Multnomah County
FY 2026 Budget Work Session Follow Up

Health Department Overview

May 20, 2025

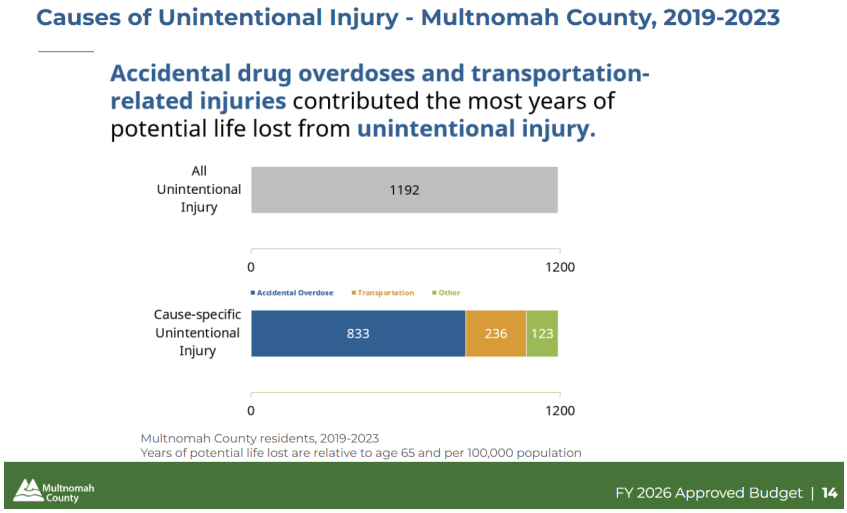
Commissioner Singleton (District 2) - Where are we with tracking outcomes for the homeless population? Their average age is below the data in slide 14.

Response:

We analyze cause of death among people experiencing homelessness from two data sources: Medical examiner data and death certificates (vital records data). Domicile Unknown is our annual report that describes the results of these analyses. Additionally, we track housing status across almost all of our MCHD programs.

These analyses are conducted distinctly from overall analysis related to leading causes of death because ascertaining housing status requires an in-depth process and cross checking with homeless management information systems.

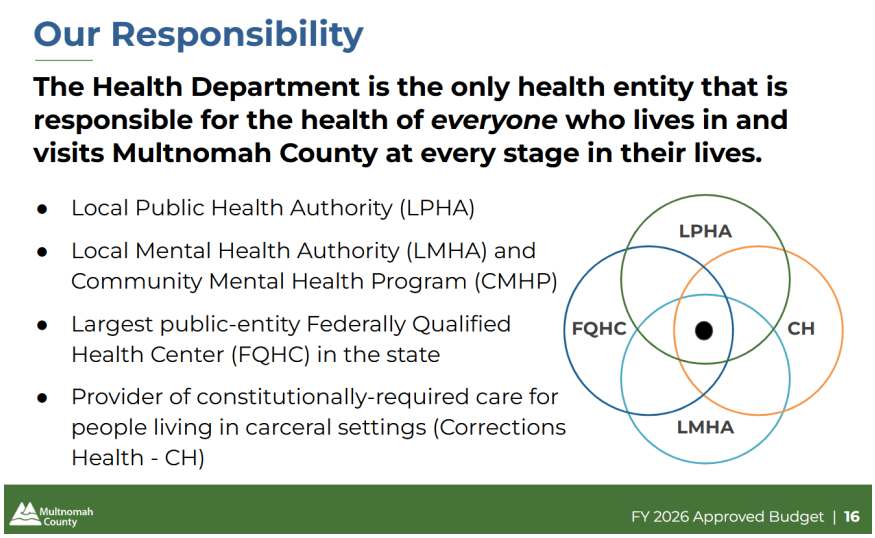
Commissioner Brim-Edwards (District 3) - For slide 14, is it possible to get comparative data for Washington & Clackamas Counties?



Response:

The Community Epidemiology Services team analyzed age-adjusted mortality rates per 100,000 people for the top 5 leading causes of death from 2019-2023 comparing Multnomah County, Clackamas County, and Washington County. The order of the 5 leading causes of death is similar among the counties. Aside from Alzheimer's disease, Multnomah County had higher age-adjusted mortality rates for all top 5 causes of death compared to Clackamas and Washington counties.

Commissioner Moyer (District 1) - FUTURE FY 2026 BRIEFING - Can you provide a breakdown of what our County Authority means in relation to statutory power and what are the responsibilities, including funding requirements, of the Coordinated Care Organizations (CCOs) and Oregon Health Authority (OHA)?



Response:

The Multnomah Board of County Commissioners is our **Local Public Health Authority (LPHA)** and our **Local Mental Health Authority (LMHA)**. Below is more specific detail of what that means.

Local Public Health Authorities are governmental entities tasked with promoting health, preventing disease, and ensuring the protection of community health. Our Local Public Health Authority Governing Body is the Board of County Commissioners. The board:

- Develops policies and goals
- Adopts public health ordinances and rules
- Adopts fees and civil penalties

The minimum services required by law (ORS 431.461) include:

- Control of disease
- Parent and child health services
- Environmental health services
- Health information and referral services

- Collecting and reporting health statistics

(Relevant statutes: ORS 431.150, 431.157, 431.262, 431.416, 446.425, 448.100, 624.510)

The Health Department Director is our Local Public Health Administrator – appointed to manage and execute day-to-day operations under the LPHA's oversight. A key function of the Health Department in its Public Health role is to design, implement, and operate the policy and regulatory decisions in statute and any made by the BOCC in its role as the Local Public Health Authority (LPHA).

The Board of County Commissioners is also our **Local Mental Health Authority** and is responsible for:

- Developing a local plan for mental health services
- Ensuring compliance with mental health service rules
- Coordinating local planning with community health improvement plans

A key function of the Health Department's Behavioral Health Division is its statutory designation as the Community Mental Health Program (CMHP). CMHP statutory requirements include:

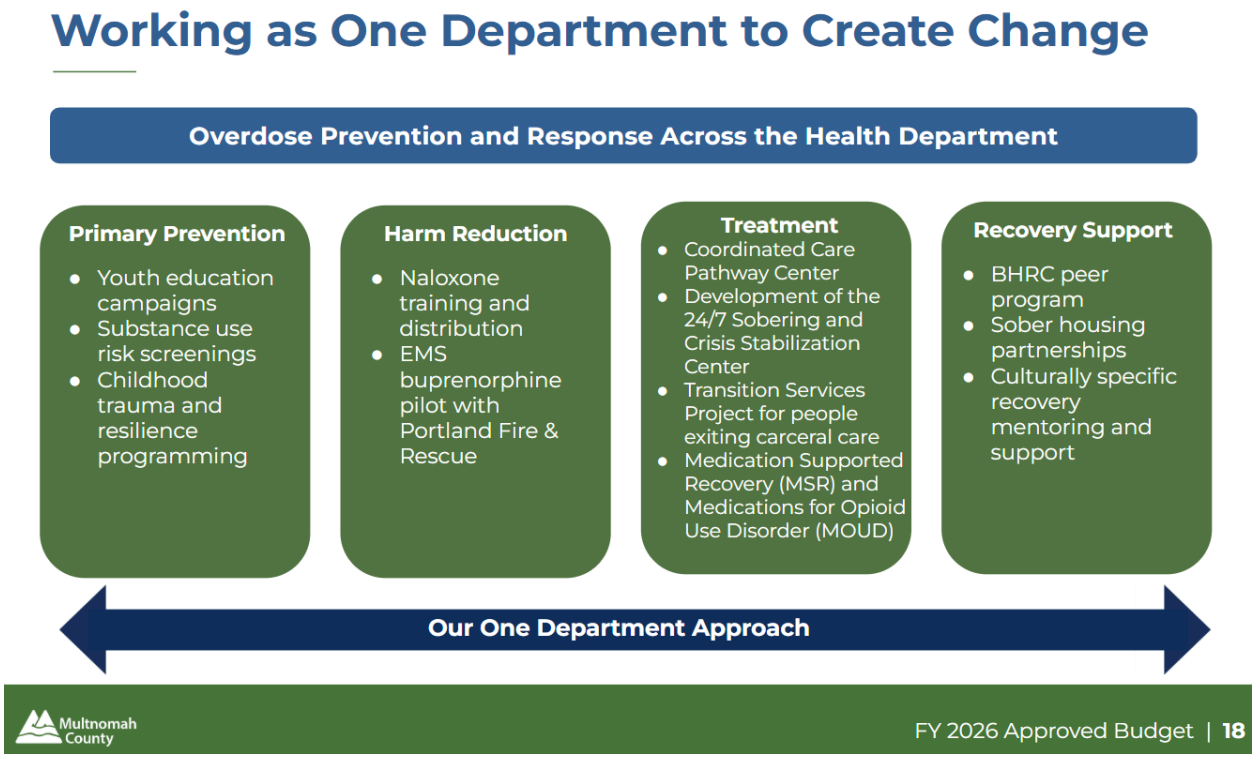
- **Service Delivery** – A continuum of services with specific service delivery stipulations that range from 24 hour crisis support to discharge/transition processes from psychiatric facilities.
- **Funding** – Funding must be coordinated with local and state budget cycles, maximized for service provision, leveraged with other funding sources; provision of services is ensured regardless of ability to pay.
- **Performance Management** – A set of expected outcomes based on service provision and actions to be achieved in a local plan that are rooted in research-based quality indicators and best practices.
- **Needs Assessment** – A Community Health Assessment (CHA) to determine local services needed that specifically address age

ranges and culturally-specific populations served by the local plan.
- **Input and engagement** – Planning activities across all work that include consumers, advocates, service providers and other stakeholders as well as specific coordination with the Local Public Safety Coordinating Committee (LPSCC), local mental health advisory committees, and local alcohol and drug planning committees.
- **Service coordination** – Coordination that spans all levels of care, includes providers of social supports (i.e. housing, transportation, and others) and health/medical care, work with criminal and juvenile justice systems and work with local law enforcement to recognize and interact with people experiencing mental illness.

As the Local Mental Health Authority (LMHA), the County must:
- Support the Multnomah County Health Department and the Behavioral Health Division to operate the Community Mental Health Program (CMHP)
- Assess the behavioral health needs of the community
- Adopt a comprehensive local plan for delivery of mental health services, including methods by which services will be provided within the plan
- Provide services, and manage/coordinate services across systems
- Collaborate with the Local Public Safety Coordinating Council (LPSCC) to ensure the needs of the criminally involved are addressed

As the Chair noted, several previous presentations and briefings lay out these responsibilities:
    - This briefing on the CLP from December 3, 2024 provides an overview of the LMHA, CMHP and CCO roles (slides 5-8).

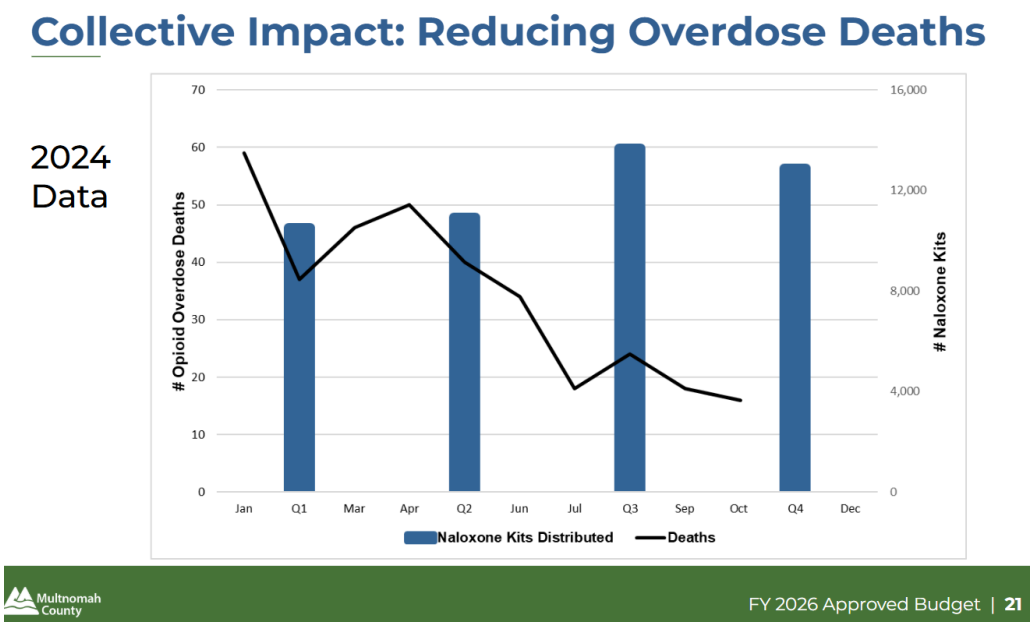
Commissioner Brim-Edwards (District 3) - Are there specific goals for these areas and do we have the data to identify where we are meeting the goals or where there are gaps?



Response:

Yes, we have a detailed plan that outlines goals. MCHD is reviewing data associated with the plan goals to measure the impact of the work and update the plan for FY 2026.

Commissioner Brim-Edwards (District 3) - Can we compare the data below to national trends?



Response:

Provisional data from the CDC's National Vital Statistics System predict a 27% decline in total U.S. drug overdose deaths, comparing December 2023 counts to December 2024 counts. For Oregon, the predicted decline is 22%.[1] This predicted value is not available at the County level. Note that 2024 data are provisional.

Multnomah County death rates have been higher than the United States for any drug, opioid, and fentanyl overdose in all years. Declines are seen in 2024 across categories for all jurisdictions (but note that 2024 data are provisional).

This series of graphs compares United States deaths (rate per 100,000 persons) to both Oregon and Multnomah County (rate per

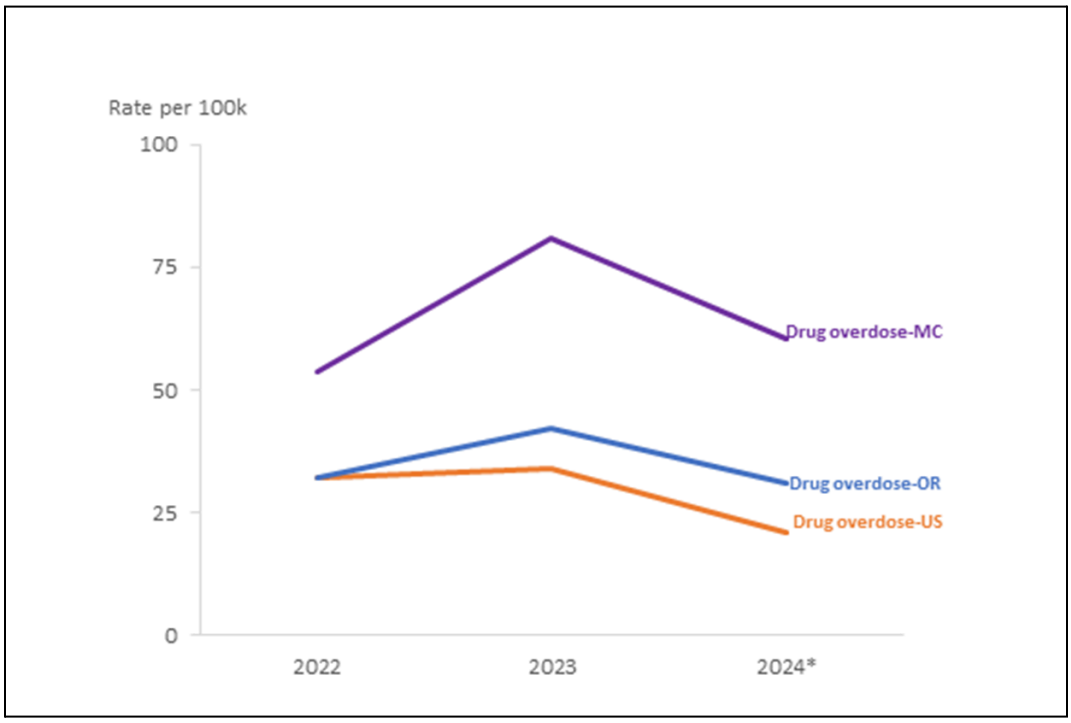
[1] https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

100,000 persons) for drug overdose, opioid overdose, and fentanyl overdose deaths between 2022 and 2024.

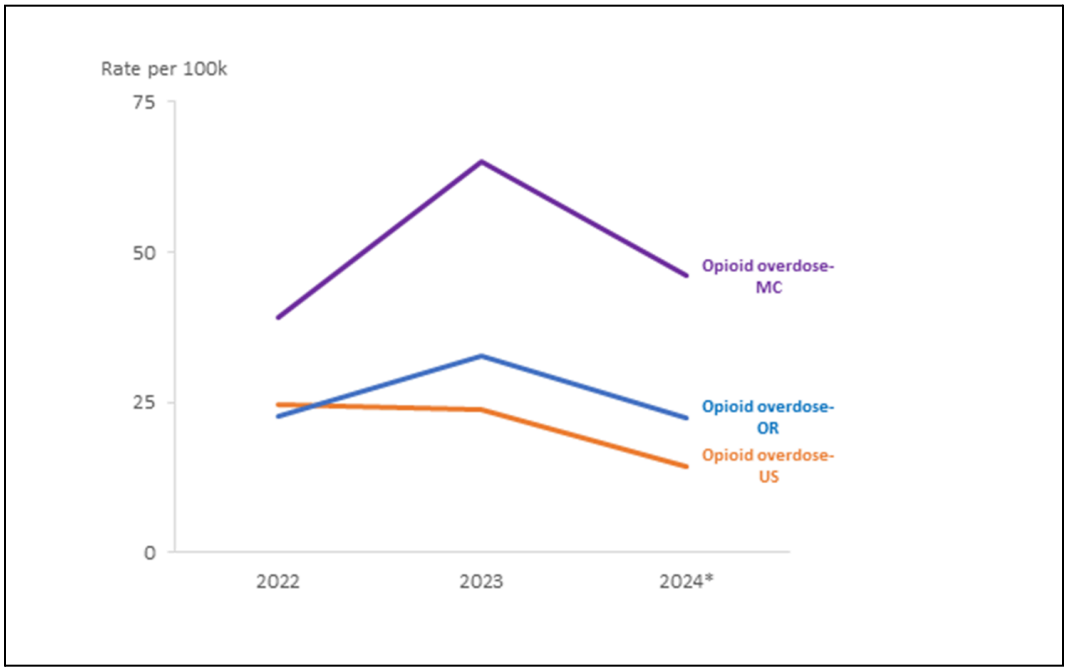
The following graphs represent data from the National Vital Statistics System, Provisional Mortality on the CDC WONDER Online Database. Data are from the Final Multiple Cause of Death files, 2018-2023 and from provisional data 2024, as compiled through the Vital Statistics Cooperative Program.

Drug overdose, opioid overdose, and fentanyl overdose, United States (US), Oregon (OR), and Multnomah County, OR (MC), 2022-2024*, death rate per 100,000

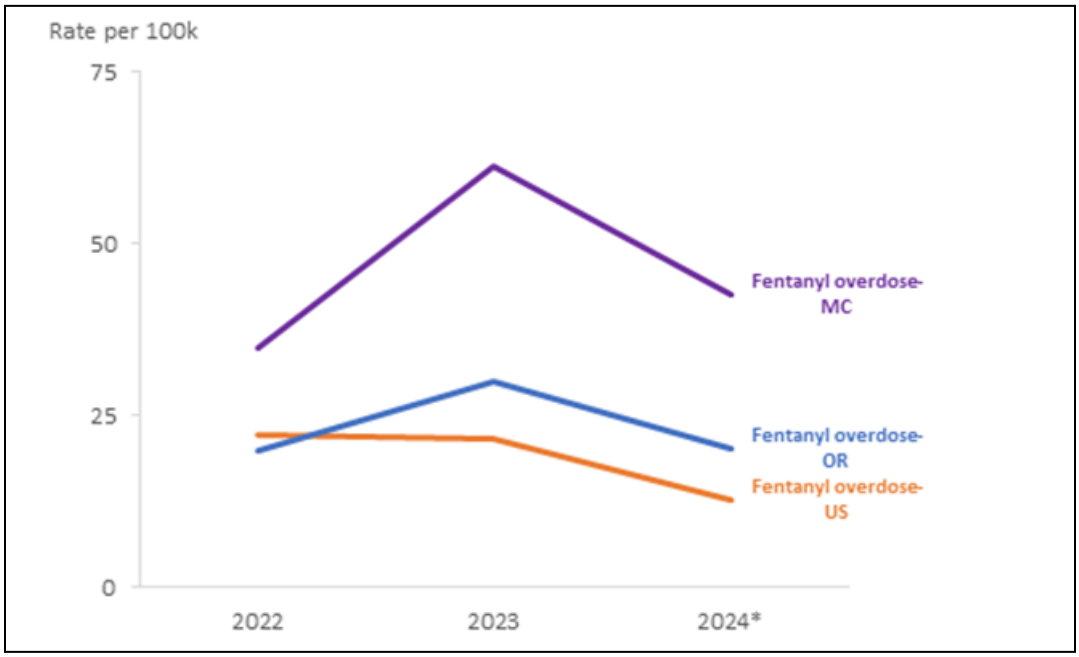
All drug overdose (2024 data are provisional) –



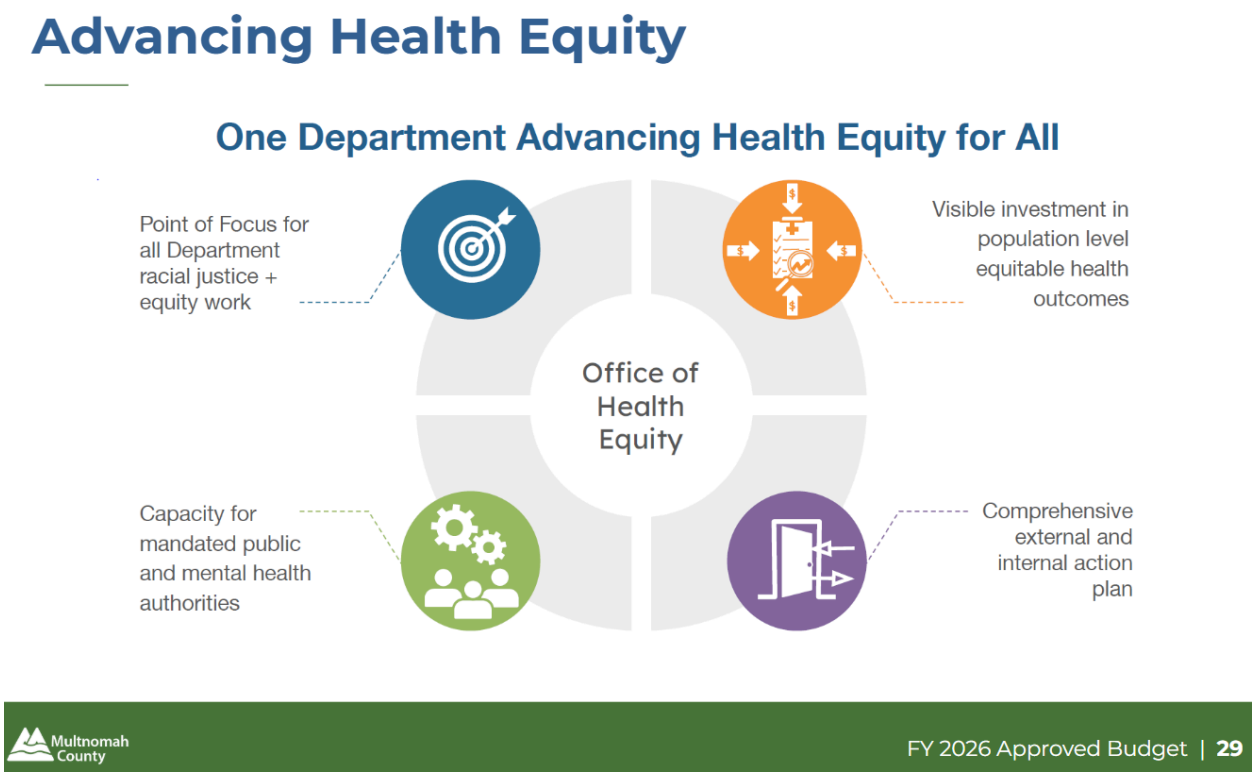
Opioid overdose (2024 data are provisional) –



Fentanyl-only overdose (2024 data are provisional) –



Commissioner Brim-Edwards (District 3) - What are our goals for reducing health disparities. Are there major areas we are focusing on at different stages in life? How do we show where we are making progress?



Response:

In order to see a reduction in health inequities in chronic diseases and unintentional injuries (among other things), Multnomah County's Five Priority Areas to reduce health inequities are derived from the 2022 Healthy Columbia Willamette Collaborative and the Multnomah County Health Department's 2022 Community Health Improvement Plan. These goal areas address concerns heard from the community. They focus efforts across the life span and aim toward what is most needed for optimal health.

- **A Neighborhood for All:** Access to safe and affordable neighborhoods and housing

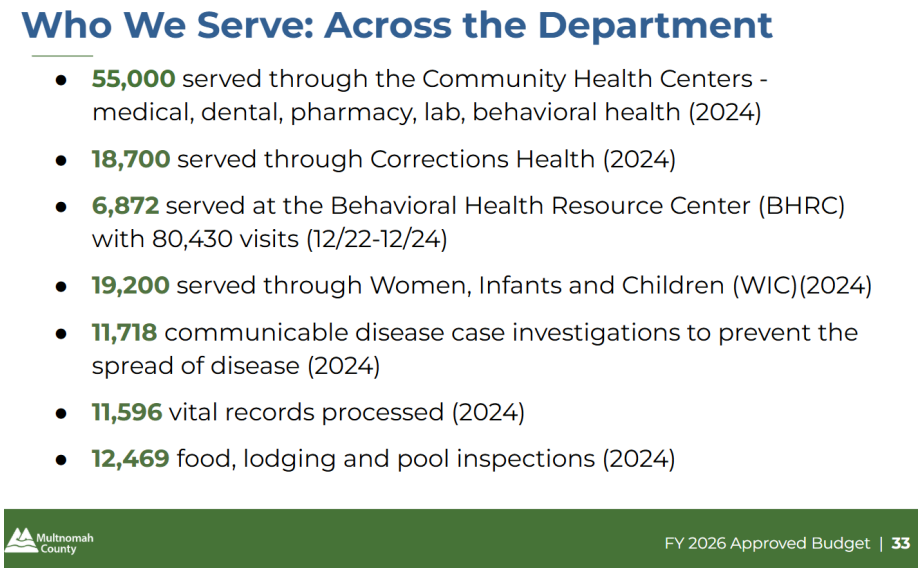
- **Essential Community Services and Resources:** Access to education, employment, nutritious food and transportation
- **Culturally and Linguistically-responsive Health Care:** Access to care that aligns with their cultural, behavioral and communication needs
- **Support Family and Community Ways:** Access to foods and healing medicines or practices specific to their communities of origin
- **Transformative Change Towards Equity Empowerment:** Multnomah County has a diverse workforce and leads with racial equity strategies, programs and partnerships through investments reflected in their budget

The Multnomah County Health Department is finalizing a set of core health indicators that will be reported annually to track health measures across the County and to capture progress toward reducing inequities in health outcomes. This data will help the County make investment decisions to make the most impact in mitigating and ultimately ending health inequities. The health indicators will reflect health across the lifespan, and will include data points required by Oregon Health Authority (OHA) as part of our accountability metrics for public health, and will be in alignment with public health accreditation metrics. Examples of data indicators include:

- Demographics and social context (i.e. race, gender, housing status)
- Living conditions and institutional context (i.e. food security, discrimination during pregnancy)
- Risk behavior and exposures (i.e. substance use, immunization rate, physical activity)
- Disease, injury and mortality (i.e. leading causes of death)

Of note: The Healthy Willamette Columbia Collaborative has recently reconvened to update the Community Health Needs Assessment (CHNA) by the end of 2025. The Multnomah County Community Health Improvement Plan (CHIP) will be updated in the summer of 2026. The PH Indicator team is working with the data team for both the community health assessment and the health improvement plan so that data indicators are in alignment with future updates of the assessment and improvement plan.

Commissioner Brim-Edwards (District 3) - Can you provide trend timeline data so we can understand if we are serving more or less people?

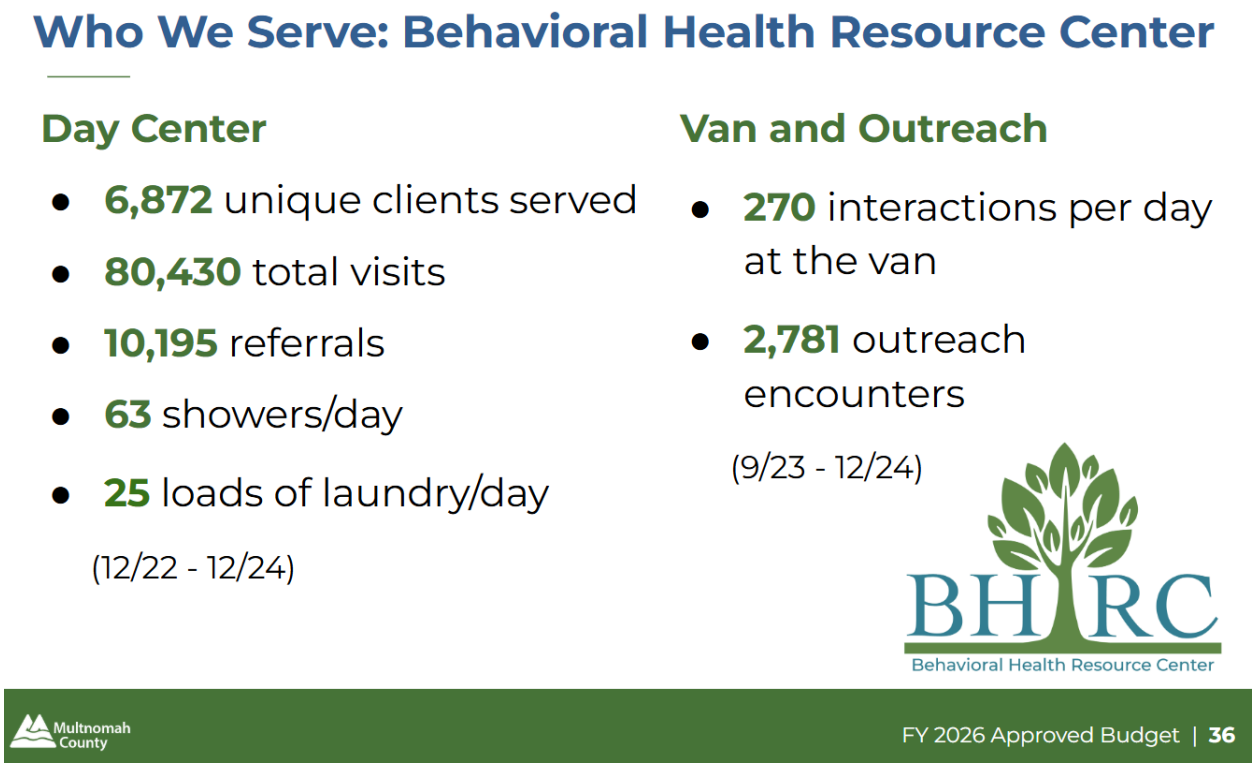


Response:

An initial assessment indicates different trends for different services. Our FQHC saw more clients in 2024 than they did in 2023. Conversely at our STI and Harm Reduction clinics we have seen fewer clients. As a Department we are trying to understand trends and needs over time particularly as we see federal reductions and/or threats to reductions in Medicaid and other services. The demand for

locally-funded programs may increase as we continue to see federal funding reductions.

Commissioner Singleton (District 2) - Can you provide the outcome data related to the BHRC referrals and more detail around the work/outcomes related to the "interactions" per day at the van?



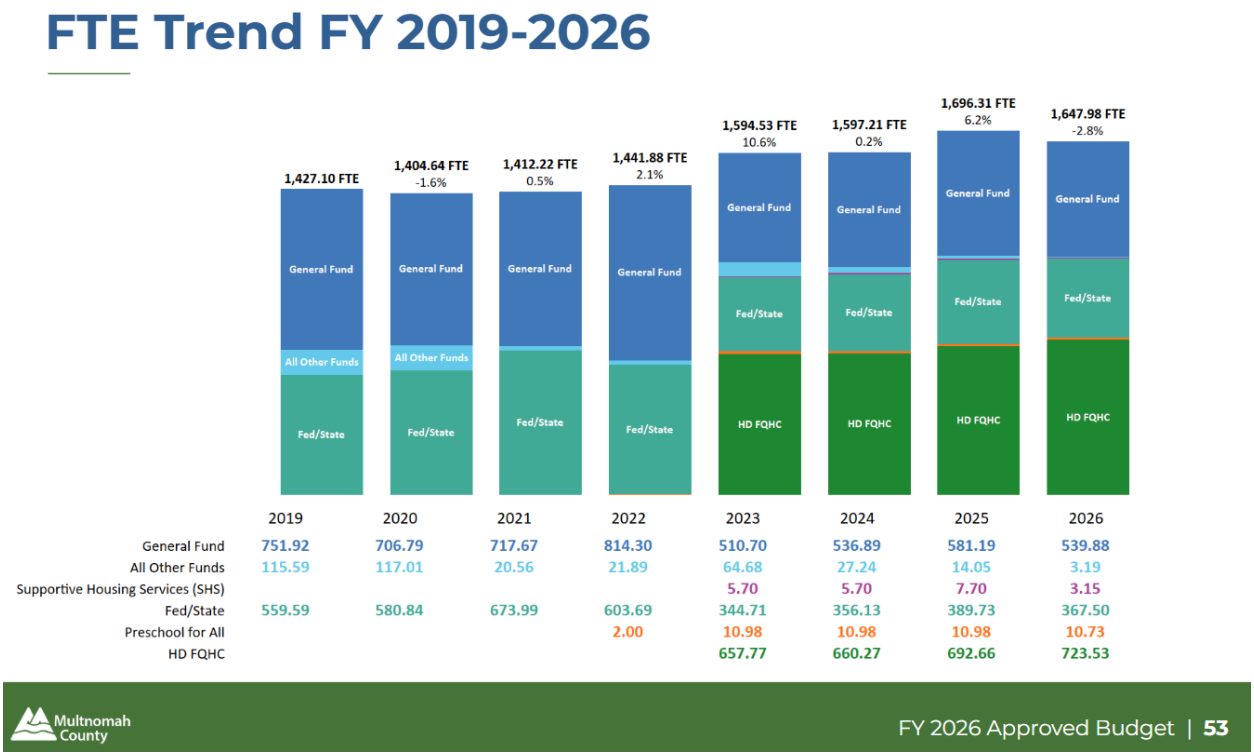
Response:

We do not have outcome data specific to referrals from the BHRC day program or the van interactions. The referrals noted in the budget presentation correspond to the BHRC day program. The day program is a very low barrier program staffed by peers with a primary goal of maintaining engagement with participants so that they will come back and engage in additional services over time. The referrals are a result of individualized conversations peers have with day program participants to "meet participants where they are

at" and refer them to services that meet immediate needs as well as to build trust so that they will return and engage in a higher level of service.

The van outreach associated with the BHRC is primarily to refer people into the BHRC to engage in day program services. This is often the first connection point that participants have and it can take multiple van interactions to build trust so that an individual accesses the day program. Participants that engage at the BHRC day program and at the van are interacting with different staff at different times.

Commissioner Moyer (District 1) - Of the 48 FTE that are being reduced, can you break it out by management vs. represented FTE?



Response:

There is a total net reduction of 48 FTE. Using our FY 2025 staffing levels as a starting point, our FY 2026 staffing includes the following reductions:

- 10.73 FTE (3.8%) in our non-represented staff, and
- 37.6 FTE (2.7%) in our represented staff (AFSCME and ONA).