Multnomah County Health Department
Programs and Activities to Address Health Inequities

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Multnomah County Health Department
Office of Health and Social Justice
Health Assessment & Evaluation

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This report may be found at:

http://www.co.multnomah.or.us/health/hra/reports/addressing_inequities_2009.pdf

The National Institutes of Health has defined a health disparity as "a population-specific difference in the presence of disease, health outcomes, or access to care."[1] Most health disparities affect groups that are already at a disadvantage because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location, or some combination of these. People in such groups not only experience worse health but also tend to have less access to the social determinants or conditions (e.g., healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination) that support health. Health disparities are referred to as health inequities when they are the result of the systematic and unjust distribution of these basic needs. It is widely recognized that eliminating health disparities of all types must be a priority in order to achieve optimal health, not only for disadvantaged groups, but also for the community as a whole.[2]

This document highlights Multnomah County Health Department's (MCHD) work to reduce health inequities. MCHD has made the elimination of health inequities a top priority, and the programs and activities listed in this report align with the Multnomah County Health Department (MCHD) strategic goals. Links, where available, are provided to the various programs for contact information.

4REAL Program (4 Relationship Education and Lifeskills) Formerly STARS

The 4REAL program addresses disparities among Latina and African Americans in rates of teen pregnancy when compared to White non-Latina teens. The program is designed to delay sexual activity and build healthy relationships for middle school students using peer educators to teach sexuality education sessions that focus on media influences, correcting misconceptions about teen sexuality, and building assertiveness skills to refuse pressure. In Multnomah County the teen pregnancy rate has continued to decline since the mid-1990s; however, the Multnomah County teen pregnancy rate remains higher than the state's rate, and is significantly higher for Latina teens. The 4REAL target populations are school age children 12 -18 with an emphasis on the African American and Latino population. The population was identified through a needs assessment including national, state and local data. Research shows that teens who delay sexual activity are more likely to have fewer partners, and to take action to protect themselves against pregnancy and sexually transmitted infections (STIs). The 4REAL program works to empower young people, and increase their sense of control over their lives and their health, focusing on skill building and assertiveness training to develop healthy relationships for life.

[1] National Institutes of Health (US). NIH Strategic Research Plan to Reduce and Ultimately Eliminate Health Disparities; Oct 6 2000. http://www.nih.gov/about/hd/strategicplan.pdf.
[2] Promoting Health Equity—A Resource to Help Communities Address Social Determinants of Health. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

Chronic Disease Prevention (CDP)

The Chronic Disease Prevention Program works to address health disparities among communities disproportionately affected by chronic disease. The CDP develops and implements population-based approaches to address the key factors that contribute to chronic diseases: tobacco use, physical inactivity, and poor nutrition. The goals of the Chronic Disease Prevention Program are to build coalitions and multidisciplinary partnerships; to implement comprehensive strategies to create policy changes; and to track, raise awareness of, and address health inequities. Key program areas include:

- ***The North Portland HEAL (Healthy Eating Active Living) Coalition*** addresses disparities by focusing on low-income and Latino communities who are disproportionately affected by obesity. The HEAL Coalition, working in the Portsmouth and St. Johns neighborhoods in North Portland, promotes healthy eating and physical activity through a variety of activities including education on pedestrian and bike safety, the Walk to School Campaign, TV Turnoff week, and a community garden project.
- ***Healthy Active Multnomah County Planning Initiative***: This initiative is focused on developing capacity for a population-based approach to reduce the burden of chronic disease most closely linked to physical inactivity, poor nutrition, and tobacco use. The Chronic Disease Prevention Program will be working with community partners to prioritize needs, and identify key strategies as a part of developing a three-year Action Plan. The initiative is guided by a community steering committee, including representatives from Upstream Public Health, Community Health Partnership, Lifeworks NW, the American Heart Association/American Stroke Association, and Kaiser Permanente.

Communicable Disease/Occupational Health Office (CD/OHO)

CD/OHO staff serve the community by providing culturally sensitive and language appropriate care regarding communicable diseases. Programs include:

- ***Community Immunization Program (CIP)*** addresses disparities in healthcare access by providing childhood vaccination services at little or no cost to low-income and uninsured clients. Off-site clinics are targeted for implementation in areas where underserved populations live. CIP collaborates with various agencies and associations in order to make immunization services for children as accessible as possible. Collaborating agencies include the African American Health Coalition, the Consulate of Mexico, Wallace Medical Concern, and the Multnomah Education Service District, as well as many others.
- ***Epidemiology Program***: Epidemiology involves studying the distribution of health and illness in specific populations to identify and ultimately help reduce the burden of disease in those populations. The epidemiology program addresses disparities by supplying data on reportable diseases, broken out by race/ethnicity and other characteristics, to better understand the health needs of vulnerable populations. Some of the populations assessed include African-Americans, men who have sex with men (MSM), and teens, all of whom are all at higher risk for Sexually Transmitted Diseases (STD's), and homeless and refugees at risk for Tuberculosis.

- ***Hepatitis C Registry Program:*** This program addresses disparities by identifying the characteristics of the hepatitis C infected population in Multnomah County including risk factors, health status, and access to health care for treatment and follow-up. Current or former injection drug users (the most common way the virus is spread in the United States) are at high risk for hepatitis C. The program offers hepatitis B and hepatitis A immunizations free of charge to protect infected individuals from acquiring these other forms of hepatitis.
- ***Oregon Refugee Preventive Health Project:*** This project addresses disparities in refugee and immigrant health by providing training and education to refugee volunteer agency staff, and providing health screenings and education/information to refugee populations. Training in the Stanford Chronic Disease Self Management Program is provided to new refugees. The Stanford model uses small-group workshops, and is designed to help people gain self-confidence in their ability to control their symptoms and how their health problems affect their lives.
- ***Tuberculosis (TB) Program:*** Those at highest risk for TB are the homeless, including those staying in shelters, the foreign-born population from countries where TB is more common, and family members, friends and co-workers of someone who has tuberculosis. The TB Program collaborates with agencies providing services to the homeless population such as Salvation Army, Union Gospel Mission and Hooper Detox Center and also with the State Health Division, CDC, and the Housing Authority of Portland.
- ***Perinatal Hepatitis B Program:*** This project addresses disparities in the health of refugee/immigrant women and children by identifying household contacts and children born to women who are infected with hepatitis B. Case management is provided to prevent disease transmission by making sure these children and contacts receive the appropriate lab tests and hepatitis B immunizations. Many of the clients are also non-English speaking. The program also conducts outreach to the populations at risk for hepatitis B by collaborating with local nonprofit organizations, such as the Asian Family Center and IRCO, to raise awareness and provide testing and immunizations through a series of community clinics.

Community Capacitation Center (CCC)

The Community Capacitation Center provides support to community agencies and leaders to develop the skills they need to identify and address health issues. The CCC provides training for community health workers (CHWs), and conducts popular education training with a variety of groups. Current projects include:

- ***Health Promotion in the Disability Community:*** This project seeks to promote health in the disability community by addressing the root causes of inequities. People with disabilities are more at risk of a variety of adverse health outcomes than people without disabilities. Specific activities have included: a Disability Health Promotion Summit (2007); a survey of primary care patients with disabilities (2007); initial assistance with development of a Voluntary Emergency Registry (VER); Autism Awareness month activities throughout the Health Department (2008); autism screening for children in primary care clinics (on-

going); and a presentation on "Disability and Health" for Integrated Clinical Services providers (2009).

- ***Youth Violence Prevention Partnership (YVPP:)*** This project addresses the disparity in the level of violence affecting youth of color in North/Northeast Portland, and seeks to prevent and reduce the incidence of violence by building relationships between youth and police officers. YVPP is a community-driven collaboration between the Community Capacitation Center (CCC), local law enforcement agencies, and community-based organizations that connect police officers with young people of color to achieve the overarching goal of preventing violence affecting youth. To make progress toward this goal, YVPP works to build mutual trust, overcome stereotypes, increase young people's knowledge of their legal rights, and promote positive future orientation. Using the principles and methods of popular education, YVPP engages youth and officers as equal participants in the process of identifying the problems in their communities, discussing the root causes, and exploring ideas for social action. The program involves participatory workshops co-facilitated by Health Department staff and police officers, as well as larger events like "Police Days," where officers from programs such as forensics and the bomb squad visit and interact with youth. Collaborators include police officers from the Northeast Precinct and staff from Self-Enhancement, Inc. (SEI), Native American Youth Association (NAYA), and the Blazers' Boys and Girls' Club.
- ***La Palabra es Salud (The Word is Health):*** La Palabra es Salud (LPES) is a community-based research project that compares different methods for training CHWs. The target population for training is Latino parish health workers, as identified by the Parish Health Worker Program of Providence Health and Services and El Programa Hispano. This type of research project increases the capacity of communities affected by health inequities to identify and address the root causes of inequity.
- ***Community Health Worker Capacitation Program*** provides empowering training for Community Health Workers (CHWs) using popular education, a philosophy and methodology that helps people and communities identify problems and causes, and develop solutions. CHWs are also referred to as *promotores/as de salud*, peer health educators, or outreach workers. Most CHWs are members of and work in communities affected by health inequities.

Diversity and Quality Team (DQT)

The mission of DQT is to ensure that the core values of diversity and quality are integrated into the daily work of the Health Department. The goals of DQT include measures for workforce diversity and health disparities. Progress on these goals is measured through the Team's monitoring and evaluation of Multnomah County Health Department's Strategic Plan. DQT strives to actively and consciously promote a highly qualified, diverse workforce at all levels, and to identify and reduce health disparities using appropriate health status indicators. The work of DQT includes:

- Developing a set of culturally competent interview questions in partnership with Human Resources as a tool and resource, available on the DQT web page.

- Creation and distribution of recruitment posters "Faces of Public Health". This poster was created to recruit and promote a culturally competent, diverse work force.
- Participation as facilitators for the screenings of the documentary series "*Unnatural Causes*" and the discussions that followed. Several Health Department "Health Equity" trainings have been conducted on health inequities and quality.
- Developing a race and ethnicity data collection training model, and providing training for Health Department staff.
- Reviewing and recommending actions based on data supplied by the Equal Employment Opportunity/Affirmative Action office, and reviews Diversity and Cultural Competence administrative guidelines.
- Circulating information that supports the Health Department's staff in learning about diversity, including a monthly diversity calendar, presentations during new employee orientations, window displays in the McCoy Building and East County Clinic, circulation of diverse publications at the McCoy Building, and regular updates in the "Notes from the Director" newsletter.

Early Childhood Services

The Healthy Birth Initiative addresses disparities in perinatal health among African American women in North and Northeast Portland by reducing the rates of infant mortality and low birth rate babies and improving the health and well being of mothers, fathers and their children, before, during and in between pregnancies. Interventions include:

- Outreach and client recruitment
- Case management
- Health education
- Interconceptional care and continuity of care for program participants
- Screening and referral for perinatal depression
- Enabling services, including transportation and childcare
- Community consortium

Clients enrolled in services are followed from pregnancy to the child's second birthday. This project is funded by the federal Healthy Start Initiative and has 13 core objectives and required national performance measures. The basic goals and objectives are to reduce infant mortality and low birthweight infants by assuring early and adequate clinical prenatal care; assessing women's perinatal risks and providing education, counseling and referral to address needs; and providing linkages to basic needs such as housing and education.

Emergency Preparedness

- ***Cultures Uniting for Emergency Preparedness (CUEP) Project:*** Hurricane Katrina demonstrated that life-saving emergency communications, designed for the majority culture, fail to reach all people affected by an emergency. The Cultures Uniting for Emergency Preparedness project was initiated by the Health Preparedness Organization to develop ways of communicating with culturally-specific populations in a large-scale health emergency. This work was done

through contracts with community based organizations that have established relationships and credibility in targeted cultural communities. The target populations for CUEP were those culturally-specific groups with the largest populations in Northwest Oregon, based on Census data. The target populations are:

- African American residents
- Chinese and Korean residents
- Russian speaking immigrants and refugees
- Latino residents
- Southeast Asian immigrants and refugees
- African immigrants and refugees
- Native Americans

Methods for communicating with culturally-specific populations in an emergency will be clearly defined and enhanced, in order to improve the timely distribution of information. As a result, culturally-specific populations throughout the region will receive, understand, trust, and be able to act upon the information they receive.

- ***Public Health Community Connectors:*** In the event of a public health emergency, Multnomah County Health Department will need to communicate with its diverse communities in order to ensure the timely distribution of information, and elicit appropriate emergency response within those communities. The Public Health Community Connectors project addresses disparities or inequities by recruiting and training MCHD employees who have strong links to various vulnerable communities to form a network and serve as liaisons between Multnomah County Health Department and their diverse communities during a public health emergency situation. The target populations include but are not limited to multi-ethnic, multi-racial, Lesbians/Gays/Bisexual/Transgendered, linguistically isolated and physically challenged groups.

Environmental Health

Lead Poisoning Prevention Program (LPPP): This program is designed to reach individuals who are most at risks for lead exposure. Often times those at most risk experience social factors that create health disparities such as low income, language and cultural barriers, etc. The program reduces these barriers through several means including:

- The LeadLine, an informational phone line that allows Multnomah County Environmental Health (MCEH) staff to reach hundreds of individuals who are potentially exposed to lead hazards in their homes, work or daily environments. Education and outreach is conducted over the phone in several languages including English, Spanish, Russian, and Vietnamese.
- Elevated blood lead levels screening (EBLL) is conducted by Multnomah County Primary Care Clinics when practitioners identify patients that have been exposed to lead and/or patients display signs and symptoms of lead poisoning. The screening process is essential for MCEH to identify individuals most at risk of lead poisoning, so that staff can help the family to intervene and reduce their exposure to lead.

- Home Risk Assessment: When individuals are identified as having elevated blood lead levels during the screening process, a follow-up Home Risk Assessment is conducted by the Environmental Health Specialist (EHS), who is a certified lead risk assessor, to determine the source of lead exposure.
- Case Management Services: From the assessment findings, the EHS develops an intervention plan to reduce the family's lead exposure. The family is referred to appropriate lead poisoning prevention community resources. The plan includes lead poisoning prevention education, basic behavioral modification training, and if needed, remediation and/or relocation services which is provided by partnering agencies.

Food Handlers: The Food Handlers Program is designed to educate, train and certify individuals who want to work in the food industry about safe food preparation, handling and storage practices. The program addresses disparities and/or inequities by developing training and testing formats to meet the language, culture and literacy needs of these individuals. Testing formats include videos, written tests, audio tests, and the online food handler test. Languages include English, Spanish, Bosnian, Cambodian, Cantonese, Mandarin, Japanese, Korean, Russian, Thai, Vietnamese, and others. These models in alternative formats assure that people with literacy and language problems are not prevented from entry into the workforce.

Healthy Homes-Home Visiting Asthma Program addresses disparities in the rates of asthma among low income families. Oregonians from a household with an income of less than $15,000 consistently report higher percentages of asthma than all other income levels. This program works with families that have children with asthma to educate and empower parents and their children to take greater control over their asthma, including increased knowledge of medication and reducing household asthma triggers. The home visiting program targets low income families with children who have asthma and access health care through the county health clinics. Sixty percent of children in the program have Spanish as their first language.

Oregon Collaborative for Healthy Nail Salons: This project addresses disparities in workplace safety for workers in nail salons, a population of mostly Asian immigrant women. Collaborators include Multnomah County Environmental Health, Oregon Health and Science University School of Nursing, Oregon Department of Environmental Quality, Immigrant Refugee Community Organization (IRCO), Oregon Environmental Council and many others. Nail salon employees are potentially exposed to dozens of recognized chemical hazards. The Collaborative works to address issues of indoor air quality and exposure to toxics in the nail salon industry through education and outreach.

Grant Development

Each year the Grant Development Team works with staff members and community partners to develop more than $20 million in grant applications to support local efforts to address health disparities in Multnomah County. Examples of grants that focus on health disparities in disadvantaged communities include the Multnomah County Healthy Homes Collaborative, Health Promotion for Disabled Persons, funding for the County's Primary Care Clinics, and funding for prevention and treatment services for HIV/AIDS. Examples of grant programs that specifically focus on health disparities in racial and ethnic communities include Refugee Preventive Health, Healthy Birth Initiative, the Ryan White

Minority AIDS Initiative, and the ACHIEVE Initiative, which will promote chronic disease prevention efforts in the African American population. These programs contain elements that focus on improving access to health services to address specific health disparities. In addition to providing direct services to address health disparities, these projects have enabled the Department to hire culturally-specific Community Health Workers to support outreach, Medicaid eligibility screening, and case management activities.

Health Assessment and Evaluation (HAE)

The Health Assessment and Evaluation unit monitors the health status of Multnomah County residents on an ongoing basis and provides reports on the health status of our diverse communities. In March 2008, HAE released the *Report Card on Racial and Ethnic Health Disparities*. This report examined 17 health indicators in order to identify health disparities between populations of color and the White non-Latino population of Multnomah County. The purpose of these efforts is to raise awareness of health disparities and to monitor progress in addressing health disparities over time. HAE staff attended the Health Equity Initiative training series "Unnatural Causes" and took notes at the discussions to capture the comments from those attending. Information collected helped to inform and prioritize policy recommendations. HAE is currently exploring the influence of the Social Determinants of Health (SDOH) on the health of Multnomah County residents. These social determinants include income and social status, employment, education, housing, the built environment, social support networks and discrimination. In recent decades, health researchers have found that social determinants exert a more significant influence on health inequities than individual behavior, genetics or access to health care. HAE is releasing a series of reports on this topic that will help to inform public health strategies to improve the community's health, and support changes in the social environment.

Health Equity Initiative (HEI)

The mission of the HEI program is to eliminate root causes of racial and ethnic health disparities. The Health Equity Initiative supports the County's commitment to improving the health of all Multnomah County's residents by considering the ways societal conditions in which we live, learn, work and play affect health. The Health Equity Initiative has three overarching goals:

- to create a common understanding among health professionals, civic leaders, and community members of the causes of and solutions to health inequities with a focus on justice and equity;
- to raise the visibility of current disparities elimination efforts of community-based organizations and county departments; and
- to explore and advance policy solutions to health inequities.

The Health Equity Initiative serves the County and community as an educator, a leader in framing the issues, and as a resource. The primary work of the HEI in the coming year is to pilot an equity and empowerment tool that will assist managers in identifying the possible effects of programs and projects on communities of color. The HEI program will be utilizing the community feedback from last year's community involvement work in policy priority-setting. The HEI program has built strong relationships with community-

of-color organizations and leaders, and will be working with these groups in focused engagement strategies. The HEI program will also engage community members from the target populations in evaluating and redesigning key policy priorities that come as a result of major projects.

HIV/HCV (hepatitis C virus) **Community Programs**

- ***African American Sexual Health Equity Program*** educates, empowers, and engages Multnomah County's African American community in reducing the sexual health disparities among youth and young adults between the ages of 14-24 years old. Examples of specific program activities include:
  - **M.A.R.S.** which stands for Male Advocates for Responsible Sexuality. M.A.R.S. is a comprehensive health education program focused on addressing the sexual and reproductive health needs and concerns of males age 13-25.
  - **Sisters informing Healing Living and Empowering** (SiHLE) is a social-skills training intervention aimed at reducing HIV sexual risk behavior among African American teenage girls, ages 14 to 18, who have been sexually active. SiHLE, which means 'beauty' in Swahili, helps young women learn to value themselves and realize their value to both family and the community. SIHLE is intended to increase knowledge about HIV/AIDS and improve communication, decision making, and condom use.
- ***HIV Care Services*** addresses disparities in healthcare access by providing medical care and support services for low-income people living with HIV disease. The percentage of people living with HIV disease that are also poor, and/or need treatment for mental health or substance abuse issues is much higher than in the general public.
  - The most commonly reported risk category among people living with HIV disease is men who have sex with men (MSM) who accounted for 75% of all living adult HIV/AIDS cases.
  - Rates of HIV disease are also much higher among African American and Latinos than among other populations. (Whites: 7.7 cases/100,000 population, Latino: 11.9 cases/100,000 population, African American/Black: 35.4 cases/100,000 population).
  - While 11.3% of people living with HIV disease are women, approximately 40% of the women are from racial and ethnic minorities.
- ***Community PROMISE:*** Since 2004, Multnomah County Health Department has been collaboratively implementing Community Promise, a CDC evidenced-based community-level HIV prevention intervention targeted to men who have unprotected sex with men. Men from this at-risk community are recruited and trained to be community advocates, and to distribute risk reduction supplies. In addition, these advocates share personal accounts explaining how and why they took steps to practice HIV risk-reduction behaviors and the positive effects the choice has had on their lives. MCHD also contracts with Cascade AIDS Project to conduct targeted HIV/STD prevention outreach both online and in public sex venues to the MSM population. This outreach is directed to men who have sex

with men engaging in high risk sexual behavior for transmitting and/or acquiring HIV/STDs.

- ***Sexual Health 4 Men Coalition (SH4MC):*** A spike in syphilis cases among men who have sex with men (MSM) in 2001 led to the development of the Sexual Health 4 Men Coalition (SH4MC). The SH4MC mission is to promote the sexual health of gay, bisexual and other MSM in the Portland Metro Area. Coalition activities include outreach to medical providers to improve MSM cultural competence, the development of consistent sexual health messages for gay, bisexual and other MSM, and monitoring of local HIV/STD data to identify disease trends.
- ***LGBTQ (lesbian, gay, bisexual, transgender and queer people) Meaningful Care Conference:*** Now in its forth year, the LGBTQ Meaningful Care Conference is a key local effort to improve the health of lesbian, gay, bisexual, transgender and queer people by training and building cultural competency among health professionals to work most effectively with LGBTQ patients.
- ***Latino Sexual Health Promotion:*** Latino men who report having sex with other men, or sex with other men and injection drug use as their risk categories represent 75% of HIV infections among Latinos. In an effort to enhance efforts to address this disparity, the HIV/HepC community programs offers weekly targeted outreach to MSM in Rockwood (the area of the county with the largest Latino population), as well as three bilingual/bicultural staff conducting HIV outreach education, HIV counseling and testing at the Northeast Health Center. Outreach is also conducted at a needle exchange site near an area where Latino day laborers gather to look for work. In addition, HIV/HepC community programs recently began efforts to coordinate with other county programs and community partners working on Latino sexual health promotion. The lack of open communication about sexuality in general, and homosexuality in particular, was identified as an issue that contributes to higher rates of HIV among MSM. HIV/HepC staff are in the process of working with other Health Department programs and community partners (including Cascade AIDS Project and promotores) to generate strategies for addressing this issue.
- ***Syringe Exchange/Reducing Drug Related Harm*** addresses several areas of health outcomes that affect people who inject drugs (PWID). The program has expanded from solely focusing on HIV and Hepatitis C (HCV) prevention through syringe exchange (including a prevention contract with Outside In to syringe exchange and targeted HIV and HCV testing) to include engaging community partners in prevention work (e.g. police, businesses, faith-based groups), providing targeted group-level interventions to PWID at Hooper detox and Inverness Jail, convening community stakeholders to understand and address the issue of drug-related harm/deaths in Multnomah County, and working with peer educators through syringe exchange to expand their capacity in the community for prevention work.
- ***HIV/HCV Community Testing*** recruits for and offers testing to those at most risk of HIV and HCV in community-based settings including county jails, MCHD Northeast Health Center, targeted bars, and in drug detox/treatment settings. In

addition to providing testing services, the program provides risk reduction counseling and referrals to other needed services.

Human Resources and Workforce Development

Training and Staff Development scheduled and helped facilitate the Health Equity Initiative Training Series "Unnatural Causes" screenings and dialogues. In 2009, Training and Staff Development partnered with Integrated Clinical Services to implement the Nurturing Cultural Competence in Nursing grant. This grant supports a series of four 2-4 hour training sessions designed to build nurses' competencies in delivering culturally appropriate care to refugees and immigrants. The lessons learned from the training will be distributed and incorporated into Health Department practice in all service areas.

Integrated Clinical Services

In Fiscal Year 2008, Multnomah County Health Department served approximately 66,500 clients, the majority of whom were low income; 97% had incomes of less than 200% of the Federal Poverty Level. Nearly half (49%) of all clients were children age 18 years and younger, over half (56%) of all clients were women and nearly half of clients were populations of color. In addition, almost half (48%) of clients had no health insurance. The Health Department's six primary care clinics are part of the health care safety net in Multnomah County; in addition, there are four dental sites and thirteen School-Based Health Centers offering access to care.

- ***Building Better Care (BBC)*** is a primary care redesign project organized around team based care, streamlined access to care, integrated behavioral health and a focus on the customer. Clinics involved include Primary Care, Homeless, and specialty HIV Care. Projects include:
  - Diabetes Care Management: The diabetes care management project has developed case management strategies, medical standards of care, and proactive population outreach.
  - Chronic Pain Care Management: The chronic pain care management project has developed the medical standard of care, case management strategies, and prescribing support for providers related to managing chronic pain.
  - Depression Identification and Management: The depression management project focuses on increasing the portion of the primary care population that has been screened for depression. Once depression has been identified, the processes for behavioral health and medical support for the patients are implemented.
  - Asthma Care Management: The asthma care management project is a collaboration between the primary care clinics and the school based health centers to develop case management and teaching strategies for children with persistent asthma.
- ***Community Health Council:*** The Council addresses disparities in the area of access to healthcare. Council members regularly participate in advocacy events. The target population of the Community Health Council program is users of MCHD's health centers services. This target population was identified based on the mandate from the Bureau of Primary Care grant requiring a patient majority

board be established and maintained to ensure that the target populations' concerns are addressed and acknowledged. The Council serves as a voice of the community, representing the community and its diverse needs to the Department. The Council aims to assure that the Department maintains the appropriate management and staff necessary to provide the scope of services needed for Multnomah County. In addition, the Council promotes the Health Department and its mission to the community.

- ***Medicaid Program:*** The Medicaid Program addresses issues in healthcare access by assisting uninsured and underinsured individuals to access and maintain health coverage through state and local medical assistance programs, and ensure dignified access to the resources and benefits for which individuals are qualified. The primary focus targets the Medicaid potential eligibles and eligible pregnant women and children. A large number of the target population is non-native English speaking and illiterate in their native language. The populations were identified with the assistance of early childhood service programs, Head Start Program employees, and school-based and community health nurses through stakeholder meetings. Program goals include educating the uninsured population about state insurance expanded services, increasing the number of clients who complete the enrollment process, assisting with application and enrollment to obtain/maintain coverage, increasing access to health care, assisting with identifying a medical home and primary care provider, and advocating on behalf of low income vulnerable individuals to ensure they receive all resources and benefits for which they are qualified.
- ***School/Community Dental Health Program:*** The School/Community Dental Health Program addresses disparities in the oral health of children. In Multnomah County in 2007, over half (55%) of White non-Latino children age 6-9 had no dental cavities; this compares to just 27% of African American children and 23% of Latino children who were cavity free. The program is designed to work with school staff, school nurses and other agencies providing oral disease prevention interventions to school aged children. Intervention is through the fluoride tablet program, oral wellness presentations, a mobile dental van program to provide dental treatment to uninsured school aged children, and a clinical dental sealant program.

Program Design and Evaluation Services

- ***Evaluation of a Smokefree Policy in Subsidized Multi-Unit Housing:*** Funded by Oregon's tobacco control program and the Robert Wood Johnson Foundation, this project will evaluate the implementation of a smoke-free policy in a group of low income subsidized housing complexes in the Portland Metro area. The goals of the project are to describe reactions to the smokefree policy among building managers, and tenants who receive housing vouchers or low-income tax credit federal housing subsidies; assess how often tenants leave because of the policy and the stability of their subsequent housing; assess how often former smokers attribute their quitting to the policy; describe tenant complaints, enforcement activities, and dispute resolutions; and determine the economic impact of the policy.

- ***HIV Morbidity Monitoring Surveillance Project (MMP):*** Funded by CDC through Oregon Public Health Division, MMP involves collection of data on persons in Oregon infected with HIV to generate estimates of the characteristics of Oregonians infected with HIV, the care they receive, and the extent of need for care and support services. CDC and participating states/cities will use these data to allocate resources to HIV prevention programs and to programs that provide care and support services to people infected with HIV. The primary objectives of MMP are to obtain data to describe the clinical status and the prevalence of co-morbidities related to HIV disease; describe HIV care and support services received and the quality of such services; determine prevalence of ongoing risk behaviors and access to, and use of, prevention services among persons living with HIV; and identify met and unmet needs for HIV care and prevention services to inform prevention and care planning groups, health care providers, and other stakeholders.
- ***Housing Opportunities for Persons with AIDS (HOPWA) program in Portland:*** PDES conducted an evaluation of the HOPWA program for the Portland Bureau of Housing and Community Development. For this project staff surveyed clients and obtained a detailed picture of their satisfaction with housing services, and the need for improvement of such services. More than 1,000 people living with HIV/AIDS in the Portland metropolitan area receive housing services through HOPWA.

Refugee and Immigrant Services Policy Development

The Refugee and Immigrant Services Policy Development addresses disparities in the health of immigrants and refugees by managing efforts related to developing, implementing, monitoring and maintaining Health Department policies that support outreach and delivery of culturally appropriate services. The majority of the targeted populations represent those who are limited English-speaking individuals and many are illiterate in their native language. Most often it is difficult to communicate with them directly. Therefore, the majority of them are identified through and/or with the assistance of several sources, such as: 1) Federal Government Immigrant and Refugee Admission Office; 2) the refugee and immigrant voluntary agencies (Catholic Charity Refugee Program, Lutheran Family Services, Sponsors Organized to Assist Refugees, Immigrant and Refugee Community Organization, and other non-profit servicing agencies); and 3) self-referrals to health care services.

Sexually Transmitted Disease (STD) Prevention and Treatment Program

The STD Prevention Program addresses disparities in the rates of sexually transmitted diseases. The mission of the program is to prevent the spread of sexually transmitted diseases and to reduce their harmful effects on individuals and communities by applying effective, population-based public health practices, focusing on those at greatest risk. The STD program collaborates with the community to provide culturally appropriate and non-judgmental interactions, deliver services regardless of ability to pay, and assure the highest degree of confidentiality. Target populations of the STD Prevention Program include:

- Men who have sex with men for HIV, syphilis, and gonorrhea

- African Americans for HIV, gonorrhea, and chlamydia
- Latinos for HIV, and chlamydia
- 15-24 year olds for gonorrhea, and chlamydia

Target populations were identified by reviewing health surveillance data, and obtaining input from community collaboratives, i.e., the *Sexual Health for Men Coalition* (SH4MC), and the *African American Sexual Health Equity Program* (AASHEP).