

BEFORE THE BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

RESOLUTION NO. 00-152

Adoption of the Multnomah County Public Health Improvement Plan

The Multnomah County Board of Commissioners Finds:

- a. Multnomah County is required by the Oregon Health Division, in collaboration with the Association of Oregon Counties, to submit a local Public Health Improvement Plan addressing public health needs and directions for FY 2001-2003.
- b. The Multnomah County Public Health Improvement Plan submitted by the Health Department has been shaped and guided by a long history of working with our community, and the strategies and recommendations made throughout are reflective of our community's needs, values and concerns.
- c. The Plan builds upon local and regional assessments, community planning activities, and national goals and is influenced by the Health Department's Strategic Plan.
- d. The Multnomah County Public Health Improvement Plan is in alignment with the three Long Term Benchmarks identified by the Multnomah County Board: Reduce Children Living in Poverty; Increase School Completion with Life Skills Equivalency; and Reduce Crime.
- e. The Health Department has taken significant steps to address public health issues affecting our community and through the Public Health Improvement Plan will continue to look to the community to find ways to strengthen public health efforts.

The Multnomah County Board of Commissioners Resolves:

1. The Board adopts the attached report developed by the Health Department entitled *Multnomah County Public Health Improvement Plan*.
2. The Health Department will continue to work with the community to develop pathways for better citizen participation in Health Department policies and decision-making.

ADOPTED this 14th day of September 2000.



REVIEWED:

BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON


Beverly Stein, Chair

Thomas Sponsler, County Attorney
For Multnomah County, Oregon

By: 

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MULTNOMAH COUNTY OREGON



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Multnomah County Public Health Improvement Plan

A. *Executive Summary*

The Multnomah County Health Department's Public Health Improvement Plan has been shaped and guided by a long history of working with our community. The knowledge and experience we have gained over the years by listening to and working with members of our community has been invaluable in moving all of us forward, constantly reshaping and refining our work. Our plan based on sound theoretical models and principles and recommendations made throughout were developed from needs assessments, ideas, beliefs, values, and concerns reflective of our community and was influenced by our Strategic Plan. The strategies/action plans identified are:

- Community Health Assessment;
- Community Environmental Health;
- Community Solutions Grants/Public Health Talks;
- Hepatitis C;
- Sexually Transmitted Disease Partner Notification;
- Heroin Overdose Deaths;
- Healthy Birth Initiative North/Northeast Portland;
- Healthy Start Countywide;
- Community Dental Collaborative; and
- Community Health Worker Capacitation Center.

The collection of strategies/action plans identified in our Public Health Improvement Plan is intended to be used as a guide, and does not represent all the strategies available to address every public health issue in our community. Unmet needs have been identified and represent the work that still needs to be done to move us as individuals and as a county toward a healthier future. These unmet needs include:

- Eliminating health disparities;
- Access to health care for all residents of our community;
- Providing language interpretation for non-English speaking clients receiving health care services;
- Maternal and child health;
- Diabetes;
- Injury prevention;
- Mental health; and
- Sexual minorities.

In an effort to strengthen our community health assessment and epidemiology function, the Health Department recently developed a community health profile. The profile looks at a variety of indicators of health, including demographic and socioeconomic backgrounds of Multnomah County residents. This past summer we brought people together from around our community to help with the development

and dissemination of the profile. Individuals invited to participate in discussion groups are listed in Appendix A. We will continue to provide opportunities for interested individuals to be part of a series of dialogues to address the needs of different populations and neighborhoods. We are looking forward to the new Mobilizing for Action through Planning and Partnerships (MAPP) developed by the National Association of County and City Health Officials and the Centers for Disease Control and Prevention and are eager to incorporate the new MAPP format for the development of our updated Strategic Plan for the next five years.

B. *BCC Involvement and Transmittal (one page maximum) Attach transmittal letter (or use form in Appendix B) from BCC in Board's language that assures:*

- 1. BCC has designated a method or process to coordinate existing planning processes and partners, and*
- 2. BCC has designated an entity responsible for representing the public health improvement planning effort, and*
- 3. BCC will:*
 - i. Maintain funding levels for public health, or*
 - ii. That funding levels will not be reduced by an amount greater than proportional reductions of county revenues, or*
 - iii. Unique financial circumstances *exist this biennium (county general fund is reduced to expenditures for critical public safety needs) which prevent the county from maintaining existing efforts for public health, and*
- 4. BCC has approved the Public Health Improvement Plan for their county and has ensured that the appropriate state, local, public and private partners are in agreement.*

The Oregon Health Division has requested all plans be submitted by September 8, 2000. Our Public Health Improvement Plan will be submitted pending BCC review and approval. The Health Department will review and discuss the Multnomah County Public Health Improvement Plan during the September 14th Board of County Commissioners Briefing at 9:30 AM. After the Board Briefing the Health Department will submit to the Oregon Health Division a modified plan, with a Board of County Commissioners Involvement and Transmittal Letter signed by Chair Stein. See Appendix B for BCC Involvement and Transmittal Letter.

C. *Partnership Involvement*

The Multnomah County Health Department (MCHD) has a strong history of a community-focused collaboration and over the years we have looked to the community to find ways to strengthen public health efforts. Numerous partnerships and collaborations have aided us in delivering essential public health services to residents of Multnomah County.

Our Community Health Council, an established 19 member board, provides budget oversight and community oversight for the Health Department and is composed of ten consumer members, five provider members, and four members who represent civic or social service organizations in the community.

Over the years the impact of our work has also benefited from the strong collaboration with the Multnomah Commission on Children, Families and Community (MCCCF), a diverse group of appointed volunteers working together, combining public and private resources, to create community conditions that protect, nurture and help realize the full potential of every member of our community.

This past year MCHD initiated a community planning partnership called "Communities in Charge" a project supported by The Robert Wood Johnson Foundation. The project brings together consumers, advocates, politicians, providers, insurers, and employers to craft a community consensus around local action to improve access for residents with low incomes. Through a series of focus groups we learned about the knowledge, perceptions, and barriers to health care of low-income uninsured residents. We also just brought together over 100 community leaders, consumers, administrators, advocates and providers to look for best practices and creative approaches for improving access for low-income uninsured County residents.

Our work with the Citizen Task Force on Smokefree Workplaces has been essential for creating increased awareness of a critical public health issue- tobacco. Recently, the Multnomah Board of County Commissioners passed an ordinance prohibiting smoking in many places of employment in the county. Health Department Tobacco Prevention staff have also worked together with community partners (including youth) to survey and educate retailers regarding tobacco sales to minors.

MCHD is an active member of the Governor's State of Oregon Racial and Ethnic Health Task Force, represented by two senior members, and provides expertise on issues related to HIV/AIDS, lead poisoning, and access to culturally competent health care. Additional members of the Health Department have brought their experience to the work of the Task Force, as well.

Members of the Health Department's Primary Care Behavioral Health program have been active participants in the Multnomah County Mental Health Task Force created to analyze the current system of public mental health treatment in the county and to recommend changes to improve services to clients and the community. We remain committed to our clients with acute and chronic health and behavioral conditions and work to establish and maintain effective linkages with specialty mental health systems and alcohol and drug treatment programs to facilitate referral of clients with specialty care needs.

MCHD has led an effort to resolve information system needs in a collective fashion for community, migrant and rural health clinics through the Oregon Community Health Information Network (OCHIN). Members of OCHIN include Multnomah County, Clackamas and Tillamook County Health Department, Oregon Health Division, Oregon Medicaid, Oregon Health Plan, Oregon Primary Care Association, and CareOregon. OCHIN was just recently awarded a national Community Access Program grant from the

US Dept. of Health and Human Services, Health Resources and Services Administration to support the implementation of a statewide safety net management services organization and data warehouse.

Another community collaboration that has shaped our work is the Portland-Area HIV Services Planning Council, a 30 member representative community body appointed by Chair Beverly Stein to set service priorities and allocate over \$3 million in federal Ryan White CARE Act funds. The Council's diverse membership reflects the demographics of the local epidemic. At least 30% of members are people living with HIV, with representation from health care providers. AIDS service organizations, mental health and substance abuse providers and public health officials. We are also an active member of the Multnomah County HIV Prevention Community Planning Team. The Planning Team is made up of individuals representing agencies that provide HIV prevention education, members of the population most at risk of HIV infection, as well as anyone in the community with an interest in participating. A three-year planning cycle with the development of a comprehensive plan to prevent the spread of HIV in our county was recently completed. MCHD's HIV Advisory Board is made up of 10 clients and two staff and works to represent clients' opinions, ideas and recommendations, and looks for new ways to assure better communication, feedback, and input.

MCHD has worked in collaboration with the Early Childhood Workgroup led by County Commissioner Lisa Naito. The purpose of the workgroup is to review current county government funded services to young children and their families and develop recommendations regarding how these resources could be better coordinated, better integrated and what services might be added if additional funding becomes available. The workgroup is composed of representatives from several county departments including Community and Family Services, Health, Juvenile Justice, the Library and the Commission on Children, Families and Community, and the Peninsula Child Care Network.

Our collaboration with the Healthy Birth Initiative Community Consortium has made it possible to improve birth outcomes and work toward eliminating disparities in vulnerable populations. The consortium serves as an advisory council and is made up of community members, program participants, agency staff, and others with an interest in promoting healthy birth outcomes.

MCHD has worked to reduce rising prescription drug costs by working with partners to evaluate approved clinic prescription drugs, obtain "best price" national contracts, bill third party payers such as CareOregon for prescriptions, and join a group purchasing alliance, Minnesota Multistate Purchasing Alliance, a group including over 30 states representing combined purchases in excess of \$200 million a year. Group membership enables the county to obtain volume discounts on pharmaceutical purchases.

Multnomah County Vector Control program is working with Columbia County (Oregon), Clark County (Washington), and Cowlitz County (Washington) on floodwater mosquito control using a helicopter to apply larvicides, with Skamania County interested in joining in the effort in the future. We have also partnered with Clark and Cowlitz on a mosquito surveillance program over the past three years to identify mosquito species and population densities in the area and provide mosquito control services for the City of Durham in Washington County. We are working jointly with the Umatilla Mosquito Control District in testing for pesticide resistance in mosquitoes.

We have also worked with a team of twenty community groups to provide information for services to incarcerated youth, including abstinence, family planning, health care access, sexually transmitted diseases and HIV through Corrections Health. We have also worked with the Urban League and

Northwest Children's Theater School to address tobacco cessation, self-esteem and conflict resolution skill development.

In collaboration with the Tri-County Dental Access Team of the Healthy Communities Coalition and the Multnomah County Dental Society, MCHD's Dental Services Division implemented the Dental Access Program, a public/private partnership. The goal of the program is to improve access to urgent dental care for low-income, uninsured residents. The program uses computer triage, patient information and referral provider lists, and links eligible clients with volunteer dentists.

Through the commitment and collective voice of the Recovery Association Project, Commissioner Sharron Kelley and the Health Department, a Special Task Force for Hepatitis C and Heroin Related Deaths was convened by the Chair of the Multnomah County Commission and was led by MCHD's Public Health Officer to address heroin overdose deaths and to develop appropriate medical treatment and public education measures. The Special Task Force includes experts from local hospitals, Multnomah County and Oregon Health Division, the Medical Examiner, alternative health care providers, the Recovery Association Project, City of Portland Police, Oregon State Alcohol and Drug Office, and those affected by Hepatitis C and alcohol and drug addiction.

D. Action Plan for Improvement of the Public's Health

1. Provide description of public health issues and needs in your community.

Demographics and Socioeconomic Background Multnomah County is the largest county in Oregon with 641,900 residents and represents 19.6% of the State's population. From 1990 to 1998, the population of Multnomah County grew 10%. In 1998, our population was 81% non-Hispanic White, 7% African American, 6% Asian, 5% Hispanic, and 1% American Indian. Based on the 1996 American Community Survey, nearly 23,000 residents over the age of four were non-English speaking or did not speak English well. Median household income was \$34,966 in 1996 and 1.5% lower than for the United States. Approximately 14% of the population had incomes below poverty level in 1996, and about one-third had incomes less than 200% of the poverty level. Seventeen percent of households received some form of public assistance in 1996.

Health of Mothers and Infants In 1998, there were 9,303 births in Multnomah County. Births to mothers under age 20 declined countywide from 13% of all births in 1994 to 11.3% in 1998. The percent of mothers who received first trimester prenatal care was up among all racial/ethnic groups between 1990 and 1998. Self-reported use of tobacco during pregnancy has declined substantially from 1990 to 1998. However, 15% of mother's giving birth reported smoking during pregnancy. There were 59.2 low birth weight (less than 2,500 g or 5.5 lb) infants per 1,000 births in 1998. There were 45 infant deaths in 1997, down from 76 deaths in 1990 and 103 in 1991. Over 60% of deaths to infants less than 28 days of age were caused by perinatal conditions such as low birth weight, prematurity, and respiratory distress. The second leading cause of neonatal death was congenital anomaly or birth defect. Sudden Infant Death Syndrome (SIDS) was the leading cause of death among post neonatal infants, ages 28 days to one year.

Health of Children There were 73,906 children ages 1-9 in Multnomah County in 1998, representing 12% of the population. In 1999, 84% of the two-year olds had been fully immunized. A 1996 study of Multnomah County elementary school children indicated that fewer than half of 6-8 year olds had no dental caries. There were 155 deaths of children ages 1-9 from 1990-1997. The average annual death rate for boys was higher than for girls. African American and Hispanic children average rates of deaths

were higher than White, Asian, and American Indian children. Injury was the leading cause of death of children ages 1-9. Cancer was the second leading cause of death among children ages 1-9.

Health of Adolescents There were 82,263 adolescents ages 10-19 in Multnomah County in 1998, or 13% of the total county population. Few high school students eat the recommended five fruits and vegetables per day and many do not participate in vigorous physical activity on a regular basis. In our county 91% of children ages 19 and under have some type of health care coverage. Based on these estimates, 9% or approximately 14,900 children are without health care coverage. Information from the 1999 Oregon Youth Risk Behavior Survey (YRBS) indicates 23% of high school students reported that they smoked cigarettes in the past 30 days. The percent of students who reported using alcohol during the past 30 days declined; however, binge drinking among 11th grade students was up from 25% in 1997 to 30% in 1999. Approximately one in five high school students reported use of marijuana during the past 30 days in 1999. The YRBS indicates that over one-fourth of high school students reported in 1999 that they had been in a physical fight during the past 12 months. In 1999, 12% of students indicated that they had carried a weapon, and 4% indicated that they had carried a gun. Teen pregnancies declined substantially in Multnomah County during the 1990s. Despite this decline, the rate of teen pregnancies remains higher in our county (52.0 per 1,000) than statewide (42.1 per 1,000). Pregnancy rates also dropped substantially among teens ages 18-19 between 1990 and 1998. Teen birth rates among 15-17 year-olds are down and birth rates dropped substantially among young women ages 18-19 from 100 births per 1,000 women in 1996 to 74.4 in 1998.

From 1990-1997, there were 313 deaths of adolescents ages 10-19 in Multnomah County, an average of 53 deaths per 100,000 youths annually. The average annual death rate was 2.8 times greater for boys than for girls, and the rate for African American youth was twice as high as for youth with other racial/ethnic backgrounds. The leading causes of death among adolescents from 1990 to 1997 were injury, suicide, and homicide or legal intervention. Among 10-19 year olds, firearms were involved in nearly two-thirds of the deaths of African American males and over one-fifth of the deaths of White males. There were 57 suicides among adolescents ages 10-19 from 1990-1997 (77% were boys and 23% were girls.)

Health of Adults There were 400,357 adults ages 20-64 in Multnomah County in 1998. The Oregon Behavioral Risk Factor Surveillance System (BRFSS) indicated that only 30% of adults ages 18-64 in eat the recommended five fruits and vegetables per day and only 25% engage in regular physical activity for at least 30 minutes on at least five days per week. The 1998 Oregon Population Survey indicate that nearly 90% of residents had some type of health care coverage. Adults ages 20-24 were the least likely to have coverage and people of color were less likely than White residents to have health care coverage.

The 1999 BRFSS indicated that 24% of adults in our county smoked cigarettes on at least some days. A telephone survey in 1999 for the Oregon Office of Alcohol and Drug Abuse Programs indicates that 23% of adults have used illicit drugs within the past 12 months. One in four men and one in eight women are substance abusers or dependent on alcohol, illicit drugs, or both. Substance abusers and dependent users are more likely to be in the 18-44 age groups than in older age groups. A domestic violence study conducted in Multnomah County in 1998-1999 found that one in seven women was a victim of physical abuse, including physical assault and sexual coercion, by an intimate partner during the previous year. Physical abuse by an intimate partner occurs more frequently among younger women than among older women.

Rates of tuberculosis (TB) have been more than twice as high in Multnomah County than in Oregon between 1990-1998. Over half, 56% of the 1998 TB cases were among foreign born residents. Chlamydia infections are the most frequent form of sexually transmitted disease (STDs) in Multnomah County. Gonorrhea case rates have declined substantially, although case rates increased in 1998 from 1997. Rates of syphilis infection per 100,000 residents have declined dramatically. The rate of reporting of new AIDS cases (late stage HIV infection) has declined substantially since 1993. The percent of women among new AIDS cases is up; however, the actual number of new AIDS cases among women is down from 1993 to 1999. The percent of new AIDS cases among men who have sex with men (MSM) has declined. Over the same period, the percent of new cases among injecting-drug users and from heterosexual contact has increased. Of those with HIV positive tests in 1998, 81% were men, 17% were women, and gender was unknown for 2%. The proportion of new HIV positive diagnoses has increased among Hispanics, and decreased for White and African American residents. MSM continues to be the leading risk factor for HIV infection. Rates of new Hepatitis A cases have dropped substantially since the mid 1990s. The rate of new Hepatitis B cases has fallen, although this rate is higher than the state rate. Between 1994 through 1999, over half of the Hepatitis C cases were among men, over 75% were among adults ages 25-49.

The average annual death rate per 100,000 20-24 year olds was 124.1. Young men in this age group were 3.5 times more likely to die than were young women. African Americans were 2.7 times more likely to die than were Whites. Death rates were also substantially higher among American Indians and Hispanics than among Whites. From 1990-1997, the leading causes of death for males and females were injury, suicide, and homicide or legal intervention.

From 1990-1997, there were 3,573 deaths of adults ages 25-44. Deaths of men in the 25-44 year old age group outnumber deaths of women by approximately three to one. The average annual death rate, 1990-1997, was highest for American Indians, followed by African Americans. Among men ages 25-44, injury was a leading cause of death between 1990-1997. AIDS or HIV infection was a leading cause of death among White, African American, and Hispanic males. Suicide was a leading cause of death for White and Asian males. Homicide or legal intervention was a leading cause of death for African American and American Indian males. Alcohol disease was a leading cause of death for American Indian males. The leading causes of death for White women were cancer, injury, and suicide. Three leading causes of death for African American women were injury, cancer, and homicide or legal intervention. Leading causes for Asian women were cancer, heart disease, and homicide or legal intervention. Leading causes of death among American Indian women were injury, cancer and death due to alcohol diseases. The leading causes of death for Hispanic women were injury followed by cancer.

There were 7,043 deaths of adults ages 45-64 in Multnomah County, 1990-1997. Sixty-three percent of deaths were men and 37% women. The death rate for African Americans is 1.6 times higher than the White death rate, and nearly 3 times higher than the Hispanic death rate. From 1990 through 1997, cancer and heart disease were two leading causes of death for all males. Alcohol diseases were a leading cause of death for American Indian and Hispanic males. From 1990 through 1997, cancer was a leading cause of death for all women. Heart disease was a leading cause of death for White, African American, and Asian women. Stroke was a leading cause of death for African American and Hispanic women. Two leading causes of death for American Indian women were alcohol diseases and chronic obstructive lung disease.

Health of Older Adults There were 76,071 adults ages 65 and over in Multnomah County in 1998, representing 12% of the total population. Sixty-two percent were women and 32% were men.

Compared with younger adults, the 65 and over age group is more likely to eat the recommended five fruits and vegetables per day and were as likely as younger adults to report that they engage in at least 30 minutes of physical activity at least five times per week. Over 71% received influenza vaccinations in 1998, and 58% received pneumococcal vaccinations.

There were 34,403 deaths of adults ages 65 and over in Multnomah County, 1990-1997. Three leading causes of death for both men and women and across all racial groups were heart disease, cancer, and stroke. Chronic obstructive lung disease was a leading cause of death for American Indian males. Diabetes was the fourth leading cause of death among African American women ages 65 and over.

2. Describe adequacy of the basic services

The Local Public Health Improvement Plan - Survey for Multnomah County Health Department is completed and can be found in Appendix C. Explanations have been provided where necessary for those questions regarding additional information.

a. Communicable Disease Prevention and Control. Describe CD system- strengths and weaknesses.

The Disease Prevention and Control Division identifies, prevents and controls communicable and environmental diseases and is made up of: Immunizations, Disease Control and Occupational Health, Tuberculosis Prevention and Treatment Center, HIV Prevention Services, HIV Care Services Planning and Administration, HIV Health Services, Sexually Transmitted Disease (STD) Clinical Services and Epidemiology, Childhood Lead Poisoning Prevention Project and Environmental Health Services.

The Community Immunization Unit in partnership with numerous private organizations coordinates and conducts free Saturday immunization clinics throughout Multnomah County. Free blood lead screening for children are also offered through the free Saturday clinics. The amount of resources necessary to sustain this program at its current level are provided through these community partnerships. If these community partnerships and resources are diminished in any way, we would be severely limited in our ability to meet the needs of our community.

The Disease Control and Occupational Health Program protects the community from communicable disease and protects Multnomah County employees from workplace exposure to communicable diseases as mandated by OSHA. We respond to reportable disease reports with appropriate investigation and carry out primary and secondary interventions, including the vaccination for Hepatitis A cases. This program continues to work more with limited resources, and as a result, we do not have the full capacity to conduct on-going quality local level epidemiology of diseases.

The Childhood Blood Lead Program reduces the risk of lead poisoning through targeted testing, blood lead investigations, and operating a lead advice telephone line. The Childhood Blood Lead program is entirely supported by external non-county funds and is vulnerable to significant reductions in funding, leaving the children in our county at risk, particularly low-income and children of color.

Our Tuberculosis (TB) Prevention and Treatment Center prevents and controls the transmission of tuberculosis, including screening, case management, treatment for latent infection, education and referral services. The TB Prevention and Treatment Center has been operating on the margin for some time now and any significant changes in the TB case rate would seriously challenge the capacity of the program to respond and deliver needed services.

HIV Prevention Services plays a leadership role in preventing the spread of HIV and educating the community on HIV/AIDS. Prevention activities include street-based education, needle exchange, HIV counseling and testing, community presentations and planning. We manage federal Ryan White funds for essential health and support services to low-income persons living with HIV/AIDS through 22 local health agencies and community-based organizations. Services include medical and dental care, case management, counseling, complementary therapies, short-term housing, emergency financial assistance and transportation services. MCHD also operates the HIV Health Services Center, a full service primary care clinic for adolescent and adult HIV-positive individuals.

Our STD Clinic, STD Epidemiology Program, and HIV Community Test Site work to control and reduce the spread of sexually transmitted diseases. Despite successes, the STD program is doing more with fewer personnel resources. Over the past several years, the reduction of federal funding for partner notification has impacted our capacity to provide quality STD prevention services. At this time, we are ill-equipped to respond to continued increases in morbidity or the possibility of an outbreak.

The Communicable Disease, STD Clinic and HIV Prevention, and Immunizations Programs are working closely together to develop Hepatitis C testing and referral strategies, as well as Hepatitis A and B vaccination series for uninsured persons infected with Hepatitis C. Hepatitis C services are also being integrated into existing disease prevention services. MCHD is developing a community planning process that will include representatives from the Recovery Association Project, service providers and others affected by the epidemic to better inform our program decisions for Hepatitis C.

The Environmental Health Services Program provides education, assures safe food, controls diseases that can be acquired from food and water, improves safety in the workplace, reduces unintentional injuries and incorporates prevention activities into the inspective process. We recently joined forces with Washington County to develop a food service inspection program management software packet. Vector Control monitors mosquito populations for vector borne diseases and targets flood plains and other breeding areas for control efforts. Programs, such as childhood lead, asthma and cleanup of polluted industrial or commercial properties, have historically been supported by one-time only categorical funding in our community and have never been tied to a department-wide strategic direction to keep them in place once outside funding was reduced. As a result, we continually face the challenge of not being able to meet the needs of our community, particularly low-income marginalized communities hardest hit by environmental contaminants. It is essential that we begin a comprehensive community planning effort to identify strategic actions to reduce environmental risk. However, these funds are currently not available

b. Describe extent to which provides five basic services contained in statute (ORS 431.416).

MCHD provides services for the epidemiology and control of preventable diseases and disorders through the following programs: Immunizations, Disease Control and Occupational Health, Tuberculosis Prevention and Treatment Center, HIV Prevention Services, HIV Care Services Planning and Administration, HIV Health Services, Sexually Transmitted Disease Clinical Services and Epidemiology, Childhood Lead Poisoning Prevention Project and Environmental Health Services.

We play a vital role in protecting and promoting the health of the maternal and child health population in our county, including the active provision of family planning services and have the responsibility to assure that the needs of women, infants, children and adolescents are adequately addressed and necessary resources are available and policies are enforced. MCHD is responsible for providing, contracting or contributing resources in the following areas of maternal and child health services:

Childhood immunizations; Maternal health programs; Family planning services; Prenatal care; and Lead screening and abatement.

Our Neighborhood Health Division serves clients where they are: in their homes, in shelters, at school and other community sites. Our School-Based Health Centers program is regarded as one of the top programs in the country and provides preventive and primary health and mental health care, health education, and health referrals to students in 13 schools at on-site health centers. We also offer the Students Today Aren't Ready for Sex (STARS) program. The Department's Connections Program and Waiting for Your Next (also known as Life Skills) provides health, social and parenting assessment for teens parents throughout the county. Our Women, Infants and Children (WIC) nutrition education program provides supplemental foods and promotes good health for pregnant, breastfeeding and postpartum women, infants and children up to age five. MCHD also works on eliminating the disparity of African American infant mortality rates and promotes healthy birth outcomes through the Healthy Birth Initiative. Case managers recruited from the community share health education and connect clients to needed parent and child services. Our community health nurses work with the families of children with disabilities, provide case management to addicted and incarcerated pregnant women while they are in jail and after they are releases, work with families affected by alcohol and/or drugs who have been reported to the Child Protective Services hotline.

Last year our Primary Care Clinics provided over 97,000 primary care visits to low-income and high-risk residents, including 9,513 family planning visits and 8,252 well child visits. Prenatal care client caseload increased 11% from the previous year, with 65% of the pregnant women starting prenatal care in the first trimester. MCHD's Dental Clinics provide oral preventive, restorative and emergent dental care services to low-income clients with access to preventive, restorative, and emergent dental care.

Within the Director's Office, we are responsible for the collection and reporting of health statistics and provides planning and data management, grants development, oversees community health initiatives and program evaluation. Through the guidance and support of the Oregon Health Division we have been able to strengthen our ability to routinely collect and store existing data as well as improve our ability to examine aggregate health and demographic information about the residents of our county.

Our Support Services Division is responsible for health information and referral services and provides diagnostic, pharmaceutical and ancillary health services. This Division is responsible for the operation of laboratory and pharmacy services, medical supplies, forms and pamphlets, language services, information and referral services, medical records management and the coordination of facilities. The Information and Referral Unit consists of three complementary programs: Health Information and Referral (I&R) serving Multnomah County; Oregon SafeNet working closely with the Oregon Health Division as a resource for social marketing campaigns statewide; and the Teen Health InfoLine providing health and sexuality information and referral services to Oregon's teens and their families. I&R was a key health care access point for 81,379 clients this year. Limited-English visits for FY 98-99 totaled 96,346, representing a 39% of the Department's total visit volume. I&R provide Spanish, Russian, and Vietnamese interpretation, schedule financial eligibility screening appointments and advocate for callers experiencing barriers to services. The most frequently requested services are primary care, immunization, family planning, pre-and peri-natal care, and dental care.

We foster a safe and healthful environment and actively promote environmental health services policies and practices related to lead poisoning, asthma, tobacco and food safety. We inform the community on children's environmental issues and provide resources and technical assistance. Our Health Officer

plays an active role in protecting and enhancing public health by enforcing public health laws and regulations and helping to analyze a wide range of community health problems. The Childhood Lead Poisoning Prevention Program prevents and reduces lead hazards for pregnant women and children. The Environmental Health Unit regulates businesses and accommodations and enforces state and local environmental health laws and rules. Vector Control controls rodents and mosquitoes and enforces nuisance abatement codes within the City of Portland and in unincorporated areas within the County.

c. Describe extent to which provides essential public health services that provide assessment, policy, assurances and research.

We monitoring the health status of our community in order to identify and solve community health problems. This involves the timely collection, analysis and publication of information on vital statistics and health status of the community and specific groups at higher risk than the population as a whole; access, utilization, costs and outcomes of personal health care services; and identification of threats to health and assessment of health service needs. We diagnose and investigate health problems and health hazards in our community. This involves epidemiologic identification of emerging health threats, public health laboratory capabilities through the use of modern technology to conduct rapid screening and high volume testing; active infectious disease epidemiology programs; and technical capacity for investigation of disease outbreaks and patterns of chronic disease and injury.

We inform, educate, and empower individuals throughout our community about individual and population-based health issues. This involves providing accessible and accurate health information resources to the community, active partnerships with personal health care providers to reinforce public health issues, and collaborative health promotion and education programs with schools, community-based organizations, churches and worksites. We encourage and mobilize community partnerships and activities to identify and solve health problems, including the role of convener and facilitator of community groups and dialogues, and active coalition-building ability in order to draw upon the full range of resources in our community to address public health issues. We bring together community partnerships, policymakers, providers, families, and general public to identify and solve issues affecting our community. We develop public health policies and plans that support individual and community health efforts. This involves providing leadership for priority setting, comprehensive local and state level planning for health improvements throughout Multnomah County and Oregon and developing and tracking measurable health objectives as part of our continuous quality improvement effort, and actively develop codes, regulations and legislation to guide public health practice.

We enforce law and regulations that protect health and ensure safety and are accountable for the well-being of community members. This involves the full enforcement of sanitary codes, especially in the food industry; protection of drinking water supplies; and timely follow-up of hazards, preventable injuries, and exposure-related diseases identified in occupational and community settings. We link individuals to health and other community and family services, and assure access to comprehensive quality systems of care when otherwise unavailable. This involves assuring effective access for disenfranchised individuals into a coordinated system of clinical care. We provide culturally and linguistically appropriate materials and staff; and provide technical assistance for effective worksite health promotion and disease prevention programs. We work to assure a competent public health and personal health care workforce. This involves education and training for personnel; the use of efficient processes for professional licensure and facilities certification with regular verification and inspection follow-up; adoption of continuous quality improvement. Staff receive training on confidentiality and culturally appropriate and competent methods. The Joint Commission on Accreditation of Healthcare

Organizations accredits our Primary Care Clinics and laboratory services. We evaluate the effectiveness, accessibility and quality of personal care and population-based health services, including evaluation of ongoing public health programs and needs assessment projects using health status and service utilization data, for the purposes of informed decision-making, resource allocation and program modification.

MCHD also actively participates and supports epidemiological and economic analyses and health services research to gain new insights and innovative solutions to health problems. We have continuous linkages with national public health organizations, institutions of higher learning and research, and disseminate public health research and evaluation findings, by giving presentations at professional meetings, providing guidance to councils and advisory boards, and by publishing articles in national peer-reviewed journals.

3. *Describe an action plan for the public health improvement plan. For each component or strategy of the plan provide:*

- a. Current condition**
- b. Goals**
- c. Activities**

The Multnomah County Health Department Public Health Improvement Plan builds upon local and regional assessments, community planning activities, and national goals, and is influenced by our three year Strategic Plan. The strategies identified in our Public Health Improvement Plan are:

- Community Health Assessment;
- Community Environmental Health;
- Community Solutions Grants/Public Health Talks;
- Hepatitis C;
- Sexually Transmitted Disease Partner Notification;
- Heroin Overdose Deaths;
- Healthy Birth Initiative;
- Healthy Start;
- Community Dental Collaborative; and
- Community Health Worker Capacitation Center.

Community Health Assessment

Current Condition: The Health Department is currently strengthening its community health assessment/epidemiology function in order to forge new and stronger community collaborations to improve the Health of Multnomah County residents. While we have developed the capabilities to provide information on health statistics and basic demographic and socio-economic characteristics, we need to strengthen our ability to conduct on-going community health assessments. We need to focus on developing systems for data collection, management, analysis and dissemination on a regular basis and develop a community pathway for better citizen participation in Health Department policies and decision-making.

Goals: Our goals for this project are to expand data sources used in health assessments and to develop systems to routinely analyze the expanded data sources; to develop and disseminate a community health profile report every two years integrating quantitative and qualitative information; and to increase the understanding and promotion of public health issues among the general public.

Activities: The first phase of the project focuses on assessing data sources and developing data systems to support on-going community health assessment. The second phase involves the development of a community health profile. Using existing data sources we developed a community health profile entitled "The Health of Multnomah County." The profile provides a snapshot, blending quantitative and qualitative statistics and information about the health issues facing our community and forms the basis for a series of on-going analyses and dialogues with the community. The third phase of our work is to engage in discussions with the community through the use of the community health profile. This past summer a series of community focused discussion groups (comprised of individuals from community-based organizations, schools, elected office, and public health) met to review the community health profile. This next year we will continue to create a shared vision of health as individuals from our community are encouraged to think and talk about broad public health issues through the Community Health Assessment Project.

Community Environmental Health

Current condition: Competing and uncoordinated interests in the area of community environmental health exists and not all issues receive equitable attention and funding. Asthma, childhood lead poisoning and industrial/commercial Brownfield sites are three areas where we need more collective appreciation and understanding for the significant impact they have on the health of our community.

Typically, the communities that reside near commercial or industrial properties with possible contamination are low-income, communities of color, and medically underserved. Children particularly suffer disproportionately from environmental health risks, with the percentage of children with asthma rising rapidly. Data continues to point to asthma as one of the leading causes of school absenteeism, limited physical activity and serious impact on the entire family. Lead exposure among children in Multnomah County continues to be one of the most common preventable pediatric health issues today, and disproportionately affects children of color. Children with elevated lead levels may suffer from learning disabilities, mental retardation, behavioral problems, lowered IQ, stunted growth and hearing impairment. A recent study conducted by the MCHD found that 70% of homes built before the 1930s in our community contain potential lead dust hazards. There are an estimated 500 Brownfield sites in North/Northeast Portland, the most racially diverse and lowest income area in Portland.

Despite the prevalence and significance of asthma, childhood lead poisoning and Brownfield sites, we currently do not have the capacity to analyze data and work with communities to help develop a prioritized comprehensive long-term local public health policy response. MCHD seeks to help identify populations disproportionately at risk of exposure and adverse health outcomes and set priorities for local solutions to address community environmental health concerns through the Community Environmental Health project.

Goals: The goals of the project are to utilize a model to acquire community input into a local environmental health plan and to develop and implement a strategy that supports community members' understanding of the potential health risks of Brownfield sites and ensures that redevelopment activities do not present health hazards to community residents. The project will also sustain integration of blood

lead testing with other childhood disease prevention efforts targeted to low income populations, maintain a lead poisoning prevention information and referral phone service/web site, sustain elevated blood lead investigation services and integrate resident-based lead hazard reduction services into child health field services.

Activities: Activities for the project include conducting a community-based environmental health assessment based on the Protocol for Assessing Community Excellence in Environmental Health developed by the Centers for Disease Control and the National Association of County and City Health Officials. This assessment will evaluate local environmental health concerns and conditions, populations at risk, environmental health data and set local action priorities. We will utilize community outreach workers who are supported by environmental health professionals to provide education and raise community awareness on Brownfields, with possible contamination. Environmental health education programs will be developed in collaboration with Portland Community College. Activities will also involve participating in local community events and forums as well as policy-level groups such as Portland Brownfields Showcase Steering Committee. Testing and follow-up of children at community immunization clinics will be carried out, as well as providing information on childhood blood lead and follow-up referrals through the Department's Health Information and Referral system. Technical assistance for environmental health investigation for lead sources will be provided for children identified with elevated blood lead levels. Field-based community health workers will be trained on how to use motivational-oriented training for new parents to reduce lead dust risks in their homes.

Community Solutions Grants/Public Health Talks

Current Condition: With recognition of the need to hear all the voices, we must search throughout our community for solutions to Multnomah County's public health challenges. We need to move away from single-issue discussions to broader public health issues, and we need to engage residents directly to find these solutions. Our ability to identify strategic actions that can strengthen the public health system and encourage new ones to emerge will be accomplished with two new strategies: Community Solutions Grants and Public Health Talks. Both of these strategies will engage public health officials and residents in collective learning and will inspire us to find common ground and build improved connections, trust, and outcomes.

Goal: The goal of the Community Solutions Grants is to look around us for individuals and organizations throughout the community and enlist them to find the solutions to critical public health issues. The goal of the Public Health Talks is to serve as a forum for public health officials and residents from all places within our county to engage in conversation on public health issues that they feel are most pressing.

Activities: Twenty-five Community Solutions Grants will be made available for \$1,000 each. Individuals and community-based organizations will be asked to submit a proposal indicating the specific use and geographic location and efforts must focus on one of the areas identified in the Multnomah County Public Health Improvement Plan.

Public Health Talks will bring together diverse voices from across our community to meet for a series of six dinners and will focus on small group dialogues (no lectures.) The Health Department will work with a local community-based organization experienced in the logistics of hosting groups of individuals to provide food for the dinners. From the dinners a written document capturing the group's knowledge

and perspective on public health issues discussed will be written and disseminated to all participants and placed on the Health Department's web site.

Hepatitis C

Current Condition: Hepatitis C virus is the most common chronic blood borne infection in the United States, and public awareness of Hepatitis C in Multnomah County is on the rise. The Multnomah County Health Department is a leader in providing hepatitis prevention services to Oregon's most concentrated population of residents who are at-risk for the disease. As the county's designated local public health authority, the Health Department documents all reportable conditions/diseases in Multnomah County, including viral hepatitis. Reducing the burden of Hepatitis C infection in Multnomah County requires implementation of primary prevention activities that reduce risk for contracting the infection and secondary prevention activities that reduce both risk of transmission and risk for liver and other chronic disease in Hepatitis C infected persons. The Hepatitis C Prevention program will be initiated by the Health Department during the Fall of 2000. The proposed components of the program include outreach and education, counseling and testing, vaccinations, referrals and the establishment of an HVC prevention community planning process.

Goals: The Two primary goals associated with the delivery of Hepatitis C prevention service are the need to integrate viral hepatitis prevention services into existing disease prevention control programs, and the need to provide an extensive evaluation of the costs and effectiveness of integrating hepatitis prevention services into the Health Department's existing disease prevention control programs and services.

Activities: This work will be achieved by organizing work groups to represent a broad range of expertise essential to the establishment and implementation of effective disease prevention program (e.g., public policy, epidemiology, data analysis, service delivery, program evaluation, and outreach. We will also implement a Hepatitis C Prevention Community Planning Process and conduct an assessment of existing disease prevention programs and services. We will identify additional viral hepatitis prevention services to be integrated into existing disease prevention services and develop specific hepatitis prevention services for populations that are at-risk for the disease. We will prepare written protocols to integrate hepatitis prevention services into the Department's existing disease prevention programs, and engage drug and alcohol treatment centers, homeless shelters, and other community-based organizations that work with the target population to deliver Hepatitis C prevention services.

Sexually Transmitted Disease Partner Notification

Current Condition: Partner notification is a sexually transmitted disease (STD) prevention strategy that has been a fundamental element of public STD clinics for years. Partner notification is conducted by Disease Intervention Specialists who work with clients to identify partners exposed to an STD for the purpose of notification and referral of these individuals to ensure they are examined and treated. Treatment of exposed or infected partners prevents re-infection, reduces the risk of complications associated with untreated infections and prevents transmission to future partners. STD Partner notification benefits the individual, partners, and the community. Over the past several years, the reduction of federal funding to the State of Oregon for partner notification has impacted our capacity to provide quality Disease Intervention Specialists services. Staffing cuts have made it difficult to case manage standard morbidity levels and maintain any semblance of a community connection (so key to

our ability to be effective.) With increases in STD morbidity, Disease Intervention Specialists' caseloads are high and they are struggling to conduct active outreach to difficult-to-reach individuals and populations. At this time, we are ill equipped to respond to continued increases in morbidity or the possibility of an outbreak.

Goal: The goal of the STD Partner Notification strategy is to improve our ability to case manage standard morbidity levels and maintain our community presence by restoring funding for quality and effective partner notification.

Activities: For this strategy we will continue to develop partnerships with programs throughout the county that provide services to high risk populations and will provide screening and outreach activities within these high-risk networks. Three new positions need to be added. These are two Disease Intervention Specialists and one support position for data collection and case assignment.

Heroin Overdose

Current Condition: Heroin overdose deaths have increased steadily in Multnomah County between 1993 and 1999. Most of these deaths were long-term users and half were 45-54 years old, 23.1% were 35-44, 22.9% were 25-34, and 4.9% were younger than 25. The race/ethnicity of people who died of heroin overdose reflected the county population. Sixty percent of heroin overdose deaths occurred in users' homes or friends' homes, only 18.8% occurred in public settings. Toxicology testing revealed that 58.3% of heroin overdose deaths involved alcohol and/or other drugs in addition to heroin. The substances most commonly identified along with heroin were cocaine (26.1%), benzodiazepines (15.7%), and alcohol (10.4%).

Ethnographic interviews with heroin users showed that "black tar" heroin is the primary type used in the community, and that heroin and other drugs are readily available and inexpensive. Heroin users reported great variability in the potency of heroin. They perceived interruption of heroin use (involuntarily, when incarcerated or lacking money, and voluntarily, during attempts to stop using) as a risk for overdose. Regardless of the reason for the interruption, users reported they tended to resume injecting heroin at their usual dose and sometimes overdosed. Users also believed that risk for overdose was greater when they used alcohol and other drugs with heroin, injected heroin without companions, and had another person inject drugs for them. Three fourths of heroin users reported that they hesitated to call 9-1-1 for a companion's overdose because of fear of being arrested. Instead, they often attempted to resuscitate overdosed companions on their own or left them in public places, hoping that they would be discovered and helped by others.

Goal: The primary goal of this strategy is to decrease heroin overdoses and heroin overdose deaths in Multnomah County and Oregon through the development and implementation of a comprehensive harm reduction information campaign targeted for heroin users.

Activities: We will develop a comprehensive set of messages that are well understood, well accepted and effective in the heroin-using population. This work will follow the example of New South Wales, Australia, and use an advertising/ marketing approach to develop messages and associated media/materials. Activities will all be carried out in partnership with current and former heroin users who are representative of the at-risk long-term user population. We will also complete the work of the current emergency 9-1-1 Overdose Work Group, a multi-agency group that has been working since March 1999 to examine the 9-1-1 response to overdose and to consider response system changes, and

we will create an ongoing training program for all workers involved in local heroin overdose reduction outreach.

Healthy Birth Initiative

Current Condition: Although infant mortality rates and rates of low birth weight in Multnomah County have declined since 1991, rates remain alarmingly high for African Americans. The African American infant mortality rate is near twice the rate for Whites in Multnomah County. The low birth weight rate continues to be higher among African Americans than among other racial/ethnic groups. A disturbing rate has also recently emerged. The low birth weight rate for Hispanic women has gone up over time from 47.0 to 61.8 per 1,000 births between 1990 and 1998, representing a 31% increase. In 1997, the Health Department was awarded a national Healthy Start Grant focusing on 38 census tracts located in North and Northeast Portland. The project, Healthy Birth Initiative, uses intensive case management relying primarily on indigenous lay workers with support and consultation from Community Health Nurses to serve high-risk women in this area. As of August 2001 the Healthy Birth Initiative will lose its funding. Despite significant improvements seen through the project much more needs to be accomplished as health disparities in infant mortality and low birth weight rates continue to exist for African Americans and Hispanics in our community. The Healthy Birth Initiative Community Consortium, an advisory council made up of community members, program participants, agency staff and others with an interest in promoting healthy birth outcomes, is seeking additional funding to continue with the project goals and activities. Such a focused strategy is absolute necessary if we are going to improve birth outcomes and work toward eliminating disparities in vulnerable populations.

Goals: The goals of the Health Birth Initiative are to reduce infant mortality in the project area; reduce the percentage of low birth weight births in the project area; reduce behavioral risk factors during pregnancy associated with low birth weight and infant mortality in the project area, such as tobacco use, drug and alcohol use, late entry into prenatal care, and develop community involvement and support for these maternal and child health issues.

Activities: The project activities involve continued development of community leadership through the Healthy Birth Initiative Community Consortium; case management services relying on indigenous lay workers with support and consultation from professional workers to serve high-risk women; culturally relevant education and information to women and family members on childbirth, breastfeeding, parenting, nutrition, and healthy pregnancy and healthy babies; and child care and transportation opportunities for women enrolled in the project.

Healthy Start

Current Condition: Multnomah County also faces a growing need for home visiting services because of the changing community demographics and an anticipated decrease in early childhood program funding. Due to the large volume of referrals received to assess new families and children and the larger than recommended caseload size of field staff, current funding and staffing prevents us from meeting the home visiting needs of all pregnant women and families with young children. Recently, Multnomah County was selected as a David Olds Nurse Home Visiting Replication Site for a small geographic area of the county. The Health Department would like to take the David Olds model to scale and provide nurse and community health worker home visiting services to families throughout the entire geographic area of Multnomah County.

Goal: The program will focus on all first-birth families and will ensure that all have access to a comprehensive, coordinated, community-based system of supports that promotes healthy family development.

Activities: The Healthy Start Team will visit with the staff of key local agencies and organizations to become more familiar with the range of services available throughout Multnomah County. In addition to Community Health Nurses, Community Health Workers will facilitate support and education groups that meet specific identified needs, tailored to the culture and time constraints of new families. In addition to home visits by Community Health Nurses, and support and education groups by Community Health Workers, participants in the program will participate in other activities, including consultation and in-home visits from a Family Services Coordinator/ Community Health Nurse, consultation and home visits from a Mental Health Consultant, and participation in numerous community activities and events.

Community Dental Collaborative

Current Condition: Currently, dental clinics operated by the Multnomah County Health Department serve a limited number of uninsured clients for emergent dental care services only. The key access limitation to dental services for the working poor and uninsured in Multnomah County is the lack of available dental care providers. Even though Multnomah County has the highest number of dentists per capita in the state, we have been designated a "Dental Health Professional Shortage Area" for indigent care by the United States Department of Health and Human Services. Consequently, a growing number of people must travel to other parts of the metropolitan area in order to access providers to meet their dental care needs, or they must do without care. In addition to access issues, the fact that Multnomah County is a Dental Health Professional Shortage Area is causing a strain on both the public and private dental care delivery system, resulting in crowding conditions causing some providers to limit or eliminate certain services, especially hard hitting to the working poor and uninsured.

In an effort to address the growing need for dental care for the working poor and uninsured within our community that government programs, nonprofit organizations and educational institutions have been unable to address, the Multnomah County Health Department, together with Neighborhood Health Clinics, Inc., Oregon Health Sciences University School of Dentistry, Mount Hood Community College and Portland Community College, are seeking to establish the East Multnomah Community Dental Collaborative. The Community Dental Collaborative seeks to establish a dental care delivery system for working poor and uninsured clients living in East Multnomah County.

Goals: The Community Dental Collaborative is designed to provide access to comprehensive oral health services for 7,500 uninsured clients per year, to create opportunities for graduate-level education, and to expand volunteerism among professionals.

Activities: The Community Dental Collaborative will involve establishing dental service capabilities at a new Multnomah County Health, Aging and Disabilities Services Building in Gresham, Oregon (i.e., purchase dental equipment, hire professional dental staff, conduct community outreach, and establish evening clinics.) The Collaborative will be housed in a new joint community facility that will provide a variety of different health and social services under the same roof (i.e., one-stop shopping.) Other activities involve developing collaborative learning institution practicum site agreements for 52 graduate level dental students per year; and developing volunteer-based dental provider agreements for service provision on-site at the new community facility.

Community Health Worker Capacitation Center

Current Condition: As our communities become more diverse and the health care system more difficult to navigate, there is an increased need for people who can serve as a bridge, who can share health education and information in ways people can understand, and who can work with communities to resolve their own health problems. The Multnomah County Health Department has employed Community Health Workers for over 25 years and believes they play an important role in our work for all individuals in our community. As the need for Community Health Workers has increased, the need for high-quality, effective training for Community Health Workers can no longer be ignored.

Currently, no centralized Community Health Worker training program exists in the state of Oregon. Inspired by numerous examples around the country, the Multnomah County Health Department in collaboration with the Community Health Worker Committee of Oregon Public Health Association has identified the establishment of a Community Health Worker Capacitation Center as one of its primary goals. (Capacitation comes from the Spanish "capacitar" and means to build capacity.) The curriculum for the Community Health Worker Capacitation Center is divided into three components: health issues, orientation to the health and social service system, and skill base. In order to realize the full development of the Center, funding and dedicated staff is now urgently needed. When it is fully operational, the Community Health Worker Capacitation Center will serve all the employers of Community Health Workers in Oregon and SW Washington by providing high-quality, effective initial and on-going capacity-building, improving the capacity and quality of outreach in smaller organizations, as well.

Goals: The goals of the Center are to develop a governance and management structure; to fully develop the curriculum; to establish a firm financial foundation; to develop the Center's physical plan; and to market the Center to area employers.

Activities: In order to achieve our goals we will develop an Advisory Board for the Center; hire staff and develop policies and procedures for the Center. A curriculum and competency-testing system will be developed, and the Center will build a contractual base through agreements with employers of Community Health Workers. Space to house the Center and needed equipment will be identified. A development campaign to create a permanent physical plant for the Center will be initiated and a market analysis will be conducted. Potential Community Health Worker employers will be informed and educated about the benefits of a centralized capacitation program.

E. *Unmet needs*

The collection of strategies/action plans identified in our Public Health Improvement Plan is intended to be used as a guide, and does not represent all the strategies needed to address fully every public health issue in our community. Even if we had the resources to fund these strategies many unmet needs remain. As part of our Public Health Improvement Plan, unmet needs have been identified and represent the work that still needs to be done to move us as individuals and as a county toward a healthier future. These unmet needs include:

- Eliminating health disparities;
- Access to health care for all residents of our community;
- Providing language interpretation for all non-English speaking health care clients;

- Maternal and child health;
- Diabetes;
- Injury prevention;
- Mental health; and
- Sexual minorities.

Eliminating Health Disparities: While poor health of many residents of Multnomah County is due to poor diet, smoking and other lifestyle choices, too many of our neighbors continue to face poor health outcomes not out of personal choice but out of the growing racial and ethnic disparities gap that persists in this country. Despite improved medicine and technology, social and economic conditions continue to foster health inequalities in Multnomah County, and it is people of color and people who live in poverty who are more likely to be burdened with substandard housing, lack of access to health care, environmental health risks, lack of understanding of cultural differences and public policy decisions that contribute to these poor health outcomes. The Health Department is dedicated to eliminating health disparities by working to educate our community about the disparities and why they exist, by listening to our community and by skillfully working to increase the impact of our limited public resources.

Access to Health Care: Although many factors affect health status, the lack of health insurance and barriers to obtaining quality and culturally competent health services markedly diminish communities of color and low-income individuals' use of both preventive services and medical treatments. While we provide direct primary care services, we alone cannot meet the health needs of our community and need to assure that others contribute to the delivery of personal care services. The Health Department strives to increase access to high quality personal care services by promoting positive relationships among organizations involved in health care, and ensure that emerging underserved populations are identified and their needs addressed. Our long-range goal is to build a local infrastructure to sustain and support our community in providing personal health care delivery, education, employment and social services and need to continue to bring together a wide range of partners to bring a community voice to policy makers to address the health care needs of the working poor and uninsured.

Language Services: As part of its mission to ensure access to care, the Health Department provides language interpretation for all non-English speaking clients receiving clinical services, including WIC and home nursing field visits. Since the 1990s interpreted visits at Health Department clinical sites have risen dramatically, primarily due to an increasing number of visits to Spanish language clients. Fifty-four percent of the 94,436 visits to primary care sites required interpreter services, and the time spent by providers for an interpreted visit is nearly double the time spent for similar non-interpreted visits. With this increasing need to care for all non-English speaking clients, the current number of Multnomah County Health Department bilingual staff is not adequate to meet the demand for interpreted services. With a commitment to deliver quality care to all low income and uninsured limited English speaking county residents and at the same time accountable to contain the rising costs of providing interpreted care, the Health Department is faced with finding new and creative ways to meet the language and health care needs of our community. The key question is how to provide language services for our clients in the most effective and efficient manner. There are a number of models used around the country and research and review must be conducted to find the model that would best meet the needs of our changing community.

Maternal and Child Health: To achieve further improvements in maternal and child health in Multnomah County, we must focus on modifying the behaviors and conditions that affect birth outcomes, such as smoking, substance abuse, poor nutrition, stress, domestic violence, lack of prenatal care, medical problems, and chronic illness. Our efforts must address health disparities by focusing on socioeconomic and demographic factors and quality of and access to health care for all individuals living in our county. Specific areas for improvement include availability of affordable and quality child care; availability of family planning services to all men and women, including state mandated coverage of contraceptives by health plans for working men and women; availability of family planning to the uninsured; availability of prenatal care to the working poor and uninsured to assure access to early entry into prenatal care, addressing the needs of communities of color, and efforts to make maternal use of tobacco unacceptable during pregnancy.

Diabetes: Diabetes is a serious chronic disease that requires intense management. By maintaining a strict regimen of testing and medical check-ups, regular blood glucose monitoring, proper nutrition, sufficient exercise, and general health promotion, complications related to diabetes can be delayed and even prevented. Diabetes that is out of control for prolonged periods can lead to any number of problems including eye damage, circulatory problems, and kidney damage. People who have diabetes and who smoke or are overweight are at increased risk for complications. The burden of diabetes falls heavily on communities of color. For the time period 1990-1997, the age-adjusted average diabetes death rate for African Americans in Multnomah County was more than 2.5 times higher than the rate for Whites (47.2 for African American, 18.2 for Whites). During this same time period, the age-adjusted average diabetes death rate for Hispanic county residents was also higher than those of Whites (19.5 for Hispanic). Not only is the disease more prevalent, the risk of complications is also higher in communities of color than in the majority community. Our challenge is to make appropriate and effective diabetes management part of routine clinical and public health practice and will require an intensified commitment in health care systems and the broader community to improve rates of early detection, screening for complications, and diabetes management, especially in communities of color.

Injury Prevention: Injury is the leading cause of death and disability among children and young adults in Multnomah County. It is the leading cause of death of children ages one to nine and one of the leading causes of death for adolescents 10 to 19 in Multnomah County between 1990 and 1997. During this same time period, injury was the leading cause of death for all adults ages 20 to 24. After this age grouping, though, it is men and women of color in our community who bear the disproportionate burden of death from injury. For 25 to 44 year old males and females, injury was the leading cause of death for African Americans, American Indians, and Hispanics. Deaths, due to injury, were caused by drug overdoses (including heroin deaths), motor vehicle accidents, drowning, and poisoning. Much can be done to reduce the burden of injury among the residents of Multnomah County, and the Health Department needs to play an important role in injury prevention efforts. We need to continue to establish relationships and form partnerships with other local organizations, citizens and the media to bring this serious public health issue to the forefront to address risk factors and disparities associated with the death and disability related to injury.

Mental Illness: The marginalized status of individuals with mental issues, coupled with homelessness and inadequate access to health care results in a considerable unmet need in our community. Homeless individuals with mental illness are disproportionately affected by HIV/AIDS. Many individuals with mental illness rely on their mental health professional to act as their primary care provider. We remain committed to our clients with acute and chronic health and behavioral conditions and work diligently to establish and maintain effective linkages with specialty mental health systems and alcohol and drug treatment programs to facilitate referral of clients with specialty care needs. More effective prevention programs, however, are needed to address the personal and environmental obstacles to safe sexual practices, inadequate or inappropriate health care, and alcohol and other substance use issues that exist for those who are homeless and mentally ill.

Sexual Minorities: While the health concerns of most gay, lesbian, bisexual and transgender individuals are similar to those facing all residents of Multnomah County, sexual minorities are at increased risk for some health problems. Many of these stem from discrimination and violence and place them at increased risk for mental health issues, lung cancer, emphysema and heart disease from cigarette smoking, lack of access to health insurance due to lack of workplace policies covering unmarried partners, finding culturally competent health care providers, lack of awareness of domestic violence, lack of culturally-appropriate health information and education, sexually transmitted diseases, homelessness, and youth suicide.

F. Budget The funds that are proposed under this initiative are listed in Appendix A. Planning for this initiative should be based on the column "New State Support for Public Health" listed in Appendix B. The availability of these funds is pending legislative approval. The formula for the funds is per capita with a minimum base of \$50,000. The funding distribution is based on 1999 Census estimates and legislative appropriation.

Community Health Assessment Project		MCHD In-Kind	Needed	Total
1.0 FTE	Health Services Specialist	\$0	\$63,384	\$63,384
0.5 FTE	Data Analyst	\$26,724	\$26,724	\$53,448
0.5 FTE	Program Development Specialist	\$26,075	\$26,075	\$52,150
Materials/Supplies		\$35,000	\$35,000	\$70,000
Printing		\$0	\$25,000	\$25,000
Community survey		\$0	\$50,000	\$50,000
Focus groups		\$0	\$9,000	\$9,000
Food		\$0	\$1,000	\$1,000
Room rental		\$0	\$1,000	\$1,000
Graphic artist		\$0	\$5,000	\$5,000
subtotal		\$87,799	\$242,183	\$329,982
indirect costs @12.81		\$11,247	\$31,024	\$42,271
Total		\$99,046	\$273,207	\$372,253

Community Environmental Health		MCHD In-Kind	Needed	Total
1.0 FTE	Health Services Specialist	\$0	\$63,384	\$63,384
1.0 FTE	Program Development Specialist	\$0	\$53,448	\$53,448
1.0 FTE	Office Assistant II	\$0	\$35,985	\$35,985
0.15 FTE	Health Services Administrator	\$0	\$41,434	\$41,434
1.0 FTE	Community Health Worker II	\$0	\$44,163	\$44,163
0.5 FTE	Environmental Health Specialist	\$0	\$23,918	\$23,918
sub-total		\$0	\$262,332	\$262,332
Materials and Supplies		\$0	\$78,700	\$78,700
Screening and follow-up		\$0	\$57,186	\$57,186
Lead Information and Referral		\$0	\$52,719	\$52,719
Elevated Blood level investigation		\$0	\$24,830	\$24,830
Training		\$0	\$30,000	\$30,000
sub-total		\$0	\$505,767	\$505,767
indirect costs @ 12.81%			\$64,789	\$64,789
Total			\$570,555	\$570,555

Community Solutions/Public Health Talks		MCHD In-Kind	Needed	Total
0.5 FTE	Health Services Specialist	\$31,692	\$31,692	\$63,384
0.5 FTE	Program Development Specialist	\$26,724	\$26,724	\$53,448
0.5 FTE	Office Assistant II	\$17,993	\$17,993	\$35,986
sub-total		\$76,409	\$76,409	\$152,818
Materials and Supplies		\$22,923	\$22,923	\$45,845
Grants	\$1,000 @ 25	\$0	\$25,000	\$25,000
Six hosted dinners	\$1500 each	\$0	\$9,000	\$9,000
sub-total		\$99,332	\$133,332	\$232,663
indirect costs @ 12.81%		\$12,724	\$17,080	\$29,804
Total		\$112,056	\$150,411	\$262,468

Hepatitis C		MCHD In-Kind	Needed	Total
0.05 FTE	Principal Investigator	0	\$6,151	\$6,151
0.8 FTE	Health Services Specialist	\$51,833	0	\$51,833
0.5 FTE	Sr. Data Analyst	\$0	\$33,842	\$33,842
0.5 FTE	Program Development Specialist	\$13,087	\$13,085	\$26,172
1.0 FTE	Health Information Specialist II	\$0	\$43,382	\$43,382
1.0 FTE	Health Information Specialist II	\$0	\$43,382	\$43,382
	sub-total	\$64,920	\$139,842	\$204,762
	Travel	0	\$4,442	\$4,442
	Supplies	\$44,970	\$67,719	\$112,689
	Other		\$22,353	\$22,353
	sub-total	\$109,890	\$234,356	\$344,246
	indirect costs @ 12.81%	\$14,077	\$30,021	\$44,098
	Total	\$123,967	\$264,377	\$388,344

Sexually Transmitted Disease Partner Notification		HIV Block Grant	MCHD In-Kind	Needed	Total
2.0 FTE	Disease Intervention Specialist	\$0	\$0	\$104,000	\$104,000
0.5 FTE	Health Information Specialist II	\$0	\$0	\$24,000	\$24,000
3.0 FTE	Disease Intervention Specialist	\$0	\$156,000	\$0	\$156,000
1.0 FTE	Disease Intervention Specialist	\$52,000	\$0	\$0	\$52,000
	sub-total	\$52,000	\$156,000	\$128,000	\$336,000
	Materials and Supplies	\$0	\$46,800	\$38,400	\$85,200
	sub-total	\$52,000	\$202,800	\$166,400	\$421,200
	indirect costs @ 12.81%	\$0.00	\$25,979	\$21,316	\$47,295
	Total	\$52,000	\$228,779	\$187,716	\$468,495

Heroin Overdose Deaths		MCHD In-Kind	Needed	Total
0.1 FTE	Health Officer	\$13,126	\$0	\$13,126
0.2 FTE	Health Services Administrator	\$4,473	\$0	\$4,473
0.1 FTE	Principal Investigator	\$8,496	\$0	\$8,496
	sub-total	\$26,095	\$0	\$26,095
	Focus Groups	\$0	\$15,000	\$15,000
	Advertising Consultant	\$0	\$5,000	\$5,000
	Graphic Artist	\$0	\$3,000	\$3,000
	Printing/Distribution	\$15,000	\$4,000	\$19,000
	sub-total	\$15,000	\$27,000	\$42,000
	indirect costs @ 12.81%	\$1,922	\$3,459	\$5,380
	Total	\$43,017	\$30,459	\$73,475

Healthy Birth Initiative		MCHD In-Kind	Needed	Total
<u>Case Management</u>				
	Personnel	\$0	\$127,713	\$127,713
	Fringe	\$0	\$49,197	\$49,197
	Local Travel	\$0	\$7,862	\$7,862
	Supplies	\$0	\$4,000	\$4,000
	Contractual	\$0	\$152,384	\$152,384
	Other	\$0	\$6,230	\$6,230
	Sub-total	\$0	\$347,386	\$347,386
	In-direct costs	\$0	\$26,046	\$26,046

	Total Case Management	\$0	\$373,432	\$373,432
<i>Education and Training</i>				
Personnel		\$0	\$13,389	\$13,389
Fringe		\$0	\$5,960	\$5,960
Local Travel		\$0	\$280	\$280
Supplies		\$0	\$350	\$350
Other		\$0	\$2,958	\$2,958
	Sub-total	\$0	\$22,937	\$22,937
	indirect costs	\$0	\$2,938	\$2,938
	Total Education and Training	\$0	\$25,875	\$25,875
<i>Facilitating Services</i>				
Contractual		\$0	\$48,232	\$48,232
Other		\$0	\$16,490	\$16,490
	Sub-total	\$0	\$64,722	\$64,722
	indirect costs	\$0	\$2,450	\$2,450
	Total Facilitating Services	\$0	\$67,172	\$67,172
<i>Administration and Evaluation</i>				
Personnel		\$0	\$47,565	\$47,565
Fringe		\$0	\$17,204	\$17,204
Local Travel		\$0	\$702	\$702
Out of Area Travel		\$0	\$7,644	\$7,644
Supplies		\$0	\$1,760	\$1,760
Consultant		\$0	\$30,191	\$30,191
Other		\$0	\$10,498	\$10,498
Evaluation		\$0	\$95,050	\$95,050
	Sub-total	\$0	\$210,614	\$210,614
	indirect costs	\$0	\$15,688	\$15,688
	Total Facilitating Services	\$0	\$226,302	\$226,302
<i>Consortium</i>				
Contractual		\$0	\$30,796	\$30,796
Other		\$0	\$2,105	\$2,105
	Sub-total	\$0	\$32,901	\$32,901
	indirect costs	\$0	\$486	\$486
	Total Facilitating Services	\$0	\$33,387	\$33,387
	Grand Total		\$726,168	\$726,168

Healthy Start		MCHD In-Kind	Needed	Total
1.0 FTE	Health Services Administrator	\$0	\$75,937	\$75,937
2.0 FTE	Community Health Worker II	\$0	\$61,644	\$61,644
3.0 FTE	Community Health Worker II	\$0	\$104,975	\$104,975
1.0 FTE	Community Health Nurse	\$0	\$54,258	\$54,258
1.0 FTE	Program Development Specialist	\$0	\$44,600	\$44,600
1.0 FTE	Office Assistant, Senior	\$0	\$39,452	\$39,452
	sub-total	\$0	\$380,866	\$380,866
	Services and Supplies	\$30,000	\$198,971	\$228,971
	sub-total	\$30,000	\$579,837	\$609,837
	indirect costs @ 20%	\$6,000	\$115,967	\$121,967
	Total	\$36,000	\$695,804	\$731,804

Community Dental Collaborative		MCHD In-Kind	Needed	Total
1.0 FTE	Dentist	\$30,876	\$61,752	\$92,628
1.0 FTE	Dentist	\$30,876	\$61,752	\$92,628
0.8 FTE	Dentist	\$23,634	\$47,268	\$70,902
1.0 FTE	Dental Hygienist	\$22,064	\$44,128	\$66,192
1.0 FTE	Dental Asst/Recp	\$12,072	\$24,144	\$36,218
1.0 FTE	Dental Asst/Recp	\$12,072	\$24,144	\$36,218
1.0 FTE	Dental Asst/Recp	\$12,072	\$24,144	\$36,218
0.8 FTE	Dental Asst/Recp	\$9,658	\$19,316	\$28,975
	sub-total	\$153,324	\$306,648	\$459,979
	Professional Services	\$6,000	\$12,000	\$18,000
	Materials and Supplies	\$134,430	\$32,682	\$167,112
	Capital/Equipment	\$1,000	\$235,000	\$236,000
	sub-total	\$294,754	\$586,330	\$881,091
	Indirect costs @ 12.81%	\$37,758	\$75,109	\$112,868
	Total	\$332,512	\$661,439	\$993,959

Community Health Worker Capacitation Center		MCHD In-Kind	Needed	Total
	Executive Director	\$0	\$81,099	\$81,099
	Capacitation Coordinator	\$0	\$63,384	\$63,384
	Admin Assistant	\$0	\$35,985	\$35,985
	sub-total	\$0	\$180,468	\$180,468
	Materials and Supplies	\$0	\$54,140	\$54,140
	Local travel	\$0	\$1,950	\$1,950
	Regional Travel	\$0	\$1,250	\$1,250
	National Travel	\$0	\$4,352	\$4,352
	Contract	\$0	\$18,000	\$18,000
	sub-total	\$0	\$260,160	\$260,160
	indirect costs @ 12.81%	\$0	\$33,327	\$33,327
	Total	\$0	\$293,487	\$293,487

G. Evaluation . Describe the evaluation plan for each component.

Intended outcomes for the Community Health Assessment Project are increased community awareness and understanding of public health issues and constituency building for subsequent needed interventions; number of issue-specific reports requested by the community; and community partner interviews to learn how used information presented in the community health profile was used.

Intended outcomes for the Community Environmental Health project include a well-documented decision-making and planning process, well-represented public participation throughout the planning process, enhanced awareness and understanding of community environmental health issues; strengthened community support for the prevention of environmental risks, appropriate and equitable distribution of environmental health programs and services for priority environmental health issues, and a plan of action that improves the community's health.

Outcomes for the Community Solutions Grants/Public Health Talks will include the number of community grants distributed and number of community dinners held. Individuals and community-based

organizations will be required to submit a written proposal describing the purpose of the project, measurable objectives to be achieved, program activities and plans to evaluate the project's success.

The evaluation of the Hepatitis C project will consist of follow-up assessments and semi-annual analysis of data to determine the success and relative effectiveness of the project. A feedback loop using the evaluation results will be developed to inform and modify the hepatitis integration model.

Intended outcomes for the Sexually Transmitted Disease Partner Notification action plan is an increased ability to effectively screen, diagnose, treatment and counsel residents of our county for STD prevention.

Heroin Overdose Deaths project activities through the use of surveillance of fatal and nonfatal heroin overdoses, and by measuring heroin users' recognition of prevention messages and images.

Intended outcomes for the Healthy Birth Initiative are reduced infant mortality in the project area, reduced low birth weight babies in the project, and increase community support for the project.

For the Healthy Start program will be report the number of support and education groups attended, number of in-home visits by Family Services Coordinator/ Community Health Nurse, and the number of community activities and events attended. The Health Department will evaluate the effectiveness of the

Project monitoring for the Dental Collaborative will document the number of clients served, number of contracts agreed to, number of participating graduate level dental students, and number of participating volunteer dentists.

For the Community Health Worker Capacitation Center we will evaluate the skills and knowledge of Community Health Workers who participate in the Center's courses and evaluate the Center's effectiveness in meeting the needs of Community Health workers and employers.

Appendix A - Community Partnerships in Community Health Profile Discussions

Individuals and agency affiliation invited to participate in the Multnomah County Community Health Profile discussions this past summer are listed below.

Community agencies: Sokhom Tauch, IRCO; Yelena Sergeyera, ROSS; Lee P. Cha, Asian Family Center; Holden Leung, Chinese Service Center; Tony Hopson, Self Enhancement Inc.; Kay Toran, Volunteers of America; John Holley, Vancouver Ave., Baptist Church/AMA; Manigeh Cannon, YWCA; John Ball, Worksystem Inc.; Theresa Enrico, Workers Organizing Committee; Francisco Lopez, El Programa Hispano; Ron Hauge, Oregon Human Development Corp; Josie Kpobe-Tee, SARNA; Evelyn Lamb, The Boys & Girls Aid Society of Oregon; Vaune Albanses, Friendly House; John Simmons, Central City Concern; Josiah Hill, The Coalition of Black Men; Helen Koba, SOAR.

Elected officials and civic groups: Commissioner Serena Cruz; Commissioner Diane Linn; Commissioner Lisa Naito; Commissioner Sharron Kelly; Senator Avel Gordley; Margaret Carter, Senator Elect and Urban League; Jo Ann Bowman; Charles Becker, Mayor of Gresham; Bonnie Kraft, Gresham City Manager; Paul Thalhofer, Mayor of Troutdale; Erik Kvarsten, Troutdale City Administrator; Roger Vonderharr, Mayor of Fairview; John Anderson, Fairview Planning Director; Donald Robertson, Mayor of Woodvillage; Mike Barclay, President Woodvillage Planning Commission.

Public health: Jackie Mercer, NARA; John Duke, Outside In; Carol Cole, Multnomah County Health Department East County Field Office; Terry Misener Dean, School of Nursing University of Portland; Claire Oliveros, Portland Community College; Ian Timm, Oregon Primary Care Association; Terry Cross, Director, NW Indian Child Welfare; Barbara Ballou, Healthy Communities; Dr. Leslie McBride, School of Community Health, Portland State University; Dr. Walter G. Ellis, Associate Dean College of Urban and Public Affairs State University; Dr. Sherril B. Gelmon, Associate Professor of Public Health Portland State University; Professor Catherine Salveson, RN, PhD, School of Nursing Oregon Health Science University; Steve Gilbert & Jarrod Sampson, NARA; Corliss McKeever, African African Health Coalition; Gerry West/NEMCCA, East County Senior Coalition; David Knowles, City of Portland Planning Bureau Director; John Legry, Kathleen Todd, County Citizen Involvement; Jeff Beiswenger, City of Gresham.

Neighborhood organizations and school groups: Joselyn Baker, Columbia-Villa Tamarack Family Resource Center; Gary Wallsworth, Madison Family Resource Center; Barbara Neeley, Multnomah Education Service District; Susan Brady/Jean Wagner, Mt. Hood Community-Maywood Park Head Start; Diane Meisenhelter, Buckman Elementary School; John Gardner, Whitaker Middle School; Assistant Superintendent, Gresham School District; Linda Jessell, Director of Secondary Education, Gresham School District; John Stanley, Director of Elementary Education, Gresham School District; Maxine Thompson, Leaders Roundtable; Kathleen Palmer, Child Services Center; Tammy Jackson, Child Services Center; Norrine Smokey-Smith, Indian Education Act Project; Martha Gaugh, Rigler Elementary School; David Lane, Amalia Alarcon-Gaddie, Office of Neighborhood Involvement; Ray Demarko, Portland Public Schools; Caring Communities Chairs from nine geographic locations around the county.

Appendix B
Board of Commissioners Involvement and Transmittal Letter

Board of County Commissioner Approval

The Board of Commissioners has designated a method or process to coordinate existing planning processes and partners, and

The Board of Commissioners has designated an entity responsible for representing the health improvement planning effort, and

The Board of Commissioners will (check one)

_____ Maintain county funding levels for health, or

_____ That county funding levels will not be reduced by an amount greater than proportional reductions of county discretionary revenues, or

_____ Unique financial circumstances exist this biennium (county general fund is reduced to expenditures for critical public safety needs only) which prevent the county from maintaining existing efforts for health, and

The Board of Commissioners has approved the Health Improvement Plan for Multnomah County and ensures that the appropriate state, local, public and private partners in the county are in agreement.

Chair, Board of County Commissioners

Date

Appendix C
Local Public Health Improvement Plan - Survey

1. Is there a mechanism for reporting communicable disease cases to the LHD?

- ☒ Yes
☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
☐ Meets some needs
☐ Meets half of the needs
☒ Meets most needs
☐ Meets all needs

2. Does the LHD conduct investigations of reportable conditions and communicable disease cases?

- ☒ Yes
☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
☐ Meets some needs
☐ Meets half of the needs
☒ Meets most needs
☐ Meets all needs

3. Does the LHD carry out control measures for reportable conditions and communicable diseases?

- ☒ Yes
☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
☐ Meets some needs
☐ Meets half of the needs
☐ Meets most needs
☒ Meets all needs

4. Does the LHD complete and submit investigation report forms in the manner and time frame specified for the particular disease or condition?

- ☒ Yes
☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
☐ Meets some needs
☐ Meets half of the needs
☒ Meets most needs
☐ Meets all needs

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5. Does the LHD provide feedback to the reporting health care provider regarding outcome for each reportable condition or disease case received?

☒ Yes
☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

☐ Meets no community needs
☐ Meets some needs
☐ Meets half of the needs
☒ Meets most needs
☐ Meets all needs

6. Does the LHD provide access to prevention, diagnosis, and treatment services for reportable conditions or communicable diseases when relevant to protecting the health of the public?

☒ Yes
☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

☐ Meets no community needs
☐ Meets some needs
☐ Meets half of the needs
☒ Meets most needs
☐ Meets all needs

7. Does the LHD have an ongoing effort to maintain and/or increase the timely reporting of reportable conditions and diseases?

☒ Yes
☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

☐ Meets no community needs
☐ Meets some needs
☐ Meets half of the needs
☒ Meets most needs
☐ Meets all needs

8. Is there a mechanism for reporting to and following up on zoonotic diseases through the LHD?

☒ Yes
☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

☐ Meets no community needs
☒ Meets some needs
☐ Meets half of the needs
☐ Meets most needs
☐ Meets all needs

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9. Does the LHD have a system for the surveillance and analysis of the incidence and prevalence of communicable diseases?

- ☒ Yes
☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
☐ Meets some needs
☐ Meets half of the needs
☒ Meets most needs
☐ Meets all needs

10. Does the LHD review and analyze averages of incidence rates for communicable diseases and evaluate the data for future program planning?

- ☒ Yes
☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
☐ Meets some needs
☐ Meets half of the needs
☒ Meets most needs
☐ Meets all needs

11. Are immunizations for human target populations available within the LHD jurisdiction?

- ☒ Yes
☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
☐ Meets some needs
☐ Meets half of the needs
☒ Meets most needs
☐ Meets all needs

12. Are immunizations for animal target populations available within the LHD jurisdiction?

- ☒ Yes
☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
☒ Meets some needs
☐ Meets half of the needs
☐ Meets most needs
☐ Meets all needs

Explanation: Immunization levels are not monitored by the Health Department. Animal control does have some immunization prerequisites for licensing, but do not have a mechanism to assess penetration into the domestic animal population.

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13. Does staff responsible for epidemiology services participate in appropriate training experiences each year.

☒ Yes

☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

☐ Meets no community needs

☐ Meets some needs

☐ Meets half of the needs

☒ Meets most needs

☐ Meets all needs

14. Does the LHD assure early detection and treatment of communicable diseases?

☒ Yes

☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

☐ Meets no community needs

☐ Meets some needs

☐ Meets half of the needs

☒ Meets most needs

☐ Meets all needs

15. Does the LHD assure education and prevention of communicable diseases?

☒ Yes

☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

☐ Meets no community needs

☐ Meets some needs

☐ Meets half of the needs

☒ Meets most needs

☐ Meets all needs

16. What percent of school entrants (K or 1) are up to date according to Schedule 1 of School Immunization Rules (OAR 333-19-070)?

92.4 Percent

17. What percent of licensed labs in the county report communicable diseases to the LHD?

100 Percent

18. What percent of primary care providers, who should report communicable diseases to the LHD, actually do so?

? Percent

Explanation: Some report directly to OHD. We are unable to evaluate without extensive research.

19. For the jurisdiction served by the LHD, is there a community needs assessment process that systematically describes the prevailing health status in the community?

☒ Yes

☐ No

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If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
- ☐ Meets some needs
- ☐ Meets half of the needs
- ☒ Meets most needs
- ☐ Meets all needs

20. In the past three years in your jurisdiction, has there been a survey of the population for behavioral risk factors, and is that data available to the LHD?

- ☒ Yes
- ☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
- ☐ Meets some needs
- ☒ Meets half of the needs
- ☐ Meets most needs
- ☐ Meets all needs

21. Does the LHD conduct timely investigation of adverse health events, including communicable disease outbreaks and environmental health hazards, on an ongoing basis?

- ☒ Yes
- ☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
- ☐ Meets some needs
- ☐ Meets half of the needs
- ☒ Meets most needs
- ☐ Meets all needs

22. Are the necessary laboratory services available to the LHD to support investigations of adverse health events and meet routine diagnostic and surveillance needs?

- ☒ Yes
- ☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
- ☐ Meets some needs
- ☐ Meets half of the needs
- ☒ Meets most needs
- ☐ Meets all needs

23. Has the LHD completed an analysis of the determinants and contributing factors of priority health needs, adequacy of existing health resources, and the population groups most impacted?

- ☒ Yes, on-going process
- ☐ No

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If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
- ☐ Meets some needs
- ☐ Meets half of the needs
- ☒ Meets most needs
- ☐ Meets all needs

24. In the past three years has the LHD conducted an analysis of the age-specific participation in preventive and screening services?

- ☒ Yes
- ☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
- ☐ Meets some needs
- ☒ Meets half of the needs
- ☐ Meets most needs
- ☐ Meets all needs

25. For the jurisdiction served by the LHD, is there a network of support and communication relationships that include health-related organizations, the media, and the general public?

- ☒ Yes
- ☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
- ☐ Meets some needs
- ☒ Meets half of the needs
- ☐ Meets most needs
- ☐ Meets all needs

26. In the past year has the LHD made a formal attempt to inform elected officials about the potential public health impact of decision under their consideration?

- ☒ Yes
- ☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
- ☐ Meets some needs
- ☐ Meets half of the needs
- ☒ Meets most needs
- ☐ Meets all needs

27. For the jurisdiction served by the LHD, has there been a prioritization of the community health needs that have been identified from a community needs assessment?

- ☐ Yes
- ☒ No *Explanation: Not formally.*

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If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
- ☐ Meets some needs
- ☒ Meets half of the needs
- ☐ Meets most needs
- ☐ Meets all needs

28. In the past three years has the LHD implemented community health initiatives consistent with established priorities?

- ☒ Yes
- ☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
- ☐ Meets some needs
- ☒ Meets half of the needs
- ☐ Meets most needs
- ☐ Meets all needs

29. Has the LHD developed a community health action plan with community participation to address community health needs?

- ☒ Yes
- ☐ No

Explanation: We have a number of initiatives in place to provide data and input to the community around priorities.

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
- ☐ Meets some needs
- ☐ Meets half of the needs
- ☒ Meets most needs
- ☐ Meets all needs

30. During the last three years has the LHD developed plans to allocate resources in a manner consistent with a community health action plan?

- ☒ Yes
- ☐ No

Although we are still in the process of developing a community action plan, our budget is always submitted and reviewed by our Citizen Health Council advisory board.

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
- ☐ Meets some needs
- ☒ Meets half of the needs
- ☐ Meets most needs
- ☐ Meets all needs

31. For the jurisdiction served by the LHD, have resources been deployed, as necessary to address priority health needs identified in the community health needs assessment?

- ☒ Yes
- ☐ No

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If yes, how effective is this activity in meeting community needs within your jurisdiction?

☐ Meets no community needs

☐ Meets some needs

☒ Meets half of the needs

☐ Meets most needs

☐ Meets all needs

Explanation: We have conducted community health assessments, but do not have a single formal assessment to-date.

32. In the past three years has the LHD conducted an organizational self-assessment?

☒ Yes

☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

☐ Meets no community needs

☐ Meets some needs

☒ Meets half of the needs

☐ Meets most needs

☐ Meets all needs

33. For the jurisdiction served by the LHD, are age specific priority health needs effectively addressed through the provision of or linkage to appropriate services?

☒ Yes

☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

☐ Meets no community needs

☐ Meets some needs

☐ Meets half of the needs

☒ Meets most needs

☐ Meets all needs

34. Within the past year has the LHD provided reports to the media on a regular basis?

☒ Yes

☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

☐ Meets no community needs

☒ Meets some needs

☐ Meets half of the needs

☐ Meets most needs

☐ Meets all needs

35. For the jurisdiction served by the LHD, have there been regular evaluations of the effects of public health services on community health status?

☒ Yes

☐ No

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If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
- ☒ Meets some needs
- ☐ Meets half of the needs
- ☐ Meets most needs
- ☐ Meets all needs

36. In the past three years has the LHD used professionally recognized processes and outcome measures to monitor programs and to redirect resources as appropriate?

- ☒ Yes
- ☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
- ☒ Meets some needs
- ☐ Meets half of the needs
- ☐ Meets most needs
- ☐ Meets all needs

37. In your jurisdiction is the public regularly provided with information about current health status, health care needs, positive health behaviors, and health care policy issues?

- ☒ Yes
- ☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
- ☒ Meets some needs
- ☐ Meets half of the needs
- ☐ Meets most needs
- ☐ Meets all needs

38. In the past three years has there been an instance in which the LHD has failed to implement a mandated program or service?

- ☐ Yes
- ☒ No

39. Does an adequate emergency response plan exist for the LHD in the event of public health emergencies?

- ☐ Yes
- ☒ No

Explanation: To be completed by June 30, 2001.

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
- ☐ Meets some needs
- ☐ Meets half of the needs
- ☐ Meets most needs
- ☐ Meets all needs

Appendix C

40. Does the LHD have a health advisory board such as provided in ORS 431.412(5)?

- ☒ Yes
☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
☐ Meets some needs
☐ Meets half of the needs
☒ Meets most needs
☐ Meets all needs

Explanation: Very effective in meetings needs for Primary Care oversight and quality; and very effective in monitoring and advising as a citizen budget review board.

41. Does the LHD have a process for identifying persons in the community who may encounter barriers to the receipt of personal health care or public health services?

- ☒ Yes
☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
☐ Meets some needs
☐ Meets half of the needs
☒ Meets most needs
☐ Meets all needs

42. Does the LHD have process for identifying persons in the community with inadequate coverage for personal health care services?

- ☒ Yes
☐ No

If yes, how effective is this activity in meeting community needs within your jurisdiction?

- ☐ Meets no community needs
☐ Meets some needs
☐ Meets half of the needs
☒ Meets most needs
☐ Meets all needs

County Multnomah

Person completing survey: Lillian Shirley

Questions 1-18 are derived from CLHO Minimum Standards for Local Health Departments, Control of Communicable Diseases. Questions 19-38 are derived from the Local Public Health Performance Surveillance Instrument being developed by CDC. Questions 39-42 are derived from the Local Public Health Performance Assessment Tool being developed by CDC. The latter two full surveys are in draft stage and information is available at: <http://www.phppo.cdc.gov/dphs/nphpsp/>

Appendix D Budget

Public Health Improvement Plan				
Fiscal Year 2001-2002				
Local Public Health Improvement Strategy	New State Support for Public Health Funds	Local Funds	Other State Federal or Grant Funds*	Total Resources Required for Strategy
Community Health Assessment	\$273,207	\$99,046	-0-	\$372,253
Community Environmental Health	\$570,555	-0-	-0-	\$570,555
Community Solutions Grants/Public Health Talks	\$150,411	\$112,056	-0-	\$262,468
Hepatitis C	\$264,377	\$123,967	-0-	\$388,344
STD Partner Notification	\$187,716	\$228,779	\$52,000	\$468,495
Heroin Overdose Deaths	\$30,459	\$43,017	-0-	\$73,475
Healthy Birth Initiative	\$726,168	-0-	-0-	\$726,168
Healthy Start	\$695,804	\$36,000	-0-	\$731,804
Dental Collaborative	\$661,439	\$332,512	-0-	\$993,959
Community Health Worker Capacitation Center	\$293,487	-0-	-0-	\$293,487

*Annotate type of fund; e.g., Old State Support for Public Health, CCF, etc.

County: Multnomah

Person completing budget: Linda Doyle