff could not carry out its work load with adequate quality, and that this situation represented a danger to the public health. The following is an analysis of trends in sanitarian staffing and work load over the past five years. This analysis is intended to look at the question of whether the current inspection work load can be reasonably met by existing staff.

Data on inspection work load was derived from numbers of licensed facilities requiring inspection, and on required inspection schedules for each facility. Data on staffing was obtained from budgeted staff levels for the past five fiscal years, and from estimates of staff time spent on inspections and on other activities. Both categories of data represent estimates that are appropriate for comparison over time. They may contain mild inaccuracies due to the difficulty in tracking hours of work by staff with duties in several different and changing program areas over the years.



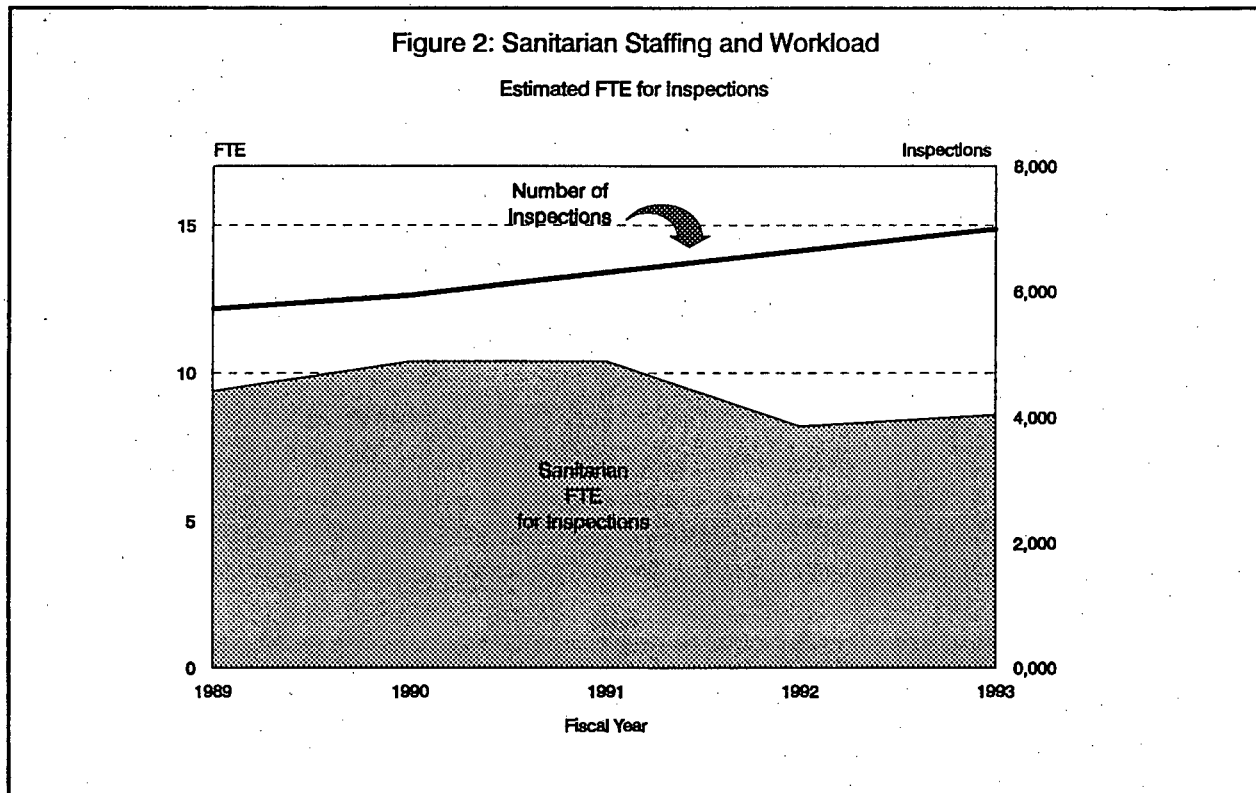
As shown in Figure 1, sanitarian staffing decreased from 14 FTEs for fiscal years 1989-90 through 1991-92 to 13 FTEs for 1992-93 and 1993-94. This decrease was intentional, and was based on the observed improvements in the efficiency in restaurant inspection, and the Environmental Health Program manager's judgement that 13 sanitarians were adequate to cover all program duties. However, as Figure 1 also shows, there was a disproportionate decrease in the number of staff FTEs available to perform delegated

inspections (food service, swimming pools, and tourist accommodations). In 1989-90, there were about 9.4 FTE sanitarians available to perform delegated inspections. This fell to 8.2 in 1992-93, and was increased slightly through shifting of duties among staff in 1993-94. These changes represent a net decrease of 8.5% in sanitarian FTEs available to perform delegated inspections between FY 1989 and FY 1993. This situation resulted from an increasing workload in other programs, most notably restaurant plan review and childhood lead poisoning prevention.

During the same five-year period, the inspections work load increased significantly. This was largely due to substantial increases in the numbers of permanent and temporary restaurants. The estimated total number of delegated program inspections for the 1989-90 fiscal year was 5,729. This rose to 7,001 for 1993-94 - an increase of 22%.

Discussion

Based on this analysis, it is apparent that the perception that sanitarians are working harder on the delegated inspection programs is based in fact. Compared to five years ago, there has been a substantial increase in work load, and a substantial decrease in staffing.



As is true for most programs, determination of an ideal staffing level is difficult. The most relevant standard for staffing is found in the Oregon Health Division's revised administrative rules relating to restaurant license fees. This standard sets allowable levels of sanitarian staffing to be charged to restaurant license fees. It was developed in cooperation with the restaurant industry. This rule would allow Multnomah County 7.9 sanitarian FTEs for inspection of full and limited service restaurants alone. These establishments account for about 60% of the total number of delegated inspections, and about 80% of the delegated inspection work load.

Over the past several years, the Department has made a concerted effort to have all delegated inspections (as well as most other Environmental Health Program activities) paid for out of license and inspection fees. This effort has been successful, as reflected by the fact that 100% of funding for inspections is supported by fees.

Beyond effective and efficient operation of delegated programs, the county has an interest in developing a dynamic environmental health program for the future. There is increasing public concern over a variety of issues involving the impact of the environment on health. Examples include environmental toxins, odors, indoor air quality, noise, and environmental equity. One effect of the current staffing situation in the Environmental Health Program is that the Department is without even minimal resources to address the range of existing and emerging environmental health problems.

Recommendations

To allow it to continue to provide quality service in traditional environmental health inspection programs, and to allow it to develop at least minimal capacity to address emerging environmental health issues, the Department recommends that the Board authorize an additional 1.0 FTE sanitarian position. This increase would provide the Department with a more reasonable, but still lean staffing level.

At the present time, the Environmental Health Program is in the early stages of adopting a self-directed work team (CQI/TQM) approach to all of its functions. This will involve redesign of both line staff work roles and management structure and roles. A participatory approach involving all staff and management personnel is being used to pursue this program redesign. Because this process is in its early stages, it is unclear what the Program's requirements for managerial resources will be relative to the currently budgeted level. Therefore, the Department recommends funding the additional requested sanitarian position from County General Funds, with the understanding that a budget modification may be forthcoming in the late Summer or early Fall to shift part or all of the funding for this position to license fees.

QUESTION (Health No. 8): Advantages of providing lab services to Planned Parenthood.

The Department will continue to research this question. An answer should be expected within two to three weeks.

QUESTION: (Health No. 9): Business Services Analyze Health Department support services that parallel centrally provided support services.

SUPPORT SERVICES

The Health Department, as well as some other County Departments, have developed departmental functions that augment central support services.

Central units providing specialized administrative support include the Auditor, Budget and Planning, County Counsel, Employee Services, Finance, and Labor Relations.

Departmental support services, as provided within the Health Department, include grant accounting, budget preparation, human resources management, management of the Health Information System, and medical receivables and payables. The development of these Departmental support services has occurred over time, and are the result of growth in size and complexity of the work force, programs and funding sources. These functions evolved in collaboration with the central units to meet specific needs of the Health Department, or have evolved in the absence of central units to provide the services.

The Health Department is a highly cohesive agency. While it is involved in a wide assortment of programmatic activities the Department shares a common commitment to consistency in management practices and procedures. This cohesion has allowed the Department to build its administrative infrastructure in a organized, centralized fashion.

This leads to a high degree of administrative visibility. However, the visibility of centralized administrative units should not be used as an indicator of our Department's relative level of administration. In combination with these central units the complete lack of administrative support at the Divisional level must be considered. The Health Department is able to operate Divisions of hundreds of FTEs without the individual budgetary, personnel, payroll, or contracting staff common to other County divisions of similar size or scope.

Are these services duplicative in nature? From the Department's perspective, they are not.

Many of the Department support services have been created due to the unique nature of the services the Health Department provides. For example, no other County agency is involved in billing insurance companies for its services. The Health Department years ago transferred Medicaid and insurance billing functions from around its clinics to form a central medical receivables unit.

Other Department support services have developed due to the lack of adequate levels of support by the County centrally. For example, the Health Department maintains internally the ability to support its Health Information System. ISD clearly is not staffed to support the HIS, and fully expects the Health Department to support its own systems.

Other Departmental support services are required by the demands of the Department's funders. The Department receives support from over 90 different funding sources, of which 44 are grants from Federal, State, or local agencies. The Department strives to blend these individual programs into a seamless product from client's point of view. This diversity of funding sources has led to a rich blend of services to the community, and to long term financial growth for the agency. However, it also brings a demand for cost accounting and cost reporting abilities far beyond that required of any other County department. Grant reporting, cost accounting, fee setting, and employee time and effort reporting activities that are managed by the Health Department would be alien to a County agency supported with local tax revenues.

Would these services be better provided centrally, rather than by the Department?

From our perspective we can not fully answer this question. The question deserves a lot of attention.

Our instinctive reaction is to maintain the control, accountability, and responsiveness that comes from maintaining these services within the Department.

Our recent experience with the absorption of the Department's Health Supply function within the County's Warehousing and Distribution office is a good example. Service to Health Department work units was reduced to the common County level, which was expected and included as a cost of the transfer. What was not expected, and was not included as a cost, was the shifting of administrative burden onto individual work units. Site staff found that supply, service, and equipment procurement responsibilities became theirs. Cash handling, chart transport, and specimen collection was compromised. Procurement became, and still is after two years, a bottle neck for clinical operations.

Would we describe the Health Supply transfer as a failure? From our perspective, we were not well served. From the County's perspective, however, the General Fund savings that resulted may have outweighed the difficulties.

EXAMPLE - EMPLOYEE SERVICES

In 1988-89 the Health Department had 429 FTE in 22 work sites. The proposed budget for 1994-95 projects 765.41 FTE in 37 work sites and includes 68 different job classifications. This represents a 78% increase in work force over 6 years while spreading them over nearly 68% more sites.

The Department conducts 32-42 selection processes annually. Currently, there are 130 new hire actions annually. In addition, there are approximately 25 transfers, 20 promotions, 40 classification reviews, and 15 reclassifications annually.

During the same six year period, staff in Employee Services dedicated to the Health Department has remained constant. In March of 1991 the Health Department shifted staff within the Department to assign Human Resources management to a half time manager. Within the last two years that staffing has been increased to full time. In July 1991 a staff position was added to support the grantor required implementation of an employee time and effort accounting system. This spring half of a position was cut to reflect efficiencies in payroll practices.

The central Employee Services and Payroll offices could not absorb this work load. They exist in a symbiotic relationship with personnel and payroll services provided at the Department level. Employee Services maintains office hours in the Department. Duties between the three offices are clearly delineated, and responsible parties established. The Department is afforded the ability to extend span of supervisory control as individual unit managers are not required or expected to individually manage their own selection processes and personnel actions.

Employee Services and Payroll functions could not be provided centrally by the County without resources being shifted from operating departments. It is entirely possible that total resources could be reduced. However, our Department's ability to maintain its existing span of control will suffer as personnel and payroll activities would be shifted onto work unit staff.

QUESTION (Health No. 10): Multnomah County Occupational Health Office: Update on the Marketing of the Blood borne Pathogens Program:

HISTORY:

The Occupational Health Office (OHO) was opened in July, 1992 to bring Multnomah County into compliance with OSHA's newly enacted Blood borne Pathogens Program (BBP) requirements.

Current Staffing:

- Manager (0.5 FTE)
- Lead RN (1.0 FTE)
- Community Health Nurses (2.0 FTE)
- Office Assistant II (1.0 FTE)

Current Contracts:

- Multnomah County (~2000 employees)
- City of Portland (~800 employees for the whole program;
~1000 police personnel for Hepatitis B injections only)
- Metro (~75 employees)
- Port of Portland (~75 employees: Hepatitis B injections only)
- Multnomah Athletic Club (MAC) (~50 employees)

Marketing Contract with Portland State University Marketing Professor:

- December, 1993-May, 1994: Just completed the brochure for marketing our program.
- Marketing Plan completed and delivered to OHO in May 1994.
- Plan: Currently making arrangements for printing the brochure and will then begin distribution according to the Marketing Plan.

Current Services provided "Fee for Service":

- Flu Shots (~1900 given in 45 work sites: Sept-Nov '93)
- Seminars for employees given for:
 - Bureau of Land Management
 - Ryan Hutchins, Arthur Southwick Advertising Firm
- BBP Program for Center for Continuous Improvement
- Hepatitis B injections for non-contracted employees, students, MR/DD clients/staff

New Prospects:

- West One Bank: Currently negotiating health education sessions for employees

Program Expansion:

- Currently developing a program to meet OSHA's newly drafted Tuberculosis guidelines. These will affect all health care facilities in the State and we are hoping to market our services to them along with our current BBP Program.

QUESTION (Health No. 11): Medical Care Costs for inmates.

The 1994-95 includes two amounts for Corrections Health:

Medical Care -	\$5,054,000
Mental Health Services -	\$791,000

These costs include juveniles, which are not separated budgetarily. However, we estimate care at the juvenile facility to run approximately \$610,000 annually.

The cost of transport and security for inmates related to medical care is budgeted at the Sheriff's Office.

The Health Department will provide additional information regarding cost containment alternatives. We will update the Board on our continuing discussion with OHSU regarding the possibility of establishing a capitated agreement for hospital and specialty care, and on the legislative history of Medicaid funding for adults in custody.

Budget Hearing
5-4-94
Handout #1

KENNETH G. YEE
Registered Sanitarian

MULTNOMAH COUNTY ENVIRONMENTAL HEALTH

TESTIMONY BEFORE MULTNOMAH COUNTY COMMISSIONERS - MAY 4, 1994

My name is Kenneth Yee. I currently work as a field sanitarian - Environmental Health Section. I am one of those professionals known as a "Health Inspector."

Throughout 16 years of county employment history, I have had numerous clashes with county managers over a wide range of issues, from unfair labor practices to race discrimination to lack of fiscal accountability and mismanagement of funds and programs. My watchdogging efforts have resulted in at least 2 resignations of county program managers whose misdeeds stood undetected for many years.

Under current management in the Health Department, I have been told in a blunt and patronizing way, in writing, that I am not allowed worktime in pursuit of any aspect of the county budget, regardless its significant impact on co-workers and myself. In effect, the message was, "Mind your own business, the budget is not in your job description!"

I hope the county health officer will take note that I am here today on my personal vacation time to testify as a concerned citizen.

BUDGET ISSUES ARE IMPORTANT! In our particular field of Environmental Health inspections, the budget is especially vulnerable to manipulation by county managers due to the substantial amount of revenue collected. If that money were funneled directly back into running the EH programs, as well it should be, funds would be far beyond sufficient and I would not be before you today. Whether hindered by accidental or intentional myopia, the end result now is a program in disarray and becoming more of a shambles with each passing day.

If the Chair's proposed budget is approved and adopted with its cuts in sanitarian staff - AGAIN - the entire program would indeed become

a joke, - an unaffordable, costly, risky joke in terms of public health.
Some of the reasons:

- (a) New restaurants opening each year, ^{more and larger temporary restaurant events,} increasing the workload -
- (b) Inspection staff **DECREASING** each year - we lost 2 sanitarian positions this fiscal year of 93-94.
- (c) Constant pressure from interim management to " ^{catch} ~~hurry~~ up, " finds ~~some~~ inspectors ^{pressured to} cranking out 15-minute inspections, just to get the work done.

This allows management then to claim that we are in compliance with the required number of inspections as an Oregon Health Division delegate county.

County management plays the numbers game of **quantity over quality**, just to perform within bounds of a contract. However, at what cost? The emphasis is NOT on food safety. Hepatitis A outbreaks have increased and we've all seen how deadly the E. Coli. ^{bacteria is.} Lawsuits are rampant in foodborne illness outbreaks. How long before Multnomah County is named DEFENDANT if inspections become hurried, sloppy, cursory? How will sanitarians comply with new FDA regulations and ^{their focus on} HACCP ^{principles} codes? HACCP is an acronym for HAZARD ANALYSIS OF CRITICAL CONTROL POINTS, an approach to food ~~handling~~ inspection procedures that place importance on food ~~control~~ ^{handling} rather than structural defect of inspected premises.

Cutting staff sanitarians flirts with disaster not just from E. Coli and Hepatitis A, but a host of other foodborne pathogens, salmonella, staphylococcus, Norwalk virus, etc. Must a child die in Multnomah County to awaken policymakers from their stupor?

The county also appears far more interested in numbers of food handler cards dispensed than in actual food handling procedures. ^{see budget (pg. 26) - Key Results} The process of obtaining a food handler card is arbitrary and lacking of any procedural or structural guidelines. There has been no data produced to indicate there is any correlation between food handler cards and effectiveness in preventing foodborne illness.

Sanitarians deal with an enormously broad range of related sciences which require constant updating through training seminars and educational courses. Epidemiology, microbiology, structural components in plan reviews, plumbing systems, cross connections, exotic animals and bee ordinances, manure complaints, water system surveys & samplings, hotel and tourist facilities, campgrounds, pool and spa regulations, and the list goes on. Regulations appear in constant flux, with frequent updating and training necessary to stay informed in order to attain satisfactory job performance in a complex profession. There are rules from FDA, OHD, EPA, just to name the more prominent.

NOW, COUNTY EXPECTS SANITARIANS TO PAY FOR TRAINING. Not only is this a violation of Local 88 contract, but for ^{some} employees who struggle paycheck to paycheck, it's an impossible situation. They cannot even afford to stay overnight in Oregon destinations, much less pay fees to register. Further, if sanitarians cannot afford the required courses to pick up continuing education units, they lose certification as registered sanitarians.

I have long had serious questions as to where some of the travel and training funds went, what amount was initially appropriated, how much was spent by management, and why all the money suddenly disappeared this year? Some sanitarians have not attended ANY training this fiscal year and are now being asked to pay their own way to training?

The Oregon Health Division is forcing counties into purchasing new computers, all coordinated by the recently-departed Multnomah County program manager, ART BLOOM. TRAINING FOR THESE NEW COMPUTERS IS SCHEDULED BY CHD FOR SUNRIVER AT THE END OF THIS MONTH.

License fees collected by our office should remain in our office to administer programs we regulate. It would adequately cover sanitarian salaries, benefits, support personnel, and all education and training required. PUTTING ALL OUR REVENUES IN THE GENERAL FUND IS NOT THE WAY TO CONDUCT BUSINESS. CUTTING SANITARIAN STAFF IS NOT THE WAY TO CONTROL FOODBORNE ILLNESS. THANK YOU.

FEE SCHEDULE
(Revised 08/01/92)

January 1 - March 31

200A	Full Service Seating Capacity 0 - 15.....	\$ 215.00
200B	16 - 50.....	\$ 280.00
200C	51 - 100.....	\$ 333.00
200D	Over 100.....	\$ 398.00
200	Limited Service Restaurants.....	\$ 215.00
202A	Commissaries 1-5 mobile units and/or 1-50 vending machines..	\$ 215.00
202B	Commissaries 6+ mobile units and/or 51+ vending machines....	\$ 323.00

April 1 - June 30

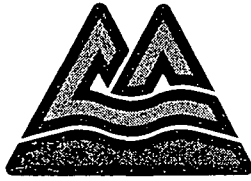
200A	Full Service Seating Capacity 0 - 15.....	\$ 161.00
200B	16 - 50.....	\$ 210.00
200C	51 - 100.....	\$ 250.00
200D	Over 100.....	\$ 299.00
200	Limited Service Restaurants.....	\$ 161.00
202A	Commissaries 1-5 mobile units and/or 1-50 vending machines..	\$ 161.00
202B	Commissaries 6+ mobile units and/or 51+ vending machines....	\$ 242.00

July 1 - December 31

200A	Full Service Seating Capacity 0 - 15.....	\$ 108.00
200B	16 - 50.....	\$ 140.00
200C	51 - 100.....	\$ 167.00
200D	Over 100.....	\$ 199.00
200	Limited Service Restaurants.....	\$ 108.00
202A	Commissaries 1-5 mobile units and/or 1-50 vending machines..	\$ 108.00
202B	Commissaries 6+ mobile units and/or 51+ vending machines....	\$ 161.00
204	Mobile Unit.....	\$ 115.00
200S/202C	Seasonal Full Service, Commissaries, Limited Service	
200J	Restaurants operating 6 months or less.....	\$ 108.00
200K	Smoke Shops.....	\$ 108.00
	Temporary Restaurant 1-day.....	\$ 59.00
	2-4 days.....	\$ 97.00
	5 days and over.....	\$ 108.00
202W	Warehouse.....	\$ 129.00
200I	Bed and Breakfast - Food Service.....	\$ 115.00
203	Vending Machine.....	\$ 118.00
	11-20.....	\$ 237.00
	21-30.....	\$ 354.00
	31-40.....	\$ 413.00
	41-50.....	\$ 471.00
	51-75.....	\$ 589.00
	76-100.....	\$ 706.00
	101-250.....	\$ 941.00
	251-500.....	\$1,765.00
	501-750.....	\$2,826.00
	751-1,000.....	\$3,532.00
	1,001-1,500.....	\$4,711.00
	1,501-2,000.....	\$4,814.00

+ \$1.00 per
each machine
over 2,000

	Food Service Plan Review	Mobile units.....	\$	97.00
		Minor remodeling.....	\$	97.00
		Major remodeling.....	\$	194.00
		New construction.....	\$	242.00
300/303	Mobile Home Park, Recreational Park,			
	And			
301	Tourist Accommodation.....	1-25.....	\$	145.00
		26-50.....	\$	172.00
		51-75.....	\$	199.00
		76-100.....	\$	226.00
		101 and over.....	\$	226.00
				+ \$1.00 per
				each unit
				over 100
301B	Bed and Breakfast - Tourist Accommodations.....		\$	59.00
302	Picnic Park.....		\$	59.00
304	Organizational Camp.....		\$	118.00
305	Day Camp.....		\$	75.00
400/401	Swimming Pool.....	1-3.....	\$	177.00 each
				+ \$89.00 per
				each pool
				over 3
	Swimming Pool Plan Review.....		\$	473.00
	Schools.....	Full service kitchens.....	\$	85.00
		Satellite kitchens.....	\$	50.00
		Serving kitchens only.....	\$	28.00
		Milk only.....	\$	0.00



MULTNOMAH COUNTY OREGON

BOARD OF COUNTY COMMISSIONERS
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PLANNING & BUDGET
PORTLAND BUILDING
1120 S.W. 5TH—ROOM 1400
PORTLAND, OREGON 97204-1934
PHONE (503) 248-3883

To: Ken Yee

8/18/93

From: Kathy Innes

Subject: Sanitation Revenues

Actual revenue collected in 92/93 for the Sanitation/Inspection program were as of 7/31/93:

	Revenue codes	Actuals 92/93
Food Serv. License	3001	\$776,431
Food Handler Cert.	3002	\$117,677
Swim Pool Inspection	3003	\$94,115
Restaurant Plan review	3005	\$45,353
Swim Plan Review	3008	\$5,676
Tourist Fac. License	3011	\$31,861
Day Care School Inspec	4002	\$14,245
State Health Water	4003	\$6,082
Boeing Water	6811	<u>\$2,944</u>

Total \$1,094,383

missing:
School cafeteria fees
Animal permit fees

The Sanitation Program projects that about the same amount will be collected in 93/94.

Estimated Revenue for 93/94 is		
Food Serv. License	3001	\$749,000
Food Handler Cert.	3002	\$126,000
Swim Pool Inspection	3003	\$91,500
Restaurant Plan review	3005	\$50,000
Swim Plan Review	3008	\$5,000
Tourist Fac. License	3011	\$32,000
Day Care School Inspec	4002	\$12,000
State Health Water	4003	\$5,163
Boeing Water	6811	\$3,000
other		<u>\$25,000</u>
Total		\$1,098,663

Budget Public Hearing
5-4-94
Agenda #1 for 4b

Roosevelt Community Family Resource Center

6941 N. Central St.
Portland, Oregon 97203

(503) 248-3909

May 4, 1994

To: Board of Multnomah County Commissioners

From: Judith Mayek ^{mm} Project Coordinator
Roosevelt Community Family Resource Center

Subject: Testimony in favor of expanded health services for middle/high school students and their families in the Roosevelt Cluster in North Portland.

A
Joint
Project
Of



Department
of Human
Resources



Multnomah
County
Oregon



Portland
Public
Schools

I want to thank the Multnomah County Chair for including in her budget the expansion of health services at the Roosevelt School Based Health Center for families of students, and adding part time on-site clinical services at George and Portsmouth Middle Schools. Over the past year I have been developing an Integrated Service Center located at Roosevelt High School for the North Portland Community. This integration project brings into the schools services and programs of the Oregon Department of Human Resources, Multnomah County and Community agencies. I have worked closely with the staff at the Roosevelt School Based Health Center in providing access for students to social service agencies in the Community.

In our work with families over the past year we have seen a need for health services to youth and their families. The expansion of health services in North Portland through the School Based Health Centers will provide greater access to primary and preventive health care for students and families. With the expansion of health services in the schools we, at the Family Resource Center, are prepared to expand our collaborative efforts to establish a Center for students and families that will include health, mental health and social services in a school setting.

The expansion of the Roosevelt School Based Health Center in collaboration with already existing services in North Portland contributes to the benchmarks of the State of Oregon and Multnomah County. In particular the following key benchmarks are: increasing access to primary health care; the reduction of teen pregnancy; decreasing the number of students involved with alcohol, tobacco and illegal drug use; increasing the percentage of children that enter school ready to learn; increasing the number of students who are able to achieve basic established skill levels; and reaching the goal of 100% graduation.

I urge you to pass a budget that includes the expansion of health services at the Roosevelt School Based Health Center and George and Portsmouth Middle Schools.

Thank you.

*Budget Public Hearing
5-4-94
Handout #2 for #12*

May 4, 1994

Multnomah County Commissioners
Portland, Oregon

Dear Commissioners,

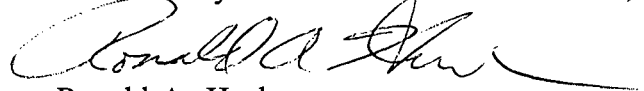
Attached is an article that appeared in The Oregonian on November 29, 1993. The article explains our family's plight in obtaining high quality caregivers for my autistic daughter who is 17. My daughter has full physical range of activity but has behavioral difficulties and lacks communication skills. As a result, she requires continuous care. The only time our family can get out is when we have arranged for someone to care for her.

My church, Good Shepherd Community Church, now provides my family with 3 hours of in home respite per month so that we are able to attend church services once per month. We are hopeful that in time additional volunteers will assume responsibility for the other three Sundays because caregiver expense for them would be about \$50.

In addition to Sundays, we would like to have at least 5 hours per week for regular family activities or to spend time as a couple. The expense for this would be \$125 per month and this does not even include family vacations. Actually, we have budgeted \$100 per month for respite to cover outings and vacations. However, in a financial pinch, these are the first expenses to be cut. This doesn't cover additional medical expenses of \$100 per month for Elizabeth's prescriptions which cost \$300 plus an additional \$100 per month for breakages, soiled mattresses, furniture, and flooring. I am not complaining because I strongly feel that Elizabeth is best cared for in a home environment.

When comparing minimal institutionalization expense for children like Elizabeth of \$25,000 per year, subsidizing respite care for parents like myself at the rate of even \$50 per month, the county realizes a return of 4,000%. Because I feel that money invested in respite will relieve stress levels and give parents a renewed energy to continue caring for these children in their homes. There have been times when we have questioned whether we can continue caring for Elizabeth in our home and these times have come when we were unable to afford or find qualified caregivers.

Thanks for your consideration and interest,



Ronald A. Hurl
15610 NE Stanton
Portland, Oregon 97230



JOEL C. DAVIS/The Oregonian

Elizabeth Hurl (left) is autistic and requires 24-hour-a-day care. Her parents, Ron and Joan Hurl; brother, David, and sister, Maryann, need help with her care.

Respite care money running out



■ The programs offer parents a break from the arduous care of a disabled family member

By DAN HORTSCH
of The Oregonian staff

Elizabeth was confused. Strangers in her home. Parents wanting her to sit still with them beneath a family portrait, while a photographer focused his camera.

She'd have none of it, despite repeated cajoling, smiles and hand signs from her parents. Her unhappiness erupting, Elizabeth flung her purple book bag wildly, knocking a brass bookend and several hard-bound books off a side table.

"This gives you a little sample of why we need respite," said Joan Hurl, Elizabeth's mother.

But the Hurls have had precious little time to recover from the demands of caring for their daughter.

That's where respite care, when available, comes in.

Such programs can give parents and other family members a break from the arduous care of a disabled family member. But they are few, and bare bones.

Several years ago the Tri-County Respite program run by the Multnomah, Clackamas and Washington county Arc agencies — private, nonprofit organizations serving developmentally disabled people — offered out-of-home respite programs two Saturdays a month plus one overnight respite a month.

"It was great," says Elizabeth's father, Ron Hurl, 46. "We planned for it."

"It helped the kids to not resent her," Joan Hurl said.

Vicki Smead, program manager for child and family services for the Multnomah Arc, said the money ran out and the three Arc agencies, formerly known

Please turn to
RESPITE, Page A10

This is the eighth in a series that accompanies "A Season of Sharing," The Oregonian's holiday fund drive to help those in need.

Respite: Recruits sought for occasional in-home care

■ Continued from Page One
as Associations for Retarded Citizens, went their own way. Multnomah County Arc runs an after-school program to aid parents who work. It also recruits people to provide in-home occasional respite care at \$4.75 an hour — minimum pay that caps at \$47.50 for a 24-hour period.

Multnomah County government recently awarded the Multnomah Arc a grant of \$15,000 to operate Saturday respite care twice a month for six months for parents with adult disabled children at home. Smead hopes that private money will allow it to continue beyond the initial period.

Some county money also is available to help pay for in-home respite care, and the Hurls occasionally take advantage of it.

But more programs would help. Elizabeth is 17. She lives with her parents, her sisters, Donna, 19, and Maryann, 17, Elizabeth's twin; and her brother David, 13, in the Reynolds School District in East Multnomah County. The corner house in the suburban development is pleasant and warm with family photos, a stack of picture puzzles, books and comfortable furniture that makes a visitor feel at home.

Nothing too out of the ordinary. Except Elizabeth. Encephalitis damaged her brain when she was almost 3, and since then, nothing has been ordinary for the Hurl family.

The illness, an inflammation of the brain, left Elizabeth classified as severely autistic. She cannot speak more than a phrase or two and does not understand spoken language. She turns inward, living in a world of her own. She suffers frequent epileptic seizures and wears a helmet to prevent head injuries when she falls.

Elizabeth has quiet periods when she plays simple video games on a computer or pieces together picture puzzles in the living room or the den, her favored hangout. A large Walt Disney Cinderella puzzle on the carpet of the den is two-thirds complete, testament to her skills.

When she is moody and emotional, however, and especially when she is frustrated, she expresses herself in tantrums.

The rest of the family tries to take those explosions in stride. "A lot of her behavior is a way of communicating," Joan Hurl said after Liz, as her family calls her, threw the bookbag. "If you think of it that way, it's easier."

But never easy.

Taking care of Elizabeth is a 24-hour-a-day job. Joan Hurl can't work outside the home because her daughter may refuse to get on the school bus that takes her to a day-school program. Doors must be

locked at all times, and family members have to keep their keys with them to prevent Elizabeth from getting them and leaving without notice. The teen-ager may be disabled, but she's clever.

The family cannot eat out as a family or do the other things that families do together: go to movies, browse in a mall, spontaneously head for the coast. Someone has to be home to care for Elizabeth.

The other Hurls have adjusted their lives to revolve around Elizabeth's needs, but that's an accommodation to difficult circumstances, not an improvement on them.

Recently, Patty Anello, 33, a substitute teacher in the Portland School District who also provides respite care, stayed with Elizabeth while Ron and Joan Hurl spent a night at the coast and visited daughter Donna at George Fox College in Newberg.

The county will pay for one day a month of such care; the Hurls have to pay for longer respite stays.

"The money spent on respite is one of the best investments that can be made" by public agencies, says Ron Hurl, a financial officer with U.S. Bank. "People reach the end of their rope and give custody to the county, and the county has a \$25,000-a-year bill" providing full-time care.

That's the ironic thing about parents who care for their severely disabled minor and adult children: These hundreds of Oregon families — often with parents in their 60s and 70s who won't be able to continue care much longer — chose to keep their disabled children at home, and now, when they need help, little exists. Not when the state of Oregon, under the Measure 5 property tax limitation that makes the state pay for most school spending, is looking at big disparities between future revenue and future costs.

The state does pay for group homes for disabled adults leaving Fairview Training Center, a large institution in Salem being scaled back by court order. But those homes rarely are available for disabled people who never went to Fairview or other institutions. They and their parents are on waiting lists numbering hundreds of families — making the term "waiting list" a joke, Smead says.

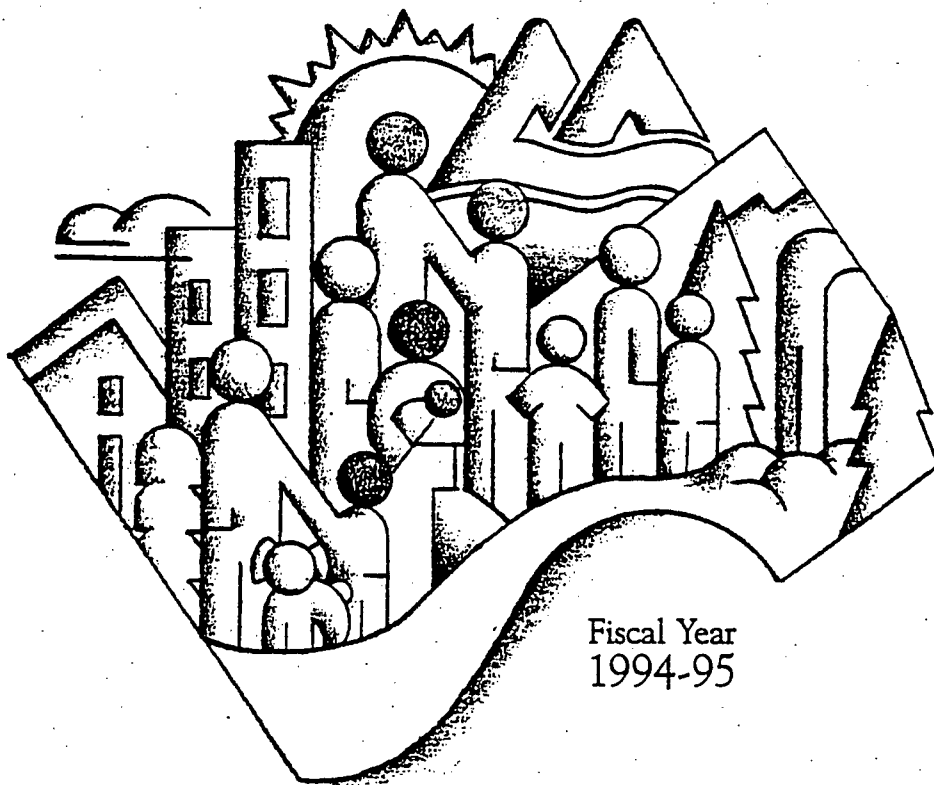
For those waiting families, respite care — generally a few hours, or a day or two — is all that's available when it can be found.

The work isn't easy — certainly not at \$4.75 an hour — but Anello helps provide that care because it's needed. "Nobody knows," she says. "People just don't realize what these parents have to live with."

"Patty," Ron Hurl says, "has been our lifeline."

Multnomah County Budget

Supplemental Information



Fiscal Year
1994-95

Packet #8
Community & Family Services

Follow-up from May 4, 1994



MULTNOMAH COUNTY OREGON

COMMUNITY AND FAMILY SERVICES DIVISION
ADMINISTRATIVE OFFICES
421 S.W. FIFTH AVENUE, 2ND FLOOR
PORTLAND, OREGON 97204
(503) 248-3691 / FAX (503) 248-3379
TDD (503) 248-3598

BOARD OF COUNTY COMMISSIONERS
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TANYA COLLIER • DISTRICT 3 COMMISSIONER
SHARRON KELLEY • DISTRICT 4 COMMISSIONER

MEMORANDUM

TO: Dave Warren
FROM: Lorenzo Poe, Community & Family Services Director
DATE: May 11, 1994

SUBJECT: FOLLOW-UP ON MAY 4 BUDGET WORK SESSION

In response to your request for information about the following questions:

1. FAMILY NETWORK:

Describe the plan for this network clearly and in a coordinated way including: collation of service components; client access; service locations; potential parallel efforts by other jurisdictions and agencies and how they related to our plan; and outreach functions.

Provide a one page description of each of the six districts, listing services provided and anticipated service location(s) for next year.

See partial response attached. Individual center overviews by June 1.

2. DIVERSION:

Describe the relationship of the CFSD diversion service contracts to JJD and its program expansion; explain the CFSD services and anticipated caseloads; provide a flow chart of referrals and capacity by geographic area.

Response by June 1.

3. HOMELESS FAMILY CASE MANAGEMENT:

Explain the effect of the outstanding receivable for this program on the 1994-95 General Fund; explain any offsets that may still be available.

Follow-Up on May 4 Budget Work Session

May 11, 1994

Page 2

An analysis of the deficit to date, along with a close review of current year expenditures, revenue collections and projections will be conducted by mid-June. This will allow us to assess the status of all CFSD program expenditures and report on any savings that might be used against the estimated \$446,000 shortfall. To date, we have received word from Commissioner Kafoury that she will seek to have the City pick up half of the deficit.

4. LEVEL 7 USE OF TITLE IV-A REVENUE:

Explanation will be provided by May 20.

5. LEVEL 7:

Describe contracting plan for Level 7 services; explain the links to the Family Network and other County programs; and identify what outcome measurements will be included in the contracts.

See attached response.

6. REGIONAL ACUTE CARE SYSTEM:

Explore for FY 94/95 - and for future years - opportunities to remove CGF support from the crisis/commitment/emergency hold programs.

See attached.

7. MANAGED CARE FOR CHILDREN:

Explain the risks County may experience in moving toward the managed care model for children.

Response available within a week (May 20).

8. HISPANIC STUDENT RETENTION:

How do we intend to address the geographic equity issue so that all school districts receive comparable levels of support.

The Multnomah County Hispanic Advisory Committee has representation from throughout the County. This issue will be presented to that group as well as to the Multnomah County Commission on Children and Families and to representatives of various school districts. It should be noted that with only \$100,000 proposed for family support and school retention, equity may not be reached. However, it will allow us to work with the above representatives to develop a plan for equity.

9. ACCULTURATION ALTERNATIVES:

A. Explain the alternative to acculturation center that we could use to accomplish the same goal.

No alternative would accomplish exactly the same goals as an acculturation center. The option of funding specific outreach staff targeted to Asian young people and their families at each existing Family Center has not been entirely effective at providing equitable and appropriate service. There are many countries of origin, cultures and languages which represent Asian families in Multnomah County. These differences are particularly apparent in the various cultures and languages of Southeast Asian immigrants.

B. Research other jurisdictions that provide publicly funded ethnic acculturation centers.

In 1993, the *Program Models for Southeast Asian Youth* was published, which contained a national model program search, key informant and community research and program recommendations about meeting the needs of Asian young people and their families. Through the national search, many programs and centers similar to the proposed Asian Acculturation Center were discovered. Most notable were centers in Minneapolis/St. Paul, Minnesota; Oakland, California; Seattle, Washington; Dallas, Texas; Houston, Texas; and Denver, Colorado. These programs are supported by some form of public funding. The proposed Multnomah County center was developed based on the recommendation in this report.

At the May 4 budget hearing held in the Central Library, testimony was given about publicly funded centers in Fresno, California; St. Paul, Minnesota; Seattle, Washington; and in Florida.

10. RESPITE CARE AVAILABILITY AND TRAINING:

Respite care services are provided by several local agencies, including Boys and Girls Aid Society, Metropolitan Family Services, ARC of Multnomah, Parry Center. Many families locate their own providers, which may be professionals, friends or families. Training is provided to staff and others by both ARC and the Parry Center.

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COMMUNITY AND FAMILY SERVICES DIVISION

RESPONSE TO MAY 4 BUDGET WORK SESSION QUESTIONS

1. Family Network

1. Describe the plan for this network more clearly and in a coordinated way including discussion of the following:
 - collocation of service components
 - client access
 - service locations
 - potential parallel efforts by other jurisdictions and agencies and how they relate to our plan
 - outreach functions

The Multnomah County Family Network is an affiliation of individuals, informal groups, organizations, and communities who believe family strength is a key element of a healthy, economically sound, and stable community. Participants in the network are committed to providing accessibility to quality services, recognizing community strengths and resources, and celebration of diversity.

GOALS

1. Support families in a positive respectful manner.
2. Ensure that families can access or receive services that will promote health, economic stability, safety, and a connection to the community.
3. Promote collaboration and cooperation among network participants to maximize the capacity of communities to strengthen families.
4. Establish a culture of caring, participation, quality services, and promotion of positive expectations and outcomes.

Contract language will require all County providers to participate in its Network. A memorandum of agreement will enroll all other participants.

All participants in the Family Network agree to:

- A. Participate in organized sharing of community strengths and resources on a regular basis.
- B. Offer referral to other resources through (a) personal connections, (b) a willingness to continue advocacy, and (c) a uniform intake process.
- C. Approach delivery of services from the basis of strengths, growth promotion and resiliency.
- D. Use family defined goals/outcome measures to determine satisfaction with services.
- E. Prominently display a symbol of membership.
- F. Fight racism and celebrate diversity.

1. FAMILY NETWORK (Continued)

Collocation of various services components will occur based upon component appropriateness in relationship to the Family Center model and philosophy, component compatibility with individual Centers and districts, and available physical space. Client access will be maximized through single entry access at the Family Centers and through referrals among Network members. Potential parallel efforts will have the option of participation with the Network or, as phased implementation progresses, becoming one of multiple Family Centers in each district. Outreach functions will occur in a variety of ways through existing and proposed staff. A task force is currently developing the model by which these efforts will be integrated and coordinated.

5. Level 7

1. Describe the contracting plan for Level 7 services.

Specific contract awards will be made in one of three ways:

- Where additional capacity of an existing service is sought and there is only one current provider of that service, awards will be made based upon a sole source exemption request/approval;
- Where a viable inclusive provider/community network exists, a process will be convened to solicit a plan for cooperative deployment of the funds. If a plan is developed and consensus reached, awards will be made based upon that plan. If a plan can't be developed and consensus can not be reached then a competitive bid process will occur, and;
- Where a new service is sought and there are multiple potential providers of that service or if solicited cooperative plans cannot be developed, awards will be made based upon a competitive bid process (RFP).

2. Explain the links to the Family Network and other County programs.

Service Access Resource Staff (SARS) will be located at each of the six Family Centers. Dedicated client services funds are allocated to each Center. Single entry access to the Level 7 system will include access to the Family Network. Juvenile Justice Division (JJD) staff and Child and Adolescent Mental Health Program (CAMHP) staff will be members of the SARS teams on an on-going basis. Where appropriate, referrals will be made to other County funded programs.

3. Address the issue of what outcome measurements will be included in the contracts.

Outcome: Young people and their families will remain outside of the child welfare and juvenile justice systems or exit them.

Measure: Number of young people and families who receive services who do not appear on caseload lists for CSD and JJD.

Outcome: Young people will remain in the home/family living environment, where appropriate, or be in another support living environment.

Measure: Number of young people who receive services who are able to identify a primary residence and to describe that residence as satisfactory in response to specific questions.

Outcome: Young people will graduate from high school, receive a GED or be employed.

Measure: Number of young people who receive services and are enrolled in high school, GED completion or employment programs.

6. Regional Acute Care System

1. Explore, for FY 94/95 and future years, opportunities to remove CGF support from the crisis/commitment/emergency hold programs.

Crisis and Commitment services are entirely funded by State revenue. They include no County General Fund support.

The Emergency Holds budget includes both State revenue and County General Fund. Emergency Hold costs have increased four-fold over the past decade, but have leveled off in the past two years. For the first time in many years, program expenses came in under budget in FY 92/93 and we experienced a small savings. We hope to recover even more savings this year and in the future.

The proposed regional agreement to pool clients and resources and, together with Washington and Clackamas counties, manage the entire system is anticipated to provide savings for all three counties. This agreement requires that participating counties maintain their current investment in the coming year. The agreement anticipates that future savings realized in coming years can be invested in other locally prioritized mental health services to offset the need for involuntary hospital holds.

The downsizing and projected closure of Dammasch State Hospital has created a crisis and also opportunity for the three Metropolitan Counties. Multnomah County has reduced use of state hospital beds by 120 or 50% in the last two years. Multnomah County was assisted in this endeavor through new State IGA base funding starting in 1991. Washington and Clackamas Counties began receiving new State funding for local inpatient psychiatric services January, 1994. All three counties have won funding for new programs to provide intensive services to long term institutionalized persons. All this has created the opportunity for the three counties to consolidate resources and regionally manage hospital services. Each county brings to services mix resources needed by the citizens of the other counties.

Multnomah County, in collaboration with the tri county region will manage resources provided by the State and local governments so the Region's citizens will have a safe and therapeutic environment when incapacitated by mental illness. The Plan is funded by approximately \$1.4 million from the three counties' general fund, \$ 4.7 million State revenue, and \$7.5 million in other third party revenue.

1. Over the next six months the counties will work toward maintaining or reducing the number of holds diverted to Dammasch State Hospital. Between January 17, 1994 and April 15, 1994, sixteen holds were diverted to DSH out of a total of 963.
2. By September 1, 1994 the region will develop an interagency committee which will retrospectively review 5 % of holds to ensure the appropriateness of hospitalization and responsiveness of the investigator.
3. CareMark (Multnomah County's preferred hospital provider for involuntary holds) has set the goal of adding 10 acute level beds to Portland Adventist Medical Center by July 1, 1994 which will reduce the pressure and costs on the peace officers of all

6. Regional Acute Care System (Continued)

jurisdictions across the 3 counties.

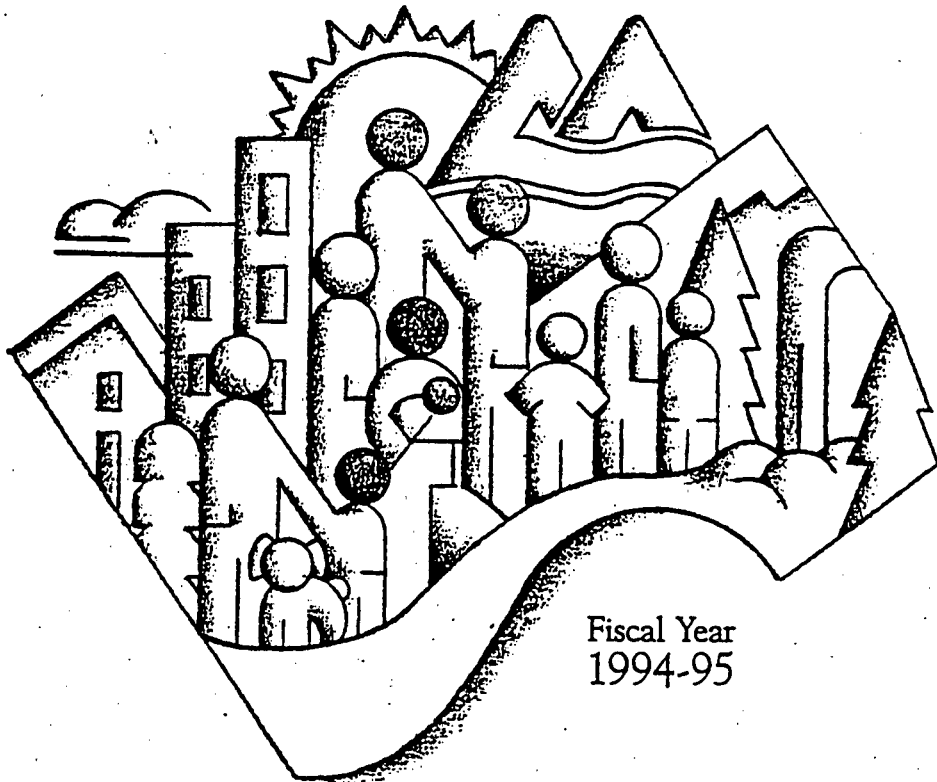
4. The region will develop a second sub-acute facility for a net increase of 10 sub-acute beds.
5. Community programs will work with police and crisis programs to assist in evaluating potential "holds" for alternatives to hospital admission.

Implementation of the above practices and additional facilities with currently budgeted funds will reduce hold expenditures to the point that savings can accrue to CGF in future years. Other service cuts may increase crisis episodes but we will endeavor to decrease hospitalization which is the most expensive service and a mandated County expense.

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Multnomah County Budget

Supplemental Information



Fiscal Year
1994-95

Packet #23
Community & Family Services

Follow-up Information

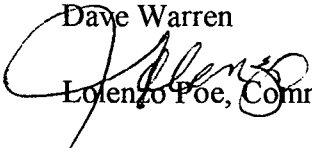


MULTNOMAH COUNTY OREGON

COMMUNITY AND FAMILY SERVICES DIVISION
ADMINISTRATIVE OFFICES
421 S.W. FIFTH AVENUE, 2ND FLOOR
PORTLAND, OREGON 97204
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SHARRON KELLEY • DISTRICT 4 COMMISSIONER

MEMORANDUM

TO: Dave Warren
FROM:  Lorenzo Poe, Community & Family Services Director
DATE: June 1, 1994

SUBJECT: RESPONSE TO MAY 4 BUDGET QUESTIONS - FOLLOWUP

The following completes our response to the questions raised at the May 4 budget work session. Number one was partially answered in our May 11 response, but is completed here, along with responses to questions 2, 4 and 7.

Question #1: Provide a one page description of each of the six districts, listing services provided and anticipated service location(s) for next year.

Along with a summary of definitions of related terms, see response in Attachment #1.

Question #2: Describe the relationship of the CFSD diversion service contracts to JJD and its program expansion; explain the CFSD services and anticipated caseloads; provide a flow chart of referrals and capacity by geographic area.

See Attachment #2.

Question #4: Explain the potential to use Title IV-A revenue to support Level 7 programs.

In discussions between CSD and CFSD staff, agreement has been reached that approximately \$300,000 to \$400,000 per year is available from this source of federal revenue as match for eligible children for emergency purposes. These are Social Security Act monies that are available for child welfare emergencies.

It is estimated that the procedure necessary to generate the match monies will be in place by October 1. It will require an agreeable method of determining eligibility, sharing MIS data, and reliance on CSD to process the reimbursement and then pass the payments on to the County. All participants are confident this will work. Success with this method of generating federal match

monies may open the door for additional federal revenue for other services that are already being provided within the County service system.

Question #7: Explain the risks County may experience in moving toward the managed care model for children.

The implementation of a managed care model of service delivery presents no financial risks by itself. The concept of managed care is, in fact, a money saving concept. Implementation of this model would put County in control of all expenditures of each client. County would determine eligibility standards and service standards. Established rates would be paid for specific kinds of service. Length of service and/or number of visits would be limited and extensions would require County approval. These are all cost control strategies and similar prepaid employee benefit plans have resulted in savings of 20%.

The potential for financial risk becomes real when a prepaid capitated funding system is added to the model. The first risk is setting an appropriate rate, which is a single dollar amount per year per eligible or potential client. It is important that both the client numbers and the potential costs are assessed by an actuary. The degree of risk is determined by the scope of services included. If only outpatient services are capitated, the risk is much smaller than if inpatient services are part of the mix, since hospital costs are high and unpredictable.

The Health Department has experienced limited risk in their several projects (PCO, REEP, CARE Oregon) with this type of pre-paid capitated managed care model. The package of services does influence the level of risk. However, Health Department has purchased reinsurance or stop loss coverage for both the primary care only package of services and the hospital care package. They verify that the risk is much greater for inpatient or hospital services. These considerations will be built into any negotiations with the State if they decide to move forward on our managed care proposal. We will know more by mid-summer.

#####

Family Support Initiative Briefing Paper II

June 1, 1994

The **Family Support Initiative (FSI)** describes the comprehensive policy making, funding allocations, service provision, advocacy and community organizing activities the County has been engaged in for the past two years to create the necessary supports for children, young people and their families which enable them to live to the best of their potential. The goal of all FSI efforts is to create healthy and productive community environments in which healthy and productive families thrive and where each member of those families can flourish. At time the FSI is comprised of the following three components.

Family Support Networks are District based affiliations of individuals, informal groups, organizations and communities who believe that family strength is a key element of a healthy, economically sound and stable community. Members of the Network are committed to providing accessibility to quality services, recognizing community strengths, building resiliency and celebrating diversity. Networks will:

- ▼ Establish a culture of caring, participation, quality service provision and positive expectation and outcome among Network members;
- ▼ Promote collaboration and cooperation among Network members to maximize community capacity to produce healthy, resilient and strong families;
- ▼ Ensure that families can access or receive services which promote health, resiliency, economic stability, safety and community interconnections; and,
- ▼ Support families in a positive and respectful manner.

Each District Network will minimally include Family Centers, Schools, Health Clinics, Community Action Agencies, Aging Service Centers, Library Branches and outstationed County staff such as those from Developmental Disabilities, Juvenile Justice, etc...

District Coordinating Teams (DCT) work toward the coordination of services within each District by:

- ▼ Evaluating resources capacity;
- ▼ Linking community strengths and supports;
- ▼ Developing coordination, cooperation and collaboration among service providers;
- ▼ Achieving quality control through monitoring and evaluation; and,
- ▼ Identifying barriers to access to services.

The mission of **Family Centers** is to support the children, young people and their families of Multnomah County so that they may enjoy positive personal and family relationships and in all ways reach their potential as productive members of their community through services which:

- ▼ Provide a highly visible, community based presence accessible to children, young people and their families actively linked to neighborhood resources and responsive to the community;
- ▼ Enhance the growth and development of children, young people, their families and the community through the provision of direct services and community activism strategies; and,
- ▼ Provide children, young people, their families and the community opportunities to acquire skills which support their resiliency in overcoming societal and environmental barriers to full growth and development.

Mandatory Services:	Alcohol and Other Drugs	Child Abuse Prevention*
	Community Activism	Community Health Nurse*
	Culturally Specific	Diversion
	Early Child Development*	Family Intervention
	Level 7	Parent Development/Education*
	Service Access	

(* will become mandatory pending budget approval of supporting resources)

Flexible Core Services:	Employment	Health Promotion
	Mentorship	Recreation
	School Based	Supportive Law

(A variety of other services as identified by the community exist at each Center.)

Collocation of various services components will occur based upon component appropriateness to the Family Center model and philosophy; component compatibility with individual Centers and districts; and, available physical space.

Client access will be maximized through single entry access at the Centers and through referrals among Network members.

Potential parallel efforts will have the option of participation with the Network or, as phased implementation progresses becoming one of multiple Family Centers in each district.

Outreach functions will occur in a variety of ways through existing and proposed staff. A task force is currently developing the model by which these efforts will be integrated and coordinated with both Networks and Centers.

Eastwind Center

Service District: East County

Center Location: 135 NW 1st Ave
Gresham OR 97030
492-3692

Contract Agency: Edgefield Children's Center
Partner: Morrison Center

Contact: Leslie Haines

Mandatory Services:

Alcohol and Other Drugs	Child Abuse Prevention
Community Activism	Community Health Nurse
Culturally Specific	Diversion
Early Child Development	Family Intervention
Level 7	Parent Development/Education
Service Access	

Flexible Core Services:

Health Promotion	Mentorship
Recreation	School Based

Culturally Specific Services: Staff languages: Spanish, Japanese, Farsi

Total FY 94-95 Allocation*: \$530,458.92
(* pending budget approval)

Mid County Family Center

Service District: Mid County

Center Location: 4110 NE 122nd
Portland OR 97230
256-2330

Contract Agency: Lutheran Family Services
Partner: Boys and Girls' Aid Society

Contact: Sue Clark

Mandatory Services:	Alcohol and Other Drugs	Child Abuse Prevention
	Community Activism	Community Health Nurse
	Culturally Specific	Diversion
	Early Child Development	Family Intervention
	Level 7	Parent Development/Education
	Service Access	

Flexible Core Services:	Employment	Mentorship
	School Based	

Culturally Specific Services: Staff languages: Lao, Vietnamese, Mien, Russian, Czech/Rumanian
Bi-lingual/cultural Mental Health for Deaf/Hard of Hearing
Asian Youth Leadership Group

Total FY 94-95 Allocation*: \$587,919.96
(* pending budget approval)

SE Family Center

Service District: South East

Center Locations: 4707 SE Hawthorne
Portland OR 97215
233-8491

7944 SE 62nd
Portland OR 97206
777-7058

Contract Agency: Portland IMPACT
Partner: N/A

Contact: Sheri Campbell

Mandatory Services:	Alcohol and Other Drugs	Child Abuse Prevention
	Community Activism	Community Health Nurse
	Culturally Specific	Diversion
	Early Child Development	Family Intervention
	Level 7	Parent Development/Education
	Service Access	

Flexible Core Services:	Employment	Health Promotion
	Mentorship	Recreation
	School Based	Skill Building
	Supportive Law	

Culturally Specific Services: Multi-language Service Access
Employment/School Retention for Latino/American Indian Young People
Asian Outreach/Service Access
Non-English Speaking Play Groups for Children and Families Birth-5 yrs

Total FY 94-95 Allocation*: \$567,611.88
(* pending budget approval)

West Side Family Center

Service District: West Side

Center Locations: 7688 SW Capitol Hwy
Portland OR 97219
244-2292

2617 NW Savier
Portland OR 97210
228-4391

Contract Agency: Neighborhood House
Partner: Friendly House

Contact: Nicole Resenbrink

Mandatory Services:	Alcohol and Other Drugs	Child Abuse Prevention
	Community Activism	Community Health Nurse
	Culturally Specific	Diversion
	Early Child Development	Family Intervention
	Level 7	Parent Development/Education
	Service Access	

Flexible Core Services:	Employment	Mentorship
	Recreation	School Based
	Summer Meal Site	

Culturally Specific Services: Lesbian/Gay/Bisexual Young People Drop-in Group
Lesbian/Gay/Bisexual Young People AOD Support Group
Hispanic Outreach/Service Access
Hispanic Youth Empowerment Group

Total FY 94-95 Allocation*: \$448,999.92
(* pending budget approval)

North Portland Family Center

Service District: North Portland

Center Locations: 7704 N Hereford
Portland OR 97203
285-0627

9130 N Woolsey
Portland OR 97203
240-8138

Contract Agency: Delaunay Mental Health Center
Partner: N/A

Contact: Diane Feldt

Mandatory Services:	Alcohol and Other Drugs	Child Abuse Prevention
	Community Activism	Community Health Nurse
	Culturally Specific	Diversion
	Early Child Development	Family Intervention
	Level 7	Parent Development/Education
	Service Access	

Flexible Core Services:	Group Challenge Course	Health Promotion
	Mentorship	Recreation
	School Based	Teen Parent

Culturally Specific Services: SE Asian Teen Parent
SE Asian Outreach/Service Access
Spanish Language PCD Groups
GIFT for African-American Young ♀

Total FY 94-95 Allocation*: \$457,999.92
(* pending budget approval)

NE Family Center

Service District: North East

Center Location: 10 N Russell
Portland OR 97227
280-2600

Contract Agency: Urban League of Portland
Partner: Volunteers of America

Contact: Larry Foltz

Mandatory Services:

Alcohol and Other Drugs	Child Abuse Prevention
Community Activism	Community Health Nurse
Culturally Specific	Diversion
Early Child Development	Family Intervention
Level 7	Parent Development/Education
Service Access	

Flexible Core Services:

Employment	Mentorship
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Culturally Specific Services: SE Asian Outreach/Service Access
YEEP for African-American Young ♂ and ♀

Total FY 94-95 Allocation*: \$566,227.92
(* pending budget approval)

1. Describe the relation of the CFS diversion service contracts to the Juvenile Justice program.

The Diversion Enhancement Project is comprised of both the Community and Family Services Division (CFSD) and the Juvenile Justice Division's (JJD) add packages. Without both components, the project can not be implemented.

The CFSD component provides additional funding for each of six Family Centers. Funds will support approximately two additional FTE at each Center for enhanced and expanded diversion programming. One position will be dedicated to working specifically with local schools in violence prevention efforts. The second position will form a team with one of the six case managers identified in the JJD component to ensure participation of those young people and families referred for diversion services. Teams will be responsible for outreach, home visits, tracking, follow up and any other support needed for young people to successfully participate in the diversion process.

2. Explain the services in CFS and the anticipated size of the caseloads.

Through the diversion process a young person and their family can access a variety of different services and activities. Minimally, diversion services include: an assessment and individual service plan based upon the assessment; a contract for participation between the young person and either diversion staff or the Neighborhood Accountability Board (NAB); education or information about delinquency; and, restitution and/or community service activities. Most often, services can also include AOD assessment, skill building, peer support, recreation, mentorship and any other Center services available.

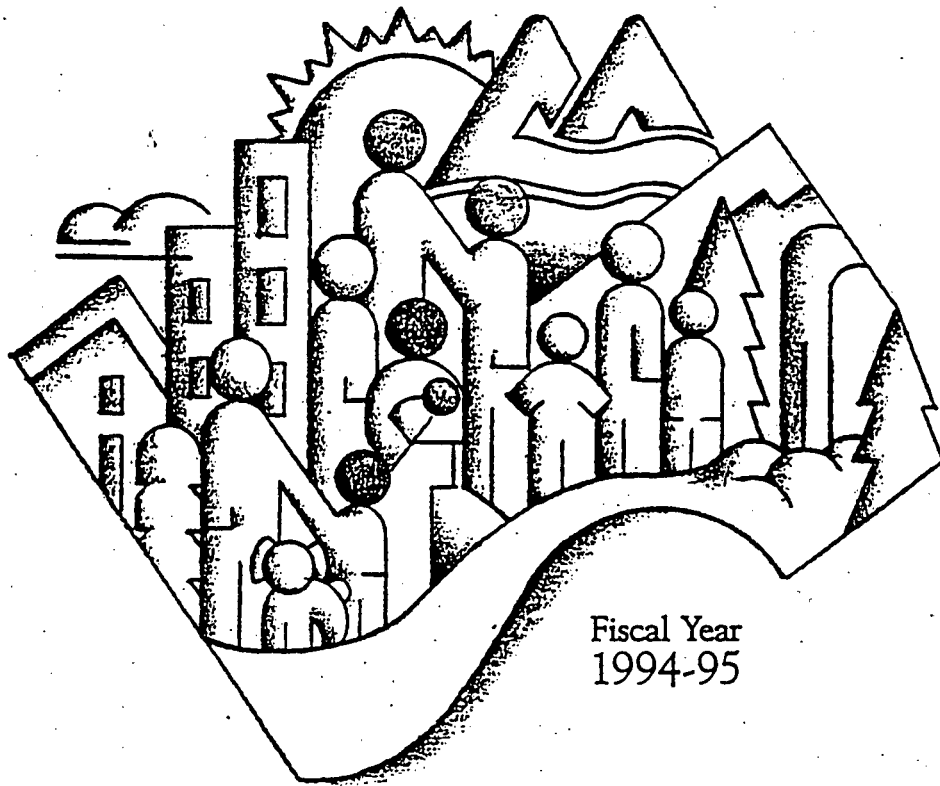
Anticipated caseload per FTE is 30-40 young people and their families per month with approximately 3 months of services. Total number of young people per FTE annually is 120.

3. Provide a flow chart of referrals and capacity by geographic area.

Service District	JJD Referrals FY 90-91	JJD Referrals FY 91-92	JJD Referrals FY 92-93	Average Referrals	Current Diversion FTE	Current Capacity
East County	646	728	666	680	.75	90
Mid County	503	517	525	515	2	240
South East	220	285	234	246	2	240
West Side	144	206	160	170	1	120
North Portland	224	301	277	267	2	240
North East	504	454	458	472	2	240
Total	2241	2491	2320	2350	9.75	1170

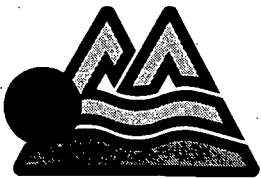
Multnomah County Budget

Supplemental Information

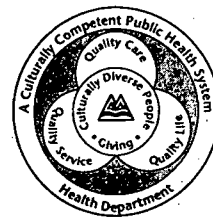


Packet #16
Health Department

Follow-up Information



MULTNOMAH COUNTY OREGON



HEALTH DEPARTMENT
426 S.W. STARK STREET, 8TH FLOOR
PORTLAND, OREGON 97204-2394
(503) 248-3674
FAX (503) 248-3676
TDD (503) 248-3816

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MEMORANDUM

TO: Bev Stein, Multnomah County Chair
Commissioner Dan Saltzman
Commissioner Gary Hansen
Commissioner Tanya Collier
Commissioner Sharron Kelley

FROM: *Bill*
Bill Odegaard, Director
Health Department

DATE: May 24, 1994

SUBJECT: QUESTIONS ARISING FROM WORK SESSIONS

Following you will find our first responses to questions that have arisen during budgetary work sessions.

Most of the questions have responses. Some will need more time, and we will forward them as soon as we are able.

If you have any questions, call either myself or Tom Fronk at 248-3674. While we may not be able to answer directly, we will direct your questions appropriately.

QUESTION (Health No. 1): CareOregon Suggest policies and strategies to deal with those who are not eligible for CareOregon but have no other health coverage.

- The Health Department entered into CareOregon and the Oregon Health Plan with the express interest of maintaining the Primary Care clinic system at a size that allows us to care for clients who are in need of subsidized health care, but ineligible for the Oregon Health Plan.
- We are investigating via client and staff input and management review the concept of enrolling clients ineligible for the OHP who need primary care. The details for this system such as eligible clients, benefit packages, access care and the enrollment process are yet to be determined.
- It is vital for us to maintain the non Medicaid funding for the Primary Care Division. Funds such as WIC (\$1.6 million), Primary Care - CHC (\$2.5), Family Planning (\$0.3), Homeless Health Care (\$0.6), MCH (\$0.5), and General Fund (\$5.4) are critical to the continued support of non Medicaid eligible patients.
- The Coalition clinics offer additional services to this population.
- We are working with OHSU to increase the amount of specialty care offered to the uninsured by coordinating our efforts.
- Health Source dollars (\$178,000) will continue to be used to support referrals and specialty care for the uninsured.
- Public Health, Field Service and Specialty clinics will continue to be available to the community and special population, examples are: Immunizations, Communicable Disease, STD, HIV, School Based Health Centers, Family Planning, WIC, Community Health Nursing
- New funds are being sought to assist the uninsured. We are currently applying to the Federal Government to add prenatal resources to the Northeast community.
- New ways of doing business are being explored and implemented, examples are: Extended hours, access/urgency services, coordination with drug and alcohol services and bilingual services.

QUESTION (OTHER No. 2): Indirect Costs Explain what is included in Indirect Costs and how these overhead charges are computed. Explain differences between 1993-94 and 1994-95.

WHAT'S INCLUDED

There are two basic types of costs associated with running a program: Direct and Indirect Costs.

Direct costs are those costs which may be assigned to specific programs with a reasonable amount of accounting ease and accuracy. For example, the Health Department operates a HIV Treatment Clinic. A nurse practicing in that clinic is a direct cost of the HIV Treatment Program.

Indirect Costs are costs incurred in supporting a wide range of programs. By their nature, these costs may not easily be linked to specific programs. For example, the Health Department employs a grant accountant. This person supports dozens of individually funded programs. As it would not be reasonable to attempt to divide employee's time into all of the programs he supports, his time is allocated to all programs as an Indirect Cost.

Indirect Costs are allocated through an Indirect Cost Allocation Plan. The development of this plan is governed by federal OMB Circular A-87, which defines cost accounting rules for states and local governments. Indirect Costs have two sources:

Central Service Costs are those arising from central County support agencies. For example, costs from the Auditor, Budget and Planning, Employee Services, and Finance are spread to Departments using allocation methodologies.

The allocations must be made using a reasonable basis, which varies based on the type of central service. For example, Employee Services costs are spread to Departments based on the number of employees each Department has, the Finance Division is spread based on the number of payment vouchers generated, and so on.

Not all central service costs are included. Some central services use accounting systems that allow direct charges to programs. Fleet and Telephones are examples of central services with enough accounting detail to allow their costs to be considered direct, rather than indirect.

Other central services are disallowed by A-87. For example, as A-87 does not allow general governmental costs to be charged to federally funded grants, activities of the Chair's Office may not be included.

Departmental Services also contribute to Indirect Costs. Each department incurs costs in support of the various programs that make up that department. Examples may include the department directors, training units, central clerical support, division managers, accounting or grants management office, planning offices, etc.

Indirect Costs are expressed as rates. The rate is established by summing Indirect Costs from these two sources, Central Service and Departmental, which together make up the Department's Indirect Cost Pool. The Indirect Cost Pool is then divided into the total dollar volume of the direct services the Department provides. For example, assume that the ABC Department has a total budget of \$10,000,000. Their Central Service allocation is \$450,000, and their Departmental Service cost is \$550,000 (45% and 55% respectively of a \$1 million total Indirect Pool). Their Indirect Rate is 10%.

The split between Departmental and Central Services as sources of Indirect Costs is important when a grant that allows Indirect Cost recovery changes. For example, assume that ABC Department receives a \$500,000 grant to do good. The grant will provide \$454,546 for services, and will pay \$45,454 in Indirect Costs (10% of \$454,546 is \$45,454; \$45,454 + \$454,546 is \$500,000).

Of the total \$45,454 of Indirect that this grant pays, 45% (\$20,454) results from Central Services and 55% (\$25,000) results from Departmental Services. Normally, if this grant award came to the Board in a budget modification the Central Service portion would increase the Contingency Account, while the Department would fund administrative support with the Departmental Services portion.

THREE INDIRECT COST RATES

In practice, three Indirect rates are established. Each Department has its own **Full Rate**, which applies to most expenditures. In 1993-94, the Health Department full rate is 12.67%, of which 4.74% originates with Central Services and 7.93% originates with Departmental Services.

In addition, the County establishes a **Pass Through Rate**. This rate, set at 0.7% County wide, applies to Pass Through contracts and County Supplements. It is based on the assumption that certain types of financial transactions require little if any County overhead. Examples of when the Pass Through rate is applied in the Health Department include the contract with Russell Street Dental (pass through of federal funds) or the subcontract with OHSU hospital care for CareOregon clients.

The third rate, applying to **Capital Purchases** only, is 0%.

DOES IT REALLY MATTER?

Indirect Costs are important for two reasons. Financially, if a funding source allows Indirect Cost Recovery, it is to the County's advantage to recover. This is true for both grant revenues, and operational revenues (fee collections, contracts, etc.).

From an accounting perspective, Indirect Cost allocation represents a convenient tool to use in showing the full cost of doing business. This is the reason that we go through the effort of transferring General Funds to grant programs who do not allow Indirect Recovery from grant funds. The transfer allows full budgeting and charging of Indirect Costs.

For both of these reasons, it is important to be as accurate as possible in identifying all overhead costs and including them in the Indirect Cost Pool.

WHY DO RATES VARY SO?

Rates vary for three reasons:

- 1) Departments are motivated to differing degrees to identify and include Departmental costs into its Indirect Pool.

Departments are organized differently. Support services in highly centralized Departments are easier to identify and include in an Indirect Pool.

Historically, the nature of a Department's funding impacts how much effort goes into identifying Departmental Indirect costs. Contrast the Health Department, with large cost based contracts and many grants that allow recovery, with the Sheriff, an agency almost wholly funded with General Funds, with Children and Family Services, a grant funded agency whose grantors have not historically paid Indirect Costs. The amount of return makes it financially rewarding to the County for the Health Department to identify to the last dollar its overhead costs.

- 2) When an Indirect Rate is established, all of the dollar figures come from the most recently completed fiscal year. For example, the rate for 1994-95 is established using dollar figures from 1992-93. This is necessary, as we are only nine months through 1993-94. Because the rate is established using one year's financial information to estimate what a future year will look like, it is called a **Prospective Rate**.

The rate, once established, is used for all of 1994-95. However, at some point an adjustment has to be made. This is necessary to account for the difference between the Prospective Rate for 1994-95 and the actual rate for 1994-95. As the actual rate for 1994-95 won't be available until the winter of 1995-96, after the books have closed on 1994-95. The adjustment is made in the rate for 1996-97. This continual multi-year adjustment process is called the Roll Forward.

How does this cause variation in rates? The Roll Forward is intended to handle the small variations that are expected annually between estimates and actuals. However, changes occur in the County that have huge impacts on this estimate and adjustment process.

The largest recent example is the establishment of Health as a separate Department. Health had no history to establish its allocations of central services, therefore, historical data for the Department of Human Services had to be assigned to Health using the information at hand. The assignments turned out to be too low, and the Roll Forward is adjusting for it by adding to Health's central service allocation and reducing Social Services. This affect is adding about 2% to the Health Department's rate, while reducing the DSS rate by 3%. In a future fiscal year this affect will wash out, and the Health rate will drop and the DSS rate will increase.

- 3) County budget practices can affect Indirect Rates. For example, the Health Department Indirect Pool includes \$814,000 of Data Processing charges, adding another 2% to our rate. For most other County agencies the service reimbursement for Data Processing is included in Non-Departmental.

QUESTION (Health No. 2): Interpretive Services Report on how the strategies for interpretive services are working this year.

FY 92-93

- Limited English encounter volume averaged 4,384 visits/month as of June 1993.
- The estimated interpreter cost per visit for the fiscal year was \$22.97.

FY 93-94, FIRST 9 MONTHS

- Limited English encounter volume has increased 15% to an average of 5,050 visits/month. Annualized growth rate is 20%.
- Interpreter cost per visit was reduced by \$4.21 to \$18.76. This is a 18% reduction.

APPROACHES TO SERVICE DELIVERY, FIRST 9 MONTHS

Bilingual Hiring

- 20 bilingual employees were hired into job classes ranging from physician to Office Assistant II. This does not include Health Assistants hired principally as interpreters.
- Local 88 has expressed serious concern with bilingual requirements and language skill assessment for potential transfers from within the Department. The Language Services manager has begun informal discussions involving Jim Smith and a small group of Local 88 members on this issue.

Spanish Language Training

- Region X eight day Spanish immersion training completed for 14 staff in October. Follow up training is being provided through Intercom language school on a limited basis.

Contracts

- Renegotiated lower rates and tight monitoring have reduced IRCO and Andalex contract interpreter expenditures from an average of \$2,083 last FY to \$559.
- AT&T Language Line contracted through the State to get volume discount rate. Initially intended to support after hours advice nurses. This service is now being used by CareOregon office and soon will be used by After Hours Clinic as a back up.
- Reduced hourly rate from approximately \$40 to \$32 per hour for sign language interpreters by contracting through the Oregon Disabilities Commission. Expenditures averaged \$1,068 per month.

Centralized Interpretation Pilot Project

Pilot Project to centralize triage interpretation and Health Information & Referral in Russian and Vietnamese languages.

6 month pilot period starting February 1994 involving Mid County and Southeast Health Centers.

Early direct client surveys indicate a major improvement in response time, and relatively good satisfaction with the new method of delivering interpretation for telephone triage and appointment service.

Volunteer Bilingual Trainees

- Steps to Success recently approved the contract language, and placed their first voluntary work experience client at Mid-County Health Center in April '94.

After Hours Clinic Telephone Interpretation

- After Hours Clinic uses speaker phone technology in exam rooms, using a telephone connection to local interpreters to handle the visit.
- A client survey will ask clients about this method of interpretation.
- Speaker phones may have potential in other clinical services where the content of the visit may be less sensitive (e.g. immunizations or on-site triage).

EXPENDITURES AND PROJECTIONS FOR THIS FISCAL YEAR

- Interpreter related expenditures for the first 9 months totaled \$820,600. Projected total for the fiscal year is \$1,114,200, which will put expenditures \$154,500 over the budgeted amount. This over expenditure is driven by the rapid growth in services to limited English speakers. Marked improvement in cost per visit has been offset by increased demand for services.

PLANS FOR NEXT FISCAL YEAR

- Decentralize budget for both permanent and temporary interpreter staff to Divisions for distribution to work units. This will increase on-site responsibility and control of interpreter related expenditures, encouraging teams to continually review site based operational decisions to minimize costs.
- Continue hiring of bilingual staff into appropriate direct service positions.
- If pilot project demonstrates success, recommend moving to permanent application.
- Build on data/experience using speaker phones in After Hours Clinic as a possible springboard for similar technology in other service areas.
- Develop and implement improved interpreter training program for temporary interpreters.
- Shift funds from selected permanent interpreter positions to other support categories.

DISCUSSION

The Department is undergoing a major change in the way it delivers services in one quarter of its encounters. Efficiency is clearly improving, but not without negative impact on some of our staff. Many are fearful of losing their options, if not their job, because of our bilingual hiring and screening policies.

Cost per visit figures indicate that the Department has made good progress in reducing interpreter expenditures, but significant growth in demand has prevented the Department from meeting the budgeted amount in the first year. Now that bilingual Civil Service exams are in place, testing and certifying processes are streamlined and many bilingual positions filled, we should see continued improvement in interpreter cost per visit figures.

The Department is now moving into the Total Quality Management/Continuous Quality Improvement (TQM/CQI) model which emphasizes the customer and moves decision making out and down in the organizational structure. Decentralized interpreter budget responsibilities will complement this approach and allow site staff to look at all aspects of their service delivery and how that impacts interpreter costs.

In addition to scheduling temporary interpreters on a daily basis and developing translated materials, Language Services will continue to track and distribute language usage data, survey clients, enhance hiring processes and improve training of temporary and permanent interpreter staff.

New approaches like the centralized telephone interpretation pilot project and speaker phone interpretation in the After Hours Clinic should lead to further efficiencies while maintaining our high level of service to our limited English speaking clients.

QUESTION (Health No. 3): Provide supplemental information about training for nurses to recognize substance abuse in prenatal clients.

Multnomah County Health Department has instituted as a part of its on-going employee orientation a two day ***Substance Abuse Training***. This training is available to both new employees as well as any employee in need of continued training in chemical dependency. Our employees also have the option of attending additional community sponsored alcohol and drug prevention/treatment workshops or trainings. The **Adapt, Start and Primary Health Care Substance Abuse Programs** are recognized as programs through which Community Health Nurses become specialist in working with perinatal substance abuse clients both in clinic and field services. Attached to this report are two of the perinatal forms used by our perinatal providers in assessing alcohol and drug use during pregnancy. In an effort to address additional supplemental education for Multnomah County Community Health Nurses in recognizing substance abuse in perinatal clients, the Health Department plans to work in collaboration with Multnomah County's Alcohol and Drug Office to sponsor a Community Health Nurse Forum on Perinatal Substance Abuse.

QUESTION (Health No. 4): Research concerning the impact of routine urine testing pregnant women willing to contact clinics for prenatal care.

Substance use among pregnant women has placed an increasing number of infants in this country at risk for prematurity, low birth weight, infant mortality, mental retardation, and severe malformations. According to national surveys, somewhere between 59% and 73% of women, 12 to 34 years of age, drink alcohol during their pregnancy. ^(1, 2) It is also estimated that of the reproductive aged women in the United States (15 to 44 years of age) approximately 6% use marijuana and 1% use cocaine. According the US Department of Health and Human Services, approximately 25% of women smoke during their pregnancy.

Prenatal care plays a key role in improving birth outcomes. Unfortunately in the general population of the United States, one out of every 18 women does not receive prenatal care or receives inadequate prenatal care. Known barriers to prenatal care are financial constraints, attitudes, beliefs, transportation, child care, disruptive family situations, immigration status, and substance use.

Pregnant substance users typically seek prenatal care late in their pregnancy or not at all. For example in New York, 33% of the women giving birth to cocaine/crack affected infants received no prenatal care; while 5% of non-drug using women received no prenatal care.

Substance use typically does not occur in isolation. Pregnant substance users are more likely to have other infections (i.e., STDs, hepatitis) and can have reduced weight gain associated with their heavy drug use. Many pregnant substance using women not only have problems with drug addiction(s), but are dealing with poverty, violence, abuse, mental illness, low self-esteem, and prostitution. As a result poor birth outcomes are not solely due to prenatal substance use. To the contrary, predictors of poor birth outcomes are substance use, poor nutrition, inadequate prenatal care, and violence. ^(4, 5, 6)

With this in mind, how can we improve birth outcomes for substance using pregnant women? One solution is to require universal urine testing for drugs of all pregnant clients coming to the Multnomah County Health Department for prenatal care.

There are many limitations to urine testing for prenatal substance use, though. A well known fact is that reporting discrepancies for drug use during pregnancy exist throughout this country. In one study they found that despite similar substance use rates, women of color were 10 times more likely to be reported for substance use compared to Caucasian women. ⁽¹⁰⁾

Another limitation is the testing and reporting bias toward poor women. Poor women have been shown to be more likely identified and reported for substance use during their pregnancy than other pregnant women. This is despite findings that private and public health clients entering prenatal care were equally likely to be using drugs during their pregnancy. ⁽¹⁰⁾ According to Zellman, et al ⁽¹¹⁾, private providers are reluctant to screen their prenatal patients for drug use for fear of losing their patients.

One important limitation with the technique of urine testing is that it only detects recent drug use. Marijuana use is detected one week before testing; while cocaine use is detected only within the last few days.

A major limitation of drug testing is the potential impact on the unborn child. Many experts in the field warn that "because of the punitive laws in many states, women fear losing their children if they seek prenatal care or substance abuse treatment". ⁽⁸⁾ One study found that "pregnant women's fear of detection of drug use was the most salient barrier" to seeking prenatal care. ⁽³⁾

Before universal urine testing for drug use during pregnancy is implemented, consistent data must exist to

show that such testing improves birth outcomes and does not cause serious adverse consequences to the unborn child. To our knowledge, "there is no empirical evidence that such legislation either deters maternal substance use or improves infant mortality or morbidity."⁽⁹⁾

According to many experts in the field, the system is already overwhelmed and not adequately addressed by the number of pregnant drug using women identified through providers. For example, in New York City during 1990 substance use treatment centers were surveyed, and 54% refused to take in pregnant women; while only 13% accepted pregnant crack addicted women on Medicaid.⁽⁷⁾ What is the point of testing pregnant women for drug use during their pregnancy if we do not have the resources available to treat them?

We should not make prenatal substance use a legal or punitive issue. Testing for the presence of drugs during a woman's pregnancy is counter-productive. Instead, we need to get them into prenatal care as soon as possible and get them into the most appropriate treatment program available. By doing this we will provide the best care to the woman and to the unborn child.

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QUESTION (Health No. 5): Immunization opportunities.

Done

QUESTION (Health No. 7): Inspection Program Overview.

Program Issues

While recent events such as the *E. coli* 0157:H7 in Washington state point out the critical importance of proper food handling in restaurants and other food service establishments, there is lack of consensus on how to further improve the safety of these establishments.

One difficulty is that most local food service establishments are safe to eat in. Multnomah County has approximately 2,000 restaurants and other food service establishments currently licensed. If each establishment serves an average of 100 meals per day (a conservative estimate), the public consumes more than 60 *million* meals in the county's restaurants each year. In a typical year, the Health Department receives about 150 complaints of illness *possibly* related to consumption of food in restaurants. A small minority of these complaints are justify detailed investigation. Only in rare instances is there compelling evidence that the complainant's illness was the result of consuming food in a restaurant.

The other major difficulty is that it is not clear that current public health interventions are optimally effective in improving food safety. Public health departments have traditionally relied primarily on inspection programs to ensure the safety of establishments that serve food. This reliance is largely based on historical evidence that inspection programs were effective in putting grossly inadequate restaurants out of business, and promoting compliance with a minimum set of standards in the others. Inspection programs operate on two key assumptions. First, they assume that the food handling practices observed during two to three hours of inspection per year are representative of practices throughout the thousands of hours that a typical restaurant operates each year. Second, they assume that inadequate practices identified in the inspection are reliably corrected on a long-term basis as the result of the inspection and the guidance given by the inspecting sanitarian. These assumptions are probably reasonable in dealing with food service establishments that have consistent, simple, and fairly obvious problems. They are probably less valid for establishments that have intermittent, complex, or subtle problems. A growing body of public health literature is questioning the effectiveness of traditional inspection programs in identifying and correcting deficiencies that create a well-defined risk to the health of the public. A local example is the study carried out by Dr. Alan Melnick, Health Officer for Washington County. This study which found a relatively poor correlation between inspection scores and the risk of food-born illness.

Many alternative approaches to food safety have been proposed in recent years. These have included modified inspection programs, self-inspection, food handler and food service manager training, and utilizing market incentives to improve food handling practices. Formal evaluation of these approaches is ongoing. There is evidence in the literature to suggest that some of these are effective (e.g., food handler training and other approaches that create internalized systems for assuring food hygiene).

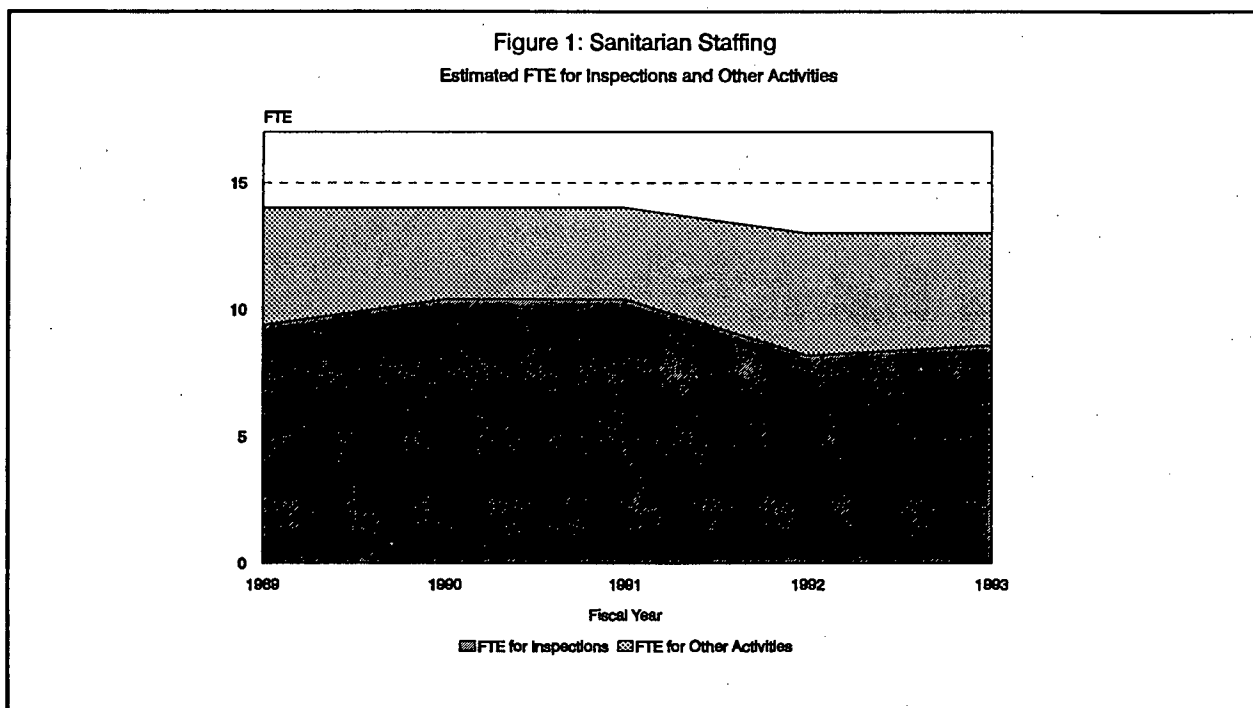
Multnomah County Health Department carries out food service licensing and regulation as a delegated program of the Oregon Health Division. The Department operates in an environment largely defined by food sanitation, inspection, and programmatic rules promulgated by the state. The state is currently re-examining some aspects of its approach to food sanitation. The emerging direction appears to be positive, but it is unclear when or to what degree these changes will be formally adopted by the state. For the time being, the most appropriate programmatic course is to 1) continue to work with the state in

evaluating and modifying the current approach to inspections and other aspects of food sanitation; 2) evaluate and modify existing local programs (e.g., food handler certification); and 3) explore new programs (e.g., awards and food manager training) to ensure that our local program is optimally effective in protecting the public health.

Sanitarian Workload

During the Budget Hearing, there was testimony that the current sanitarian staff could not carry out its work load with adequate quality, and that this situation represented a danger to the public health. The following is an analysis of trends in sanitarian staffing and work load over the past five years. This analysis is intended to look at the question of whether the current inspection work load can be reasonably met by existing staff.

Data on inspection work load was derived from numbers of licensed facilities requiring inspection, and on required inspection schedules for each facility. Data on staffing was obtained from budgeted staff levels for the past five fiscal years, and from estimates of staff time spent on inspections and on other activities. Both categories of data represent estimates that are appropriate for comparison over time. They may contain mild inaccuracies due to the difficulty in tracking hours of work by staff with duties in several different and changing program areas over the years.



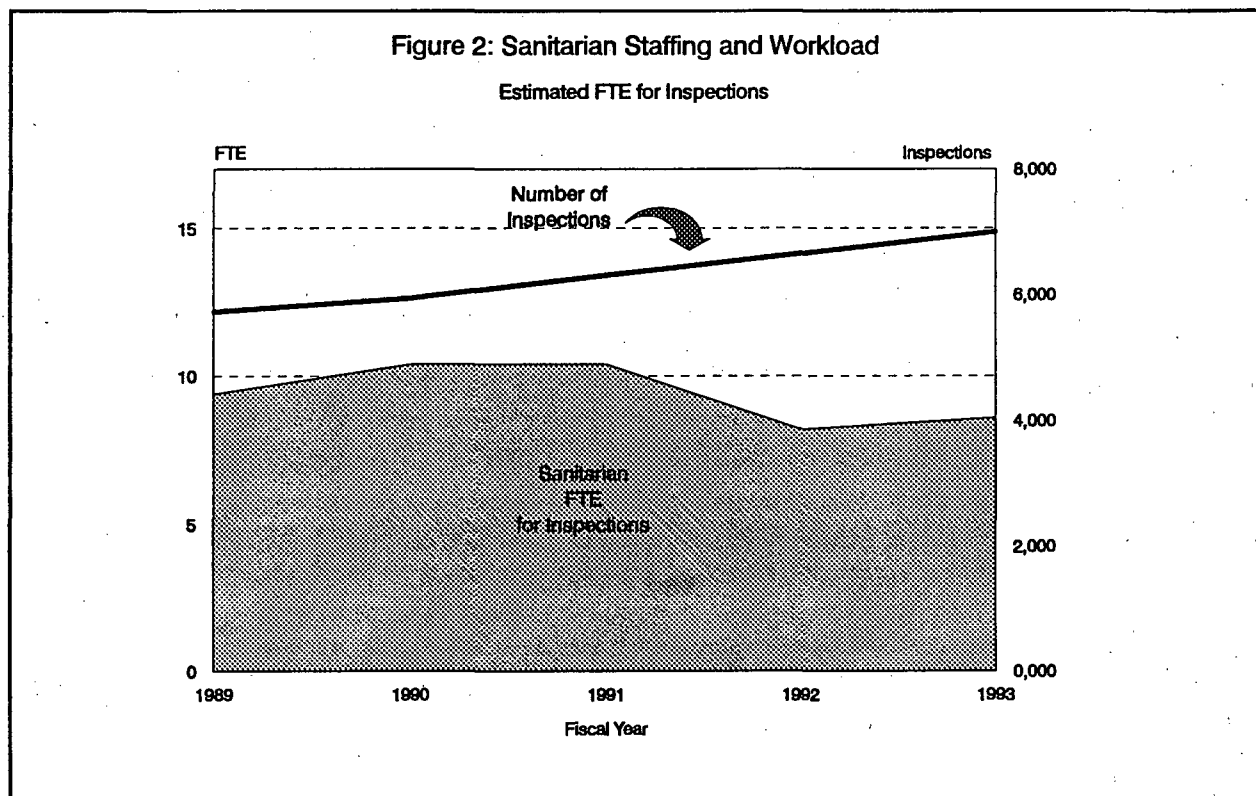
As shown in Figure 1, sanitarian staffing decreased from 14 FTEs for fiscal years 1989-90 through 1991-92 to 13 FTEs for 1992-93 and 1993-94. This decrease was intentional, and was based on the observed improvements in the efficiency in restaurant inspection, and the Environmental Health Program manager's judgement that 13 sanitarians were adequate to cover all program duties. However, as Figure 1 also shows, there was a disproportionate decrease in the number of staff FTEs available to perform delegated

inspections (food service, swimming pools, and tourist accommodations). In 1989-90, there were about 9.4 FTE sanitarians available to perform delegated inspections. This fell to 8.2 in 1992-93, and was increased slightly through shifting of duties among staff in 1993-94. These changes represent a net decrease of 8.5% in sanitarian FTEs available to perform delegated inspections between FY 1989 and FY 1993. This situation resulted from an increasing workload in other programs, most notably restaurant plan review and childhood lead poisoning prevention.

During the same five-year period, the inspections work load increased significantly. This was largely due to substantial increases in the numbers of permanent and temporary restaurants. The estimated total number of delegated program inspections for the 1989-90 fiscal year was 5,729. This rose to 7,001 for 1993-94 - an increase of 22%.

Discussion

Based on this analysis, it is apparent that the perception that sanitarians are working harder on the delegated inspection programs is based in fact. Compared to five years ago, there has been a substantial increase in work load, and a substantial decrease in staffing.



As is true for most programs, determination of an ideal staffing level is difficult. The most relevant standard for staffing is found in the Oregon Health Division's revised administrative rules relating to restaurant license fees. This standard sets allowable levels of sanitarian staffing to be charged to restaurant license fees. It was developed in cooperation with the restaurant industry. This rule would allow Multnomah County 7.9 sanitarian FTEs for inspection of full and limited service restaurants alone. These establishments account for about 60% of the total number of delegated inspections, and about 80% of the delegated inspection work load.

Over the past several years, the Department has made a concerted effort to have all delegated inspections (as well as most other Environmental Health Program activities) paid for out of license and inspection fees. This effort has been successful, as reflected by the fact that 100% of funding for inspections is supported by fees.

Beyond effective and efficient operation of delegated programs, the county has an interest in developing a dynamic environmental health program for the future. There is increasing public concern over a variety of issues involving the impact of the environment on health. Examples include environmental toxins, odors, indoor air quality, noise, and environmental equity. One effect of the current staffing situation in the Environmental Health Program is that the Department is without even minimal resources to address the range of existing and emerging environmental health problems.

Recommendations

To allow it to continue to provide quality service in traditional environmental health inspection programs, and to allow it to develop at least minimal capacity to address emerging environmental health issues, the Department recommends that the Board authorize an additional 1.0 FTE sanitarian position. This increase would provide the Department with a more reasonable, but still lean staffing level.

At the present time, the Environmental Health Program is in the early stages of adopting a self-directed work team (CQI/TQM) approach to all of its functions. This will involve redesign of both line staff work roles and management structure and roles. A participatory approach involving all staff and management personnel is being used to pursue this program redesign. Because this process is in its early stages, it is unclear what the Program's requirements for managerial resources will be relative to the currently budgeted level. Therefore, the Department recommends funding the additional requested sanitarian position from County General Funds, with the understanding that a budget modification may be forthcoming in the late Summer or early Fall to shift part or all of the funding for this position to license fees.

QUESTION (Health No. 8): Advantages of providing lab services to Planned Parenthood.

The Department will continue to research this question. An answer should be expected within two to three weeks.

QUESTION: (Health No. 9): Business Services Analyze Health Department support services that parallel centrally provided support services.

SUPPORT SERVICES

The Health Department, as well as some other County Departments, have developed departmental functions that augment central support services.

Central units providing specialized administrative support include the Auditor, Budget and Planning, County Counsel, Employee Services, Finance, and Labor Relations.

Departmental support services, as provided within the Health Department, include grant accounting, budget preparation, human resources management, management of the Health Information System, and medical receivables and payables. The development of these Departmental support services has occurred over time, and are the result of growth in size and complexity of the work force, programs and funding sources. These functions evolved in collaboration with the central units to meet specific needs of the Health Department, or have evolved in the absence of central units to provide the services.

The Health Department is a highly cohesive agency. While it is involved in a wide assortment of programmatic activities the Department shares a common commitment to consistency in management practices and procedures. This cohesion has allowed the Department to build its administrative infrastructure in a organized, centralized fashion.

This leads to a high degree of administrative visibility. However, the visibility of centralized administrative units should not be used as an indicator of our Department's relative level of administration. In combination with these central units the complete lack of administrative support at the Divisional level must be considered. The Health Department is able to operate Divisions of hundreds of FTEs without the individual budgetary, personnel, payroll, or contracting staff common to other County divisions of similar size or scope.

Are these services duplicative in nature? From the Department's perspective, they are not.

Many of the Department support services have been created due to the unique nature of the services the Health Department provides. For example, no other County agency is involved in billing insurance companies for its services. The Health Department years ago transferred Medicaid and insurance billing functions from around its clinics to form a central medical receivables unit.

Other Department support services have developed due to the lack of adequate levels of support by the County centrally. For example, the Health Department maintains internally the ability to support its Health Information System. ISD clearly is not staffed to support the HIS, and fully expects the Health Department to support its own systems.

Other Departmental support services are required by the demands of the Department's funders. The Department receives support from over 90 different funding sources, of which 44 are grants from Federal, State, or local agencies. The Department strives to blend these individual programs into a seamless product from client's point of view. This diversity of funding sources has led to a rich blend of services to the community, and to long term financial growth for the agency. However, it also brings a demand for cost accounting and cost reporting abilities far beyond that required of any other County department. Grant reporting, cost accounting, fee setting, and employee time and effort reporting activities that are managed by the Health Department would be alien to a County agency supported with local tax revenues.

Would these services be better provided centrally, rather than by the Department?

From our perspective we can not fully answer this question. The question deserves a lot of attention.

Our instinctive reaction is to maintain the control, accountability, and responsiveness that comes from maintaining these services within the Department.

Our recent experience with the absorption of the Department's Health Supply function within the County's Warehousing and Distribution office is a good example. Service to Health Department work units was reduced to the common County level, which was expected and included as a cost of the transfer. What was not expected, and was not included as a cost, was the shifting of administrative burden onto individual work units. Site staff found that supply, service, and equipment procurement responsibilities became theirs. Cash handling, chart transport, and specimen collection was compromised. Procurement became, and still is after two years, a bottle neck for clinical operations.

Would we describe the Health Supply transfer as a failure? From our perspective, we were not well served. From the County's perspective, however, the General Fund savings that resulted may have outweighed the difficulties.

EXAMPLE - EMPLOYEE SERVICES

In 1988-89 the Health Department had 429 FTE in 22 work sites. The proposed budget for 1994-95 projects 765.41 FTE in 37 work sites and includes 68 different job classifications. This represents a 78% increase in work force over 6 years while spreading them over nearly 68% more sites.

The Department conducts 32-42 selection processes annually. Currently, there are 130 new hire actions annually. In addition, there are approximately 25 transfers, 20 promotions, 40 classification reviews, and 15 reclassifications annually.

During the same six year period, staff in Employee Services dedicated to the Health Department has remained constant. In March of 1991 the Health Department shifted staff within the Department to assign Human Resources management to a half time manager. Within the last two years that staffing has been increased to full time. In July 1991 a staff position was added to support the grantor required implementation of an employee time and effort accounting system. This spring half of a position was cut to reflect efficiencies in payroll practices.

The central Employee Services and Payroll offices could not absorb this work load. They exist in a symbiotic relationship with personnel and payroll services provided at the Department level. Employee Services maintains office hours in the Department. Duties between the three offices are clearly delineated, and responsible parties established. The Department is afforded the ability to extend span of supervisory control as individual unit managers are not required or expected to individually manage their own selection processes and personnel actions.

Employee Services and Payroll functions could not be provided centrally by the County without resources being shifted from operating departments. It is entirely possible that total resources could be reduced. However, our Department's ability to maintain its existing span of control will suffer as personnel and payroll activities would be shifted onto work unit staff.

QUESTION (Health No. 10): Multnomah County Occupational Health Office: Update on the Marketing of the Blood borne Pathogens Program:

HISTORY:

The Occupational Health Office (OHO) was opened in July, 1992 to bring Multnomah County into compliance with OSHA's newly enacted Blood borne Pathogens Program (BBP) requirements.

Current Staffing:

- Manager (0.5 FTE)
- Lead RN (1.0 FTE)
- Community Health Nurses (2.0 FTE)
- Office Assistant II (1.0 FTE)

Current Contracts:

- Multnomah County (~2000 employees)
- City of Portland (~800 employees for the whole program;
~1000 police personnel for Hepatitis B injections only)
- Metro (~75 employees)
- Port of Portland (~75 employees: Hepatitis B injections only)
- Multnomah Athletic Club (MAC) (~50 employees)

Marketing Contract with Portland State University Marketing Professor:

- December, 1993-May, 1994: Just completed the brochure for marketing our program.
- Marketing Plan completed and delivered to OHO in May 1994.
- Plan: Currently making arrangements for printing the brochure and will then begin distribution according to the Marketing Plan.

Current Services provided "Fee for Service":

- Flu Shots (~1900 given in 45 work sites: Sept-Nov '93)
- Seminars for employees given for:
 - Bureau of Land Management
 - Ryan Hutchins, Arthur Southwick Advertising Firm
- BBP Program for Center for Continuous Improvement
- Hepatitis B injections for non-contracted employees, students, MR/DD clients/staff

New Prospects:

- West One Bank: Currently negotiating health education sessions for employees

Program Expansion:

- Currently developing a program to meet OSHA's newly drafted Tuberculosis guidelines. These will affect all health care facilities in the State and we are hoping to market our services to them along with our current BBP Program.

QUESTION (Health No. 11): Medical Care Costs for inmates.

The 1994-95 includes two amounts for Corrections Health:

Medical Care -	\$5,054,000
Mental Health Services -	\$791,000

These costs include juveniles, which are not separated budgetarily. However, we estimate care at the juvenile facility to run approximately \$610,000 annually.

The cost of transport and security for inmates related to medical care is budgeted at the Sheriff's Office.

The Health Department will provide additional information regarding cost containment alternatives. We will update the Board on our continuing discussion with OHSU regarding the possibility of establishing a capitated agreement for hospital and specialty care, and on the legislative history of Medicaid funding for adults in custody.