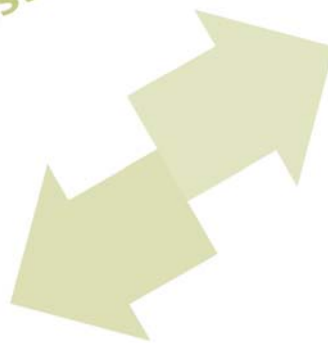


# THE HEALTH EQUITY INITIATIVE

A Five Year Reflection:  
The Policy Crosswalk

2008 - 2013



Health Department

Public Health

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## **Introduction**

In 2008 Multnomah County Health Department's Health Equity Initiative (HEI) hosted a series of conversations based on screenings of the PBS video series Unnatural Causes. These screenings and subsequent conversations were conducted with both community members and Multnomah County employees.

Recommendations made by employees or community members about actions that could be taken by local governments were compiled and presented to the community for review and prioritization.

The results of the community review process are covered in HEI's 2009 annual report.

The Health Equity Initiative feels that it is incumbent upon itself to update the community on the Health Department's activities related to these recommendations.

## **Scope of this Report**

This report presents a brief summary of key activities (policies, programs, advocacy, and so on) for those recommendations within the sphere of the Health Department's mission of Healthy People in Healthy Places.

This report is not an exhaustive scan of the Health Department's activities related to health equity. The Health Department does much work that is not addressed by these recommendations. And within each recommendation key activities are highlighted rather than attempt to report an exhaustive list of everything that the Health Department is doing. The activities listed are not necessarily a direct response to the recommendations but may have been inspired, generated or facilitated by other causes.

## **Methods**

The list of recommended policies and actions covered in this report were taken from the appendix of Health Equity Initiative's 2009 Annual Report, which is an extensive list of recommendations, organized by applicable county department, compiled from the 2008 screenings of Unnatural Causes. That list is a compilation and condensation of extensive comments made by county staff, community members in response to the Unnatural Causes videos supplemented with key policy actions identified through literature review and interviews with national leaders in health equity.

HEI reviewed the appendix and pulled all recommendations that were either directly or indirectly related to Multnomah County Health Department (MCHD) mission, services or activities. Eight-three recommendations from across jurisdictions were pulled to create the policy list for this report. Each recommendation was given a code for ease of identification and to assist reference to the original list of recommendations.

The 83 recommendations were reviewed and organized into 18 categories such as Healthcare, Education, and Community Built Environment.

A list of 15 potential key informants was developed in collaboration with Health Equity Initiative manager. All but one of the potential key informants is a Health Department employee.

Key informants were e-mailed a list of the 83 recommendations and asked to indicate the level and type of work MCHD had done that was related to the recommendation. All but one of the 15 potential key informants responded. Two of the 14 key informants preferred to give their responses by phone. The remaining 12 key informants submitted their responses in writing (comments made on a spreadsheet that was e-mailed to them).

Follow up phone conversations were conducted with 11 of the key informants to clarify and expand upon the information provided.

Key informants identified another nine individuals for evaluation to follow up with for more information. Evaluation used a mix of e-mail and phone calls to contact these individuals. All of the nine responded with more information.

Not all key informants made comment on every recommendation. Any blanks (no comment) were coded as “don’t know” in the spreadsheet.

Summaries of results for each recommendation are organized below by area. A few sentences of summary are provided for each area.

## **Results**

### ***Addictions and Mental Health***

1. Expand residential and outpatient drug and alcohol treatment centers (DCJ3).

Status: Partnering

“The Healthy Columbia Willamette Collaborative includes 14 hospitals, four health departments and two coordinated care organizations in the Clackamas, Multnomah and Washington counties of Oregon and in Clark County, Washington. This unique public private partnership aims to improve the health of the community.” Alcohol and drug abuse treatment is one of four focus areas currently being considered by the collaborative as its top priority. Strategies to address the need have yet be determined but may include expansion of services. The priorities and strategies for the collaborative may be clearer by fall 2013.

### ***Community Built Environment***

2. Partner with CBOs to change underlying physical structure of neighborhoods to enhance community connections (C2).

Status: The Health Department is currently leading efforts to address this area.

There are several efforts within the Health Department that are addressing neighborhood design including:

- Communities Putting Prevention to Work (CPPW) grant has a built environment workgroup that is working on a comprehensive plan update that outlines land use goals including neighborhood connectivity and other "livability" indicators.
- Striving to Reduce Youth Violence Everywhere (STRYVE) grant: a Centers for Disease Control and Prevention (CDC) five year grant. Multnomah County Health Department (MCHD) is one of four local health departments (LHD) nationally that received funding. Purpose of the grant is to support LHD to bring prevention and public health approach to reduce violence affecting youth. Years 1-2 are planning years. Years 3-5 are implementation. Currently nearing end of 2nd year. Committee is currently recommending implementation of 2 strategies: youth empowerment and Crime Prevention Through Environmental Design (CPTED). CPTED design principles include making public space more attractive and usable which would have the affect of bringing community together and discouraging crime. Rebecca Stavenjord is main contact for CPTED.

### ***Community Safety***

3. Facilitate neighborhood level strategies to address unfavorable neighborhood conditions (C18):

Status: The Health Department (HD) is currently leading efforts to address this topic.

See STRYVE grant (C2) above.

4. Tax gun sales to leverage funds for violence prevention activities (MC8):

Status: HD not currently working in this area.

While the health department is not specifically leading work in this area Commissioner Kafoury's office just sponsored an ordinance which was passed that addresses gun violence.

### ***Community Social Capital***

5. Establish benchmarks for community building; incorporate community building capacity into grants (DCM5):

Status: Health Department is partnering with community organizations to address this area.

There are many examples but the one of the most prominent is the Future Generations Collaborative. MCHD staff identified a disparity in the amount of alcohol use during pregnancy by American Indian women. MCHD initiated a partnership with Native American Rehabilitation Association of the Northwest (NARA) and Multnomah County mental health and addictions to address substance use by native women during pregnancy. The collaborative uses a community participatory grant model to "implement culturally-specific practice-based evidence (vs. evidence-based practice)" and build community capacity. Another example is the Healthy Retail Food Initiative funded by Kaiser which has provided business training to local retailers.

6. Connect youth and elders (e.g. Experience Corps model) (H9).

Status: HD partnering with community groups

An excellent example of the kind of partnering MCHD does is the Future Generations Collaborative. This may even be a model for how MCHD can partner more with community groups in the future. Another example is Healthy Birth Initiatives community consortium which gives input to the program on policy and programming. The HBI consortium is comprised of local agencies, community groups and program consumers.

7. Include community members in decision making (MC7).

Status: HD is leading and partnering in this area.

Many examples. Here is a brief list of the ones mentioned by key informants: Community Health Council (<http://web.multco.us/health/community-health-council>). HBI community consortium, Future Generations Collaborative (see H9 above), prenatal work with immigrant and refugee communities, the community health council, and number of other advisory council's (Vector Advisory, Bedbug Workgroup, Food Service Advisory exist just in Environmental Health), also each of the primary care sites has an individual health site councils with patient representation and focus on quality (<http://web.multco.us/health/councils-and-advisory-boards>).

8. Oppose policies that deny access to indigenous cultures and that promote cultural disconnections between immigrant parents and children (S41).

Status: MCHD working on

Key informants did not have information on whether the health department is actively opposing such kinds of policies but they did remind us that MCHD addresses this area with extensive translations services thus increasing access for non-English speakers, and programs like the Community Capacitation Center, Healthy Birth Initiative, Future Generations Collaborative, and Rockwood Clinic that try to address family cohesion.

## ***Criminal Justice***

9. Implementation of corrections health transition planning (DCJ2).

Status: working on

MCHD Director of Nursing is trained Adult Nurse Practitioner with experience working in corrections, and currently keeps a part-time practice of working in corrections health.

Director of Nursing and PDES recently applied to HRSA (Health Resources Services Administration) for a grant to form teams of nurses and community health workers to do case management around chronic disease treatment for incarcerated individuals transitioning to life outside of incarceration. HRSA is currently reviewing the grant application.

Youth Corrections Health: <http://web.multco.us/dcj-juvenile/detention-programs>.

## ***Early Childhood***

MCHD is doing extensive work in the area of early childhood primarily of course through programming and maternal child services but also through collaboration with All Hands Raised and participation on the Communities Supporting Youth Collaborative, Cradle to Career and Ready For Kindergarten subcommittees, Early Childhood Council and health care transformation work.

10. Expand programs that provide early identification and intervention with children missing school (DHS3).

Status: MCHD is partnering in this area.

MCHD is partnering with All Hands Raised, a community collaborative focused on “education, equity and excellence.” Early identification and intervention is a focus of All Hands Raised.

MCHD collaborating on The Communities Supporting Youth Collaborative, which is a cross-sector collaborative of people committed to supporting youth and families through working at various levels across diverse organizations.

Convened by SUN Service System Coordinating Council and Portland State University's Center for Improvement of Child and Family Services, the Collaborative aims to align and increase school and community supports, for children, youth and their families, that contribute to academic and life success with a focus on eliminating disparities. The Collaborative has focused specifically on increasing engagement of student and families as measured by improved school attendance. Part of All Hands Raised collaborative, for which early identification and intervention is a focus area.

11. Advocate for full funding for early childhood programs like Head Start (F1).

Status: Partnering and leading

Through its work with the Cradle to Career (C2C – a subcommittee of All Hands Raised) and the Governor's Early Learning Council MCHD is working address advocacy for full funding of Head Start and other early childhood programs. (see F2 below).

From the All Hands Raised website (6/21/13): "This community is one of seven national demonstration sites as a part of the [Strive Network](#). Strive is a Cradle to Career Partnership that began in Cincinnati in 2006 and has achieved measurable improvement around academic outcomes for children and youth in their community. Founded in 2011, the national Strive Network works with communities across the country to help create a civic infrastructure to unite stakeholders around shared goals, measures, and results in education, supporting the success of every child, cradle to career."  
<http://allhandsraised.org/vision/cradle-to-career/>

12. Expand childhood early intervention programs. Increase screening for developmental delays (F2).

Status: HD is partnering in this area.

There are several efforts addressing this area:

- Joanne Fuller, CCO for MC was on Governor's Early Childhood Design Team.
- MCHD may have role on ELC currently.
- The health department's early childhood programs are working with HealthShare (the tri-county coordinated care organization) around increased access to screening for developmental delays.
- MCHD is part of the R4K (Ready For Kindergarten) which is a subcommittee of Cradle to Career (C2C) which is a multi-jurisdictional and non-profit (CBO) collaborative with goal to increase success from cradle to career; there are supports for early childhood in the R4K plan. MCHD provides consultation on community health worker (CHW) model of service delivery.
- MCHD staff co-lead Early Childhood Council for Multnomah County which is the advisory board to Head Start.

## ***Economy***

While the economy is not its usual purview, the Health Department none-the-less is doing some work that is tangentially related primarily through micro-enterprise efforts of vulnerable communities and using its power as a contractor of services to promote equity practices.

13. Fund micro-enterprise and entrepreneurial training that could be linked to empowerment and health promotion (S30).

Status: Partnering and leading.

The Healthy Retail Food Initiative is an excellent example of this kind of work of linking food, local business and health outcomes (see Food Security/DCS1). Another example is MC Environmental Health's pilot program to promote licensure and success of micro-enterprise tamale vendors.

14. Promote streamlined process for contracting with Minority, women and emerging small businesses (S58).

Status: uncertain/working on

MWESB Summits are part of the county's Sustainable Purchasing & Social Equity Policy and that the county is leading quarterly summits with over 20 public agencies to share best practices, enhance existing policies, and coordinate on new policies to ensure the success of Minority-owned, Women-owned, and Emerging Small Businesses regionally. Another reports that the Future Generations Collaborative has been working on this with Business Services. Another key informant is frustrated with progress on promoting equity in our business services/budgeting practices.

## ***Education***

Highlight HEI's internal work and roots of inequity training

15. Continue screenings of Unnatural Causes for county employees (DCM2).

Status: MCHD shifting strategies for increasing awareness of health inequities

HEI is conducting screenings (at least for the community), but very rarely. HEI has focused on developing trainings using "Roots of Health Inequities" module created by the National Association of City County Health Officials (NACCHO)

16. Provide Undoing Institutional racism training for managers (DCM6).



Status: Some work being done but at County level

According to one key informant Talent Development at the county level is working on incorporating Race: Power of an Illusion into training and leveraging in conjunction with the Equity and Empowerment Lens.

17. Include Unnatural Causes in health curriculum in high school (H10).

Status: Limited work in this area

According to one key informant HEI has partnered with St Mary's academy but to limited extent.

18. Educate and inform teachers about diversity of their students (H12).

Status: HD is working in this area.

From its work with North Portland's Health Eating Active Living Coalition (HEAL) MCHD is working with North Portland Neighborhood - Cesar Chavez school in Portsmouth - on race, ethnicity, diversity, cultural sensitivity, translation services, bilingual materials.

As part of the Communities Putting Prevention to Work grant, MCHD is working with Centennial School District in developing an equity policy inspired by Healthy Active Schools coordinators sparking conversations around equity and shifting school/neighborhood demographics; Centennial School District reached out to MCHD regarding cultural approaches.

19. Expand youth education programs which provide skills and resources (e.g., SUN) (H6).

Status: Partnering and leading

Several examples of this kind of work, the most prominent being:  
SUN schools program which is undertaking using the Equity and Empowerment Lens, integrating race, ethnicity, poverty considerations into their RFP process;  
Youth Empowerment Strategies which was one of two intervention models chosen by the STRYVE (Striving to Reduce Youth Violence Everywhere) grant.

20. Raise awareness of social determinants of health among community, staff and policy makers (PAO1).

Status: leading and partnering

Many examples of this kind of work including: Healthy Birth Initiatives (HBI) Consortium and male engagement assessment (community assessment of needs of men related to parenting). Also HBI and Health Equity Initiative are sharing health educator position, HEI is working to advance the use of the Equity and Empowerment Lens within the Health Department; HEI is developing trainings internally for staff and providing consultation with other jurisdictions, including City of Portland and Metro. HEI is still conducting trainings for community organizations.

### ***Emergency Planning***

21. Consider equity and vulnerable populations in the development of regional emergency response plan (DCS3).

Status: leading and partnering

From Emergency Preparedness Manager: “Multnomah County Health Department’s Emergency Preparedness and Response Program has worked on several vulnerable populations projects since the 2008 Health Equity Initiative screenings where recommendations were made to “*Consider equity and vulnerable populations in the development of regional emergency response plan.*” At that time, we were working with regional vulnerable population and government partners to identify and address the disaster-related needs of vulnerable populations before, during, and after an emergency or disaster. The project team agreed to the following definition of vulnerable populations: “*Populations limited in their ability to take emergency protective action (e.g. evacuation, sheltering in place) or tolerate extended isolation from routine support networks due to physical, sensory, mental health, cognitive, or developmental conditions.*” Seven critical functions were chosen to focus on and workshops identified needs, recommended strategies, and resources available. These critical functions include:

1. Emergency Coordination Center (ECC)/Emergency Operations Center (EOC) representation;
2. Identification/location of vulnerable populations;
3. Communication;
4. Sheltering;
5. Transportation;
6. Evacuation; and
7. Medically related topics.

“Counties are or will be using this resource to build their individual vulnerable populations plans.

“In addition, we hired a Community Liaison to help build relationships with vulnerable population community partners before and during emergencies. She has built a relational database showing the relationships of health department units/programs and community partners and continues to form those relationships. We continue to build our Push Partner Registry, a program originally designed for people who would not otherwise be able to walk in to a public point-of-dispensing to receive life-saving medication in the event of a large-scale public health emergency. This Registry contains many vulnerable populations service providers who have agreed to pick up medication and take it back to their organization and dispense it to their staff, families of staff, and clients, where applicable. In 2011, we developed a vulnerable populations tab to our Emergency Response Plan. This tab describes the Health Department’s role in serving vulnerable populations during a public health emergency and identifies likely impacted populations, the service providers to those impacted populations, and our relationships with those service providers.

“With consequences as seen in disasters like Hurricane Katrina, Multnomah County Health Department’s Emergency Preparedness and Response Program works to bring the equity lens to the table when writing or coordinating plans, and works to ensure an equitable distribution of resources during emergencies.”

## ***Food Security***

22. Consider Food Policy Council's recommendations regarding policies promoting independence and equity in neighborhoods (C20).

Status:MCHD leading and partnering

The key recommendation from the Food Policy Council’s (which is currently disbanded) 2003 Annual Report was that the city “Conduct a pilot planning process, conducting outreach to residents and working with community partners to develop solutions such as expanding retail options, developing farmers’ markets, creating community gardens, or expanding access to federal or state food and nutrition programs.” (accessed 6/27/13 <http://www.portlandoregon.gov/bps/article/116841>) The health department is leading and partnering to support this recommendation –see DCS1 and H1 below.

Environmental Health had a nurse intern who created educational and outreach materials distributed to community groups that put together resources available to low income residents in “deserts” where healthy food and cleaning products (those that don’t trigger asthma for example) are not available.

23. Establish and promote cooking and canning classes (DCM17).

Status: limited

HBI occasionally has a cooking class and WIC will periodically offer classes through some of our community partners (i.e. Ecumenical Ministries does an approved class through us). Due to only one clinic having a kitchen (East) WIC hasn't been teaching cooking classes "in house."

24. Promote connections between small local farmers and low-income neighborhood (DCS1).

Status: HD is partnering in this area.

There are several examples of the kind of work MCHD is doing in this area:

The Healthy Retail Initiative (HRI) – MCHD is working with 13 Latino, African American and African neighborhood small grocery stores to make available fresh fruit and vegetables by linking residents, retailers and local farmers. Currently HRI is surveying grocers and community residents to see what kind of fruit and vegetables they want to see in their local small grocery stores. HRI is looking at national models (for example, CSA model or regional distributor) for providing access.

Another example is MCHD's partnership with Ecumenical Ministries of Oregon. EMO sits on the ACHIEVE coalition and runs food buying clubs through churches. Highland Church runs a farm stand out of their church on Sundays. Both projects funded, in part, through Communities Putting Prevention to Work grant.

25. Increase % of fruit and vegetable content of food purchased by Multnomah Co (DCS6).

Status: MCHD is working on this.

The County passed resolution 2012-150, Healthy Purchasing Initiative aimed at strengthening demand for safer products.

26. Expand connections with community food programs such as community gardens, gleaners, harvest share programs etc (H1).

Status: HD is very active in this area.

ACHIEVE (Action Communities for Health, Innovation and Environmental Change) coalition work focused on access to healthy food; Community Capacitation Center working in partnership with Village Gardens of Janus Youth.

Working with 3 north Portland community developments: St Johns Woods, Tamarask, and New Columbia; goal is to build community leadership capacity through community garden programs; HD has provided 3 years of CHW popular education training and technical assistance and connections to north Portland health center there; CHWs sit on site council.

- The county's Communities Putting Prevention to Work (CPPW) grant funded several farm-to-school activities in school districts throughout the county. Specifically, Parkrose, Reynolds, and Gresham-Barlow school districts enhanced or established school gardens that provide produce for school lunch and/or are incorporated into classroom curricula.
- Multnomah County Health Department was an important supporter of the development of the Urban Food Zoning Code Update in the City of Portland. Under CPPW, the project, led by the Bureau of Planning and Sustainability (BPS) in partnership with the Oregon Public Health Institute (OPHI) and members of the community, addressed developed a new set of regulations to support growing, buying and selling food at a scale that is appropriate to residential neighborhoods and that increases access to healthy food. CPPW funding ensured that health and equity were central considerations and that decisions related to urban food production and distribution maximized public health benefits.
- The CPPW grant funded Multnomah County Aging and Disability Services (ADS) work with the county's senior meals provider, Loaves and Fishes, to move from mostly pre-cooked, canned, or frozen fruits and vegetables to fresh and locally sourced produce in all Loaves and Fishes senior meal sites. The fresh produce procurement changes cumulatively impact 34 meal site locations across three counties, serving about 2,000 seniors each weekday. The changes impact an additional 3,000 meals made at senior meal sites and delivered to seniors in their homes. ADS institutionalized these changes in an amendment to its contract with Loaves and Fishes to ensure a continued focus on sustainable fresh produce procurement.
- CPPW funds helped Multnomah County Aging and Disability Services (ADS) implement nutrition standards for food served outside of the federal meals program by developing nutrition standards for the 2011 contract bid process for senior centers. The 70,000 seniors served at five District Senior Centers in Multnomah County are impacted by the new standards. ADS provided support to senior center managers, providing connections to needed resources to ensure that the changes could be implemented well, including working with volunteer organizations, churches, and other community-based organizations to connect resources with identified needs. These efforts resulted in the development of at least three new community gardens that produce fresh food for senior meal sites and senior centers, a farmers' market gleaning program, and culturally-relevant, age-appropriate cooking classes and nutrition education materials.

27. Geographic equitable access to healthy and affordable food (H7).

Status: Partnering and leading

Healthy Eating Active Living Coalition in North Portland (<http://www.multco-itstartshere.org/news/north-portland-heal-coalition-celebrates-success>) dynamic coalition/partnership among PSU, MCHD and Latino residents of Portsmouth neighborhood. HEAL plus ACHIEVE outreach and CPPW funding and Kaiser funding led to the Healthy Retail Initiative. Part of HRI is mapping food deserts in North Portland.

### ***Health Impact***

28. Conduct health impact assessments on ballot measures (DCM21).

Status: MCHD beginning to do more of this kind of work.

Health Assessment and Evaluation is working on a health impact assessment re: coal exports being transported through the county, requested by Chair Cogen. Unclear on whether coal export will go to the voters or the legislature.

29. Increase funding of health impact assessments (S40).

Status: MCHD building capacity but not funding at this point

See DCM21/Health Impact (above). We won't necessarily see increased funding per se, but we did build additional capacity internally (allocation of existing resources) and improved the Board's awareness and understanding of health impact assessments.

### ***Health Promotion***

30. Increase focus on women's health issues (DCM14).

Status: MCHD leads on this issue

MCHD has a strong focus on women and early childhood issues, especially with the new work within the CCO.

31. Raise community awareness of risks of low birth weight and infant mortality (H5).

Status: MCHD leads in this area.

This work is being done through MCHD's Healthy Birth Initiatives, Early Childhood Services and WIC programs; also, there are objectives within strategic

plan draft that outline focused attention on disparities for birth outcomes in AA community.

32. Support water fluoridation policy (S35)

Status: MCHD supports

The health department supported the ballot measure. The County is a partner of HealthShare and FamilyCare of Oregon, which has voted to support water fluoridation. Since voters declined ballot measure, not sure what next steps are. One key stakeholder suggests working with those opposed to fluoridation around other interventions to improve dental health and remove disparities.

County Health Officer also testified in support and served as an evidence-based resource for information on fluoridation.

33. Expand funding for health promotion programs as an investment (S62).

Status: MCHD leading

These are specific goals for STRYVE and the Health Promotion Change process. Also work within the local Coordinated Care Organizations – HealthShare and FamilyCare.

### ***Human Services Access***

34. Co-locate culturally specific services: "one-stop-shopping" centers (DCS4).

Status: MCHD partnering

While not representing services located at a physical center, Environmental Health is partnering with WIC to pair some of their services together since they serve some of the same people. For example, they are partnering with WIC to do lead screening with WIC clients. This kind of work is more efficient and extends the reach of health promoting services.

35. Establish a domestic violence all-in-one service center (H11).

Status: Accomplished

From county website: After two years of planning and multi-agency collaboration, a "one-stop center" for domestic violence services opened for victims and their families. The Gateway Center for Domestic Violence Services opened its doors on September 9, 2010 at 10305 East Burnside St. within the Gateway Children's Campus. More than a dozen agencies now provide services at the center, which will be open Monday through Friday during regular business

hours (no overnight stays).

The center, a cooperative effort by Multnomah County, the City of Portland and various public and private partners, is a place where victims, survivors, and their children can find the support and information they need to achieve safety in their lives. Chair Cogen and City Commissioner Dan Saltzman spearheaded this project together with support from the county's Domestic Violence coordinator.

Also MCHD is participating in the Defending Childhood Initiative-- Criminal Justice grant through DCHS where CHWs are being trained about the dangers of childhood exposure to violence.

## ***Healthcare***

### **Access**

36. Revise forms and procedures to make them accessible (grade level appropriate).  
Make video options available (DCM9).

Status: MCHD working on this area.

This seems to be standard procedure. Key informants reported that this was happening in various programs.

Related: MCHD Informatics groups and working with programs to use LEAN processes to improve program responsiveness e.g. recent work with HBI referral process has dramatically shortened time it takes to contact when a client is referred to the program.

37. Sponsor free clinics, health fairs and community fairs (H2).

Status: MCHD does this

MCHD supports the Coalition of Community Clinics: (from website) The Coalition of Community Health Clinics improves healthcare for vulnerable populations residing in the Portland metropolitan area. We achieve this mission by strengthening community health clinics and fostering collaboration across the safety net delivery system.

38. Expand county services by geographic area of need (e.g., preventive services for children)(H3).

Status: MCHD leads

Examples:

- One key informant says this is on the commissioners radar
- Geographic distribution of need has been incorporated into the Equity and Empowerment Lens;



- Southeast Health Center was reopened and primary care services to the homeless brought there as part of response to rapidly shifting demographics
- Siting of the Rockwood clinic was based on geographic analysis of need
- And one key informant says that many programs are increasingly focused on East County because of the growing needs there.

39. Expand School Based Health Care Centers (H8).

Status: MCHD operates and has expanded some SBHC services

MCHD added Franklin SBHC and the Billi Odegaard Dental Clinic in the recent past. MCHD is also planning to open a new SBHC at Centennial High School in Spring 2014.

40. Universal healthcare including mental health and prevention (S1).

Status: Limited work on universal healthcare; but extensive work via CCO in expanding services and prevention.

While Health Department doesn't actively support "universal healthcare" as a formal policy priority, the department is integrated with HealthShare of Oregon and partners with FamilyCare and through the Affordable Care Act expanding services to those in need. Mental Health has been incorporated into the Equity and Empowerment Lens.

41. Require health insurers to cover health promotion and prevention activities (S12).

Status: MCHD working on

Much of this work being done through work on the CCOs--see S62/Health Promotion CCO work.

42. Require health insurers to cover alternative care (S8).

Status: limited

This recommendation is outside of the purview of the health department but definitely within the department's sphere of concern that all receive the appropriate support for their health.

Under healthcare transformation there is much greater emphasis on prevention and wellness but under OHP (HealthShare, FamilyCare CCOs) alternative care such as chiropractic and acupuncture are not covered.

43. Enhance mental health systems of care--require affordable access (S9).

Status: limited—outside purview of MCHD.

Mental Health services and planning sits more solidly in Human Services, but the Health Department is supporting legislation that may lead to new money to fund mental health and addictions services. Some work on access and affordability is being done through CCO and health care reform.

### **Access & Quality**

44. Provide English as a second language services (interpretation) (H13).

Status: working on

MCHD provides extensive interpretation services through the clinics. Increasingly interpretation is being highlighted as an issue of equity.

45. Examine funding equity for general vs. culturally specific service delivery models (S48).

Status: Unknown

Of all the 83 activities/policies, this was one of only a very few that none of the key informants had any information on. While this isn't specifically happening yet (something that may be the purview of the EE Lens applied to all our programs) targeting services to particular populations is an essential feature of the health department's work.

### **Quality**

46. Establish plan for coordinated mental health system enhancements (DCJ4).

Status: Happening as part of health care transformation but MCHD has limited role.

See S9/Healthcare Access.

47. Lengthen patient-provider visit time so that providers can take time to understand concerns and needs of patient (DCM19).

Status: Leading and partnering

Multnomah County Health Department is not specifically working toward increasing the time that patients and providers spend together, however much

work is being doing to improve patient experience, quality of care and patient empowerment.

Under health care transformation through the Affordable Care Act, the Health Department is collaborating with 10 other organizations, including hospitals and insurers, to form the HealthShare Coordinated Care Organization (and partners with FamilyCare CCO), which will bring a more holistic and integrated experience to patients.

In 2009-2011 Multnomah County Health Department's Health Promotion Community of Practice developed and piloted the Patient Empowerment Tool, a 3-stage approach that includes listening, dialogue, and action. The first stage in the Tool encourages clinicians to spend at least one minute listening to their patients (research shows that the average time healthcare providers spend listening to patients is 22 seconds). Currently, the group is working with clinical leadership to explore ways to integrate the Tool into County clinics.

48. Support expansion of community health worker programs to communities affected by inequities (DCM22).

Status: MCHD doing lots of work and partnering in this area.

The health department is doing this work, mostly through the Community Capacitation Center, but it is mostly unfunded. MCHD is advocating with CCOs to get this paid for. Currently, HD has partnership with CareOregon who employs the CHWs. Through CCO work, CHWs are being used to reach out to community beyond the health clinic.

49. Form healthcare related patient support groups (H4).

Status: working on

One example is chronic disease support groups, especially for Diabetes; MCHD advocating with CCOs to get group visits billable.

50. Support collaboration of medical providers to establish urgent care system to divert use of expensive ER use (S13).

Status: Working on

One key informant provided information about the Tri-County 911 Service Coordination Program which serves Washington, Clackamas, and Multnomah county residents who call 911 frequently for emergency medical services (EMS) when other health and social services would most appropriately serve their needs.

Program goals are to reduce demands on EMS services by linking clients to the right care, at the right place. Four Licensed Clinical Social Workers (LCSWs) do this through:

- Provider notification of client EMS use and consultation;
- Care Coordination, including partnering with various service providers to assure continuity of care.;
- Short-Term Intensive Case Management , such as direct assessment of needs and care management until other service linkages are made.

Clients are identified by data received or through direct referrals from emergency response partners in the three counties.

51. Use holistic approach to providing services (S27).

Status: partnering

The work under Affordable Care Act and in forming HealthShare could fall under this recommendation, especially the forming of patient centered teams. MCHD also partners with FamilyCare CCO. Expanded use of Community Health Workers could fall under this area too. One key informant mentioned the using of CHWs to reach out to community beyond the health clinic as part of the CCO. See DCM22/Quality for more information.

52. Engage with regional health systems to encourage the collection of county specific data on health services and outcomes by race and ethnicity (S53).

Status: partnering

According to key informants there are many examples where the Health Department is leading or partnering to encourage the collection of data by race and ethnicity. One example is that Program Design and Evaluation Services used MCHD's disparities report as a template example in its work with state Oregon Health Authority in helping state DHS/OHA offices shift to collecting and analyzing data by race/ethnicity.

Another example is MCHD's work in the Healthy Columbia Willamette project, where the health department is facilitating and coordinating conversations among 14 hospitals, four health departments and two coordinated care organizations in the Clackamas, Multnomah and Washington counties of Oregon and in Clark County, Washington in developing their policies vis a vis Affordable Care Act requirements for assessing needs of community. Using race/ethnicity data to look at disparities. Have done focus groups with Latino and immigrant

and refugee communities; working with the major local CBOs-- APANO, NAYA, IRCO and so on. Lots of community input.

## ***Housing***

53. Promote creative design of affordable housing to enhance community connections (C15).

Status: MCHC partnering and advocating

Health Department staff have participated on “expert policy groups” as part of the development of City of Portland’s Comprehensive Plan and the Portland Plan. Staff have made recommendations for housing that include features that promote community connection, health and livability such as covered bike racks, green space, park space, tree cover. The health department staff have advocated for the “20 minute neighborhood,” a national movement to have neighborhoods designed such that all the basic needs can be met within a 20 minute walk or bike ride from where people live. Such design would increase community connection and health.

54. Increase availability of affordable housing (C17).

Status: MCHD supporting

MCHD is providing data and evaluation to support legislation that would repeal the state-wide ban of municipalities establishing inclusionary zoning. Inclusionary zoning, if adopted, would allow the city to provide incentives and requirements of developers of multi-unit housing to build affordable housing of the same quality as market value housing.

55. Establish mandatory proactive rental housing inspection policy c.f. city of Gresham (DCS5).

Status: DONE

MCHD worked with City of Portland to create language in habilitation housing code that made health effects more tangibly measureable, e.g., humidity % levels now measured where before it was a subjective measure of mildew/mold.

City of Gresham passed mandatory inspection of multi-unit housing complexes on a three year rotation i.e., one-third of the complexes are inspected every year, and by the end of every 3 year cycle all the units have been inspected at least once.

City of Portland passed a similar mandatory inspection ordinance but this one creates an “enhanced” inspections list where an inspection will trigger inquiry

into inspecting other units in the same complex, in an attempt to identify “hot spots.”

56. Ensure that all jurisdictions in Multnomah Co enforce lead-based paint and mold protocols consistent with the international housing code standards (DCS8).

Status: leading and partnering

MCHD has worked with partners to promote the adoption of healthy housing protocols. The City of Gresham and unincorporated Multnomah County have adopted the international property maintenance code which has the highest standards for mold and lead prevention. The Multnomah County Health Department has worked to increase the stringency of much of the City of Portland’s title 29 housing habitability code related to health, especially the following areas:

- Lead Hazards and Lead-based paint
- Interior Dampness
- Integrated Pest Management
- Carbon Monoxide
- Hazardous Materials

57. Establish property tax incentives to remove lead-based paint (S42).

Status: Unknown

While none of the key informants had any information about MCHD activities related to promotion changes in the property tax code to support removing lead-based paint, the Health Department has been working with partners to promote the adoption of other strategies to reduce exposure to lead-base paint (see DCS8 above).

58. Promote a greater focus on energy conservation (S43).

Status: Beginning conversations

The County (not MCHD necessarily) is focused on energy conservation through the implementation of the sustainability and social equity in purchasing policy.

Conversations have just begun on ways to integrate energy efficiency (weatherization) inspections/consultations with environmental/health inspections.

59. Advocate and partner for elimination of no-cause eviction policy for rental housing (S44).

Status: leading and partnering

Multnomah County Health Department is working intensively with partners on better understanding the problem of no cause eviction, retaliation and its health impacts and developing recommendations to address the issue.

The Health Department conducted a review of current research examining the health effects of no cause eviction and retaliation on renters in Multnomah County. Based on this review, the Health Department identified the following concerns about no-cause eviction and its impacts on healthy housing:

- The number of tenants who receive no cause evictions are underrepresented in the court's record-keeping process.
- Discrimination and retaliation are the only defenses available for a no cause eviction and are difficult to prove.
- Tenants on month-to-month leases who have lived in their property for less than a year are afraid to ask for repairs because they fear eviction.
- When tenants are afraid to ask for repairs, they often remain in unhealthy housing.
- Numerous studies show that low-income communities, women, and minorities make up a large number of individuals evicted.
- Children are vulnerable to the health effects affected by no-cause eviction.
- The abuse of no case evictions places monetary burdens on low-income people and on society.
- By providing families with greater residential stability, just-cause eviction can reduce stress and adverse health conditions.

Some of the health department's research is showing that, for example, families who reported they were not comfortable approaching their landlord are 30% more likely to have mold in their apartment, are twice as likely to have cockroach infestations, 60% more likely to report their housing is making them and their family sick, and twice as likely to report poor or bad health.

The health department is currently finalizing a list of recommendations to the City of Portland and Board of County Commissioners on policies and practices related to no cause eviction, housing development and evictions reporting.

60. Assure availability of healthy homes including setting standards for indoor air quality (e.g., "breathe easy homes") (S46).

Status: MCHD provides related services

Initially granted funded but now 65% Medicaid funded, the Healthy Homes Asthma program provides free services to eligible families. Services include home inspection and consultation, referral, help work with medical provider on an Asthma Action Plan, help with Asthma medication management and help to

make the home healthier. A related program, the Community Asthma Inspection Referral Program is similar to the Healthy Homes program but is open to families with children who have other environmentally caused health conditions (respiratory problems, skin problems). Staff will help link families to resources to repair housing, needed supplies and/or access medical care.

61. Examine long term costs of displacement during development (S61).

Status: limited – recommend HD put more energy into directly addressing this recommendation.

Though this recommendation was placed in housing because gentrification directly impacts where people live, the consequences of displacement have broad ripple effects. Most key informants did not know of any MCHD activities directly or tangentially related to examining long term effects and costs of displacement. One key informant pointed to the Health Department's partnerships through the STRYVE grant (see C2/Community Built Environment).

### ***Physical Activity & Nutrition***

62. Promote alternative modes of transportation (C1).

Status: MCHD has partnered and lead in this area

Two examples: City of Gresham and City of Portland planning processes. Both cities used technical advisory groups to address equity in the city plans. MCHD had a key role in that the CPPW grant funded some of the work and paid for MCHD advisors to be on the TAGs. Gresham collaborated with community groups like Urban League and CPPW helped fund community group participation. Both cities incorporated alternative transportation concerns into their planning.

63. Use zoning laws to limit the number of liquor stores and fast food places in neighborhoods (C12).

Status: Unknown

None of the key informants had information about MCHD activities related directly or tangentially to this area.

64. Coordinate with Portland Parks to evaluate health impacts of exercise programs and park space (C13).

Status: Partnering and leading.

Through ACHIEVE coalition and CPPW grants MCHD helped fund community partners (African American Health Coalition) to work with parks bureau around



barriers for African Americans to use the park spaces. Parks bureau also incorporated the community feedback into planning and remodeling parks.

65. Expand quantity and quality of parks and green space to enhance access for those affected by inequities (C8).

Status: Partnering and leading

See C13/Physical Activity & Nutrition

66. Remove junk food from buildings and replace with healthier choices (DCM10).

Status: working on

According to one key informant, MCHD is supporting and closely tracking policy that sets guidelines for vending machines in publicly owned buildings.

67. Establish restaurant menu labeling ordinance (DCM20).

Status: working on/leading

MCHD did a lot of work to get menu labeling passed in Multnomah County but the ordinance was preempted by state legislation which was then preempted by the federal Affordable Care Act. This could be very positive in that there will be some kind of menu labeling nationally -currently in rule making phase; per AP article from March 2013, FDA still in rule making process; getting push back from convenience stores and grocery stores but expect final rules soon.  
(<http://health.usnews.com/health-news/news/articles/2013/03/12/fda-head-says-menu-labeling-thorny-issue>)

68. Improve physical activity and nutrition in schools and day care centers (DHS2).

Status: leading and partnering

Through CPPW, MCHD funded 7 school districts to develop and implement policies supporting physical activity and nutrition.

Community Health Services in MCHD is working with the Oregon Public Health Institute to implement the Right From the Start project. From OPHI's website:

The Right from the Start Child Care Assessment examines child care practices and policies and attitudes and beliefs of child care providers in four key areas:

- Nutrition
- Physical activity
- Support of breastfeeding families

- Screen time

OPHI and [partners](#) developed and piloted the Right from the Start Childcare Assessment with all licensed child care providers in Multnomah County, OR. We use the findings to drive improvements in the child care system, to provide meaningful recommendations for training and support of child care providers and to collaborate with public health and child care partners on evidence-based strategies for healthy child care.

69. Ban marketing/sale of junk food in schools (S2).

Status: DONE

2011 Oregon legislature passed legislation on nutrition standards for food dispensed via vending machines. MCHD staff sit on Oregon Nutrition Policy Alliance and probably gave support, data etc (this was prior to current staff's tenure) in support of the legislation.

The Oregon legislation will be pre-empted by the just released USDA's federal school nutrition standards (accessed 6/27/13 <http://www.usda.gov/wps/portal/usda/usdahome?contentid=2013/06/0134.xml>) which will impact all schools receiving federal funds for food which is nearly all schools within Multnomah County. Standards go into effect July 2014.

MCHD's Community Wellness and Prevention Program is working with schools and community groups to promote nutrition and physical activity in Multnomah County Schools. From their website: The Healthy Active Schools Program works in partnership with school districts, SUN Community Schools, and community partners to develop and implement policy and systems change strategies that promote healthy eating and physical activity in schools. The Program works at three levels: 1) advancing district-wide policy change to promote population-wide student health, 2) implementing nutrition, physical activity, and screen time standards for after-school programs in schools identified as high need and serving communities disproportionately affected by chronic diseases, and 3) coordinating a Healthy Eating Active Living Coalition in partnership with the Cesar Chavez K-8 School community in North Portland as an on-going neighborhood-based demonstration project.

70. Increase taxes on unhealthy products (e.g. tobacco, sodas, junk food) (S6).

Status: working on/leading

According to several key informants, MCHD is supporting state legislation that would end state preemption of local jurisdictions from enacting (or posing the option to voters) to increase tobacco tax. Also MCHD is currently supporting sugar-sweetened beverage tax legislation.

## ***Racism & Equity***

71. Convene community dialogues to understand racism (C7).

Status: working on related

The County's Office of Equity and Inclusion helps promote Uniting to Understand Racism's Race Talks series: (accessed 6/26/13  
<http://web.multco.us/events/2013/07/02/race-talks-opportunities-dialogue>)

MCHD also addresses dialogues about race and racism through its Building Partnerships Across Difference training series and forums for employees.

72. Create list of individual actions to reduce health inequities (DCM15).

Status: some work

While none of the key informants new about a specific list of individual actions, some of this (actions to take) is built into the process of the Equity and Empowerment Lens.

73. Promote the adoption of an equity lens by other local governments (DCM4).

Status: limited work by MCHD/ more direct work at county level

County level is working on promoting EE Lens with other jurisdictions in particular City of Portland and Metro. Also at county level the county hosting/participating quarterly MWESB Summits with over 20 public agencies to share best practices, enhance existing policies, and coordinate on new polices to ensure the success of Minority-owned, Women-owned, and Emerging Small Businesses regionally.

## ***Workforce Development***

74. Hire, retain and promote diverse workforce (DCM1).

Status: MCHD leading

MCHD has done a lot of work on cultural competence policy framework directly related to hiring, training, retaining and promoting a diverse workforce. Also, Human Resources is working on applying an equity lens to their hiring and recruitment practices.

75. Provide trainings in reducing stress (DCM11).

Status: MCHD leading

See DHS4/Workforce Development below

76. Allow the combining of sick and vacation time in donations for catastrophic leave (DCM12).

Status: NONE

None of the key informants had information on this recommendation. Expanded research to include in-house managers and found that this recommendation is contrary to current County policy—employees cannot donate sick time for catastrophic leave requests.

77. Provide cultural competence training for all county employees; required for health providers (DCM3).

Status: MCHD working on

MCHD adopted a policy framework focused on cultural competence.

78. Establish tuition re-imbusement programs for entry-level employees (DCM7).

Status: unknown

None of the key informants had any information on MCHD activities in this area.

79. Sponsor free or reduced cost fitness club memberships (DCM8).

Status: unknown

Key informants had no knowledge of Multnomah County or the Health Department sponsoring free or reduced cost for fitness club memberships

80. Restructure Employee Wellness Program to target health disparities among County staff (DHS4).

Status: Health Department is leading this area in addressing employee wellness and job satisfaction.

A new wellness coordinator was hired in Central Wellness division

BRITE (Building Resilience Innovative Team of Employees) was formed and has recommended ways to improve employee satisfaction and build resiliency in the Health Department. The key areas are: Management Support, Employee Wellness, Workload and Time, Democracy and Empowerment, and

Communication. A phased plan has been created to implement BRITE's recommendations.

Recommendations are:

- Institutionalize more routine staff recognition and engagement.
- Standardize and expand opportunities for flexible schedules, participation, and training.
- Create a shared working definition of an effective "leader" and "leadership" skills.
- Apply & evaluate standardized application of the Organizational Democracy and Empowerment Lens (ODEL) Questions.
- Strengthen management support and accountability.
- Address survey responses regarding affects of race/ethnicity and age in the workplace.

81. Create a "Health Equity" section for new employee orientation (DHS6).

Status: DONE

The New Employee Orientation provides health literacy training, empowering health promotion training and cultural competence training with a section on health equity.

82. Require employers provide a "living wage" (S3).

Status: Unknown

None of the key informants had any information on MCHD activities in this area.

83. Mandate paid sick leave (S7).

Status: Policy in place.

MCHD has a paid sick leave policy. Full-time, part-time and limited duration County employees receive paid sick leave, however, on-call and temporary employees do not. Also now a city policy, though none of the key informants said that MCHD had a role in passing the city ordinance. Also, the Sustainable Purchasing and Social Equity Policy scores vendors on providing paid sick leave.

## **Limitations**

The main limitation of this report is that we may have missed identifying a possible key informant within the health department who has critical information relevant to one of the recommended actions. Given that we have important information on nearly all of

the recommendations, this does not seem to be a serious limitation but the possibility still exists.

Another limitation is around categorizing the recommendations. Some of the recommendations are very difficult to categorize. Take, for example, the recommendation “Expand quantity and quality of parks and green space to enhance access for those affected by inequities” (C8). We put it into the category of Physical Activity and Nutrition but it could have easily been put into a category of Built Environment and, given how important park access and utilization can be for people, it could have been categorized under Community Social Capital.

## **Summary**

The health department is leading, partnering or working on projects, policies or programs related to nearly all of the recommendations from community members and employees. This is especially encouraging as some of the categories (such as Housing) are outside of the direct purview of the health department.

Much of the work the work of advancing equity is the result of key initiatives that have formed strong partnerships and coalitions with communities such as ACHIEVE, CPPW, HRI, HEAL. Healthcare transformation under the Affordable Care Act has also been a major initiative carry forward equity work.

Two areas that the Health Department might consider bringing more attention to are Mental Health and Addictions, and Criminal Justice.

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## **Appendix A: Acronyms and Abbreviations**

ACHIEVE - Action Communities for Health, Innovation and Environmental Change

BRITE - Building Resilience Innovative Team of Employees

CPPW – Communities Putting Prevention to Work

HEAL – Healthy Eating Active Living Coalition

HRI – Healthy Retail Initiative

## Appendix B: Table of Recommendations by Code

<b>Code</b>	<b>Category</b>	<b>Recommendation</b>
C1	Physical Activity & Nutrition	Promote alternative modes of transportation.
C12	Physical Activity & Nutrition	Use zoning laws to limit the number of liquor stores and fast food places in neighborhoods.
C13	Physical Activity & Nutrition	Coordinate with Portland Parks to evaluate health impacts of exercise programs and park space.
C15	Housing	Creative design of affordable housing to enhance community connections.
C17	Housing	Increase affordable housing.
C18	Community Safety	Facilitate neighborhood level strategies to address unfavorable neighborhood conditions.
C2	Community Built Environment	Partner with CBOs to change underlying physical structure of neighborhoods to enhance community connections.
C20	Food Security	Consider Food Policy Council's recommendations regarding policies promoting independence and equity in neighborhoods.
C7	Racism/Equity	Convene community dialogues to understand racism.
C8	Physical Activity & Nutrition	Expand quantity and quality of parks and green space to enhance access for those affected by inequities.
DCJ2	Criminal Justice	Implementation of corrections health transition planning.
DCJ3	Addictions and Mental Healthcare Access	Expand residential and outpatient drug and alcohol treatment centers.
DCJ4	Healthcare Quality	Establish plan for coordinated mental health system enhancements.
DCM1	Workforce Development	Hire, retain and promote diverse workforce.



DCM10	Physical Activity & Nutrition	Remove junk food from buildings and replace with healthier choices.
DCM11	Workforce Development	Provide trainings in reducing stress.
DCM12	Workforce Development	Allow the combining of sick and vacation time in donations for catastrophic leave.
DCM14	Health Promotion	Increase focus on women's health issues.
DCM15	Racism/Equity	Create list of individual actions to reduce health inequities.
DCM17	Food Security	Establish and promote cooking and canning classes.
DCM19	Healthcare Quality	Lengthen patient-provider visit time so that providers can take time to understand concerns and needs of patient.
DCM2	Education	Continue screenings of Unnatural Causes for county employees.
DCM20	Physical Activity & Nutrition	Establish restaurant menu labeling ordinance.
DCM21	Health Impact	Conduct health impact assessments on ballot measures.
DCM22	Healthcare Quality	Support expansion of community health worker programs to communities affected by inequities.
DCM3	Workforce Development	Provide cultural competence training for all county employees; required for health providers.
DCM4	Racism/Equity	Promote the adoption of an equity lens by other local government.
DCM5	Community Social Capital	Establish benchmarks for community building; incorporate community building capacity into grants.
DCM6	Education	Provide Undoing Institutional racism training for managers.
DCM7	Workforce Development	Establish tuition re-imbusement programs for entry-level employees.

DCM8	Workforce Development	Sponsor free or reduced cost fitness club memberships.
DCM9	Healthcare Access	Revise forms and procedures to make them accessible (grade level appropriate). Make video options available.
DCS1	Food Security	Promote connections between small local farmers and low-income neighborhoods.
DCS3	Emergency Planning	Consider equity and vulnerable populations in the development of regional emergency response plan.
DCS4	Healthcare & Human Services Access	Collocate services culturally specific "one-stop-shopping" centers.
DCS5	Housing	Establish mandatory proactive rental housing inspection policy c.f. city of Gresham.
DCS6	Food Security	Increase percentage of fruit and vegetable content of food purchased by Multnomah County.
DCS8	Housing	Ensure that all jurisdictions in Multnomah Co enforce lead-based paint and mold protocols consistent with the international housing code standards.
DHS2	Physical Activity & Nutrition	Improve physical activity and nutrition in schools and day care centers.
DHS3	Early Childhood	Expand programs that provide early identification and intervention with children missing school.
DHS4	Workforce Development	Restructure Employee Wellness Program to target health disparities among County staff.
DHS6	Workforce Development	Create a "Health Equity" section for new employee orientation.
F1	Early Childhood	Advocate for full funding for early childhood programs like Head Start.
F2	Early Childhood	Expand childhood early intervention programs. Increase screening for developmental delays.
H1	Food Security	Expand connections with community food programs such as community gardens, gleaners, harvest share programs etc.
H10	Education	Include Unnatural Causes in health curriculum in high schools.

H11	Healthcare & Human Services Access	Establish a domestic violence all-in-one service center.
H12	Education	Educate and inform teachers about diversity of their students.
H13	Healthcare Access & Quality	Provide English as a second language services.
H2	Healthcare Access	Sponsor free clinics, health fairs and community fairs.
H3	Healthcare Access	Expand county services by geographic area of need (e.g., preventive services for children).
H4	Healthcare Quality	Form healthcare related patient support groups.
H5	Health Promotion	Raise community awareness of risks of low birth weight and infant mortality.
H6	Education	Expand youth education programs which provide skills and resources e.g., SUN.
H7	Food Security	Geographic equitable access to healthy and affordable food.
H8	Healthcare Access	Expand School Based Health Care Centers.
H9	Community Social Capital	Connect youth and elders (e.g. Experience Corps model).
MC7	Community Social Capital	Include community members in decision making.
MC8	Community Safety	Tax gun sales to leverage funds for violence prevention activities.
PAO1	Education	Raise awareness of social determinants of health among community, staff and policy makers.
S1	Healthcare Access	Universal healthcare including mental health and prevention.
S12	Healthcare Access	Require health insurers to cover health promotion and prevention activities.

S13	Healthcare Quality	Support collaboration of medical providers to establish urgent care system to divert use of expensive ER use.
S2	Physical Activity & Nutrition	Ban marketing/sale of junk food in schools.
S27	Healthcare Quality	Use holistic approach to providing services.
S3	Workforce Development	Require employers provide a "living wage."
S30	Economics	Fund micro-enterprise and entrepreneurial training that could be linked to empowerment and health promotion.
S35	Health Promotion	Support water fluoridation policy.
S40	Health Impact	Increase funding of health impact assessments.
S41	Community Social Capital	Oppose policies that deny access to indigenous cultures and that promote cultural disconnections between immigrant parents and children.
S42	Housing	Establish property tax incentives to remove lead-based paint.
S43	Housing	Greater focus on energy conservation.
S44	Housing	Advocate and partner for elimination of no-cause eviction policy for rental housing.
S46	Housing	Assure availability of healthy homes including setting standards for indoor air quality (e.g., "breathe easy homes").
S48	Healthcare Access & Quality	Examine funding equity for general vs. culturally specific service delivery models.
S53	Healthcare Quality	Engage with regional health systems to encourage the collection of county specific data on health services and outcomes by race and ethnicity.
S58	Economics	Promote streamlined process for contracting with Minority, women and emerging small businesses.

S6	Physical Activity & Nutrition	Increase taxes on unhealthy products e.g. tobacco, sodas, junk food.
S61	Housing	Examine long term costs of displacement during development.
S62	Health Promotion	Expand funding for health promotion programs as an investment.
S7	Workforce Development	Mandate paid sick leave.
S8	Healthcare Access	Require health insurers to cover alternative care.
S9	Healthcare Access	Enhance mental health systems of care--require affordable access.

### Appendix 3: Code Meanings

The codes and definitions that follow refer to the original jurisdiction to which a particular recommendation was assigned as listed in Appendix A: Policy Priorities by Government Jurisdiction in Health Equity Initiatives Annual Report 2009.

<b>Code</b>	<b>Meaning/Jurisdiction</b>
C	City Government
DCJ	Multnomah County Department of Community Justice
DCM	Multnomah County Department of County Management
DCS	Multnomah County Department of Community Services
DHS	Multnomah County Department of Human Services
F	Federal Government
H	Multnomah County Health Department
MC	Multnomah County Chair and Commissioners
PAO	Multnomah County Public Affairs Office
S	State Government