Community Health Improvement Plan

2019

GOOD SHEPHERD
HEALTH CARE SYSTEM

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Community Benefit

Dennis E. Burke
President & CEO

In our Community Health Needs Assessment (CHNA), we take an in-depth look at the "health" of our region. This study measures acute and chronic diseases, behavior health, accidents, health practices, lifestyles and preventative measures. This study breaks these findings into various cohorts: age, ethnicity, sex and economic factors.

Our CHNA serves as a guide in the development of Good Shepherd Health Care System's Community Health Improvement Plan (CHIP) and our organization's strategic plan. Our mission continues to drive our efforts in improving the health status of our communities in a manner that balances attention and resources between acute care and prevention/early intervention – where opportunities to improve quality of life and reduce healthcare costs are greatest.

GSHCS also recognizes the importance of identifying and addressing key social determinants of health in developing and maintaining a healthy community.

This year, our Community Health Improvement Plan will focus on:

- Social Determinants of Health/Health Equity
- Access to Services
- Obesity
- Chronic Disease
- Violence
- Behavioral Health

In 2018, GSHCS invested more than $14 million in Community Benefit. We provided more than $8 million in Subsidized Health Services and more than $3 million in Charity Care.

Each of us plays an important role in improving health within our communities. Thank you for your interest in our CHNA, CHIP and the health and well-being of our area. Please share this site with others. We also welcome your comments and suggestions on ways that we may continue to improve the health status of everyone living within our region.

Thank you,

Dennis E. Burke
President & CEO

How We Assessed Our Community's Health & Established Action Priority Areas

ADULT AND PARENT RANDOM SAMPLE MAILED SURVEYS

- Survey questions were developed with the help of our community partners, in order to learn more about our community's characteristics and health behaviors.
- In 2018, 1200 Adults and 2400 Parents of children 0-11 in Umatilla County received our survey, through a 4-wave mailing process.
- 254 Adult surveys and 161 Parent surveys were returned, allowing us to compare our community to the state and nation in several different categories.

HISPANIC/LATINO ADULT AND PARENT CONVENIENCE SAMPLE SURVEYS

- Our Adult and Parent Surveys were translated into Spanish by our staff members and with the help of our community partners.
- In 2018, we collected surveys from Spanish speaking Hispanic/Latino community members in a variety of locations with the help of our community partners.
- 186 Adult surveys and 156 Parent surveys were collected, allowing us to compare Hispanic/Latino responses to the general population in Umatilla County, helping us to better identify health disparities.

HEALTH PRIORITY MEETING

- Once we received our Community Health Assessment report, we looked for health issues that had serious consequences if left unaddressed, and often where our community's health issues were experienced at higher rates than Oregon or the United States.
- We asked our community partners to choose their top health priorities and meet with us to discuss what should be on our priority list.
- The top priority areas identified were: the Social Determinants of Health/Health Equity, Chronic Disease, Obesity, Behavioral Health, Access to Services, and Violence.

Health Improvement Priority Areas

Social Determinants of Health/Health Equity

Access to Services

Obesity

Chronic Disease

Violence

Behavioral Health

Our Process to Create this Plan

- After priority areas were selected, our team chose key issues in each priority area, to focus our efforts and set realistic goals. A worksheet titled “Identifying Key Issues and Concerns” provided by the Hospital Council of Northwest Ohio helped to narrow down focus in each priority area. This included ranking each concern by magnitude (number of actual or potential community members affected), seriousness of consequences (societal/economic burden and amount of disability/ premature death caused by the issue), and feasibility of correcting (can the issue be prevented or can an intervention make an impact based on scientific evidence).

- We took these into consideration when selecting goals, in addition to: whether other community partners were already addressing these issues, whether our actions could supplement the current and future efforts of community partners, the resources (financial and staff) available to address the issues, and strategies/ focus areas within each priority area where our actions would make the greatest impact. This led us to the areas of concern and goals within our Community Health Improvement Plan. Drafts of this plan have been discussed and revised with the advice of the Community Benefit Oversight Committee, Administrative Council, Good Shepherd Department Managers and the Board of Trustees.

Access to Services Social Determinants of Health/Health Equity

Areas of concern (CHA Data):

1. Adults utilizing the Emergency Department in the last year (51% Adults) and (53% Hispanic/Latino Adults)
2. Adults traveling outside the county for health care in the last year (71% Adults) and (42% Hispanic/Latino Adults)

Efforts we will continue:

Offering Urgent Care Services, ConneXions Program (case management and resource referral), Hermiston High School Wellness Clinic, membership in the Local Community Advisory Council (LCAC) and support of LCAC objectives

New Strategies/Action items:

1. Community education on appropriate use of the Emergency Department, Urgent Care, and Primary Care Providers (PCPs)
2. Increase efforts to recruit healthcare providers to meet the growing population
3. Making urgent care services more accessible

Goal(s): Reduce misuse of Emergency Department and percentage of community members leaving the county to obtain care

Outcome Objective(s): By the time of the next CHA, the annual rate of Emergency Department utilization at GSHCS will meet EOCCO metric goals

Process Objective(s):

1. By the end of the 2021 Fiscal Year (FY), GSHCS will have increased our staff of healthcare providers by hiring a minimum of 2 more PCPs
2. By the end of the 2021 FY, GSHCS will have extended our Good Shepherd Urgent Care hours by (2) more hours per week
3. By the end of the 2021 FY, an ED vs. Urgent Care Q+A live stream will be posted on applicable GSHCS social media feeds
4. By the end of the 2021 FY, contingent upon funding, (2000) pieces of information on ED vs. Urgent Care will be distributed to the community

Measures: ED utilization numbers, number of print materials distributed, extension of urgent care hours, event tracking forms, number of PCPs

Resources we hope to devote to these efforts: Staff time/financial resources to add urgent care tab to website, financial resources to live stream and better promote urgent care, staff time/financial resources to recruit/hire more providers

Potential Partnerships: Distribute ED vs. Urgent Care materials to LCAC members/Healthy Communities Coalition so they may be diffused to partner organization's clients

Access to Services Social Determinants of Health/Health Equity

Areas of concern (CHA Data):

1. Parents reporting their healthcare provider always explained things in a way they could understand (72% of Parents) and (53% of Hispanic/Latino Parents)
2. Hispanic/Latino Adults, Parents, and Children without health insurance (56% Hispanic/Latino Adults uninsured vs. 7% of Umatilla County Adults) (31% of Hispanic/Latino Parents uninsured vs. 14% of Umatilla County Parents) (10% Hispanic/Latino Children uninsured vs. 6% Umatilla County Children)
3. Low income health disparities (15% lower rate of having a routine check-up in last year, 9% higher rate of hypertension, rates of obesity 23% higher, 8% higher rate of asthma, 3% higher rate of diabetes, 6% more likely to describe health as fair or poor, 7% more likely to report being current smokers compared to those with incomes greater than $25K)

Efforts we will continue: Translation services for patients, ConneXions Program (case management and resource referral), membership in the Local Community Advisory Council (LCAC) and support of LCAC objectives

New Strategies/Action items:

1. Integrate health literacy and cultural humility training into GSHCS Service Excellence Initiative training
2. Offer one health education class exclusively in Spanish
3. Partnering with LCAC to participate in health insurance enrollment and health promotion event accessible to Spanish speakers

Goal(s):

1. Reduce barriers for all community members to effectively and proactively manage their health
2. Improve health equity through culturally and linguistically relevant, and accessible health care
3. Reduce racial/ethnic and income based disparities in rates of chronic disease, access to care, understanding of prevention and disease management recommendations, and health status perceptions

Outcome Objective(s): By the end of the 2021 FY, 75% of GSHCS staff will have received training in health literacy and cultural competency

Process Objective(s):

1. By the end of the 2021 FY, health literacy and cultural humility components will be integrated into the GSHCS Service Excellence Initiative training
2. By the end of the 2021 FY, at least one community health education class will be offered exclusively in Spanish
3. By the end of the 2021 FY, GSHCS will work collaboratively with community partners to host a community health insurance enrollment event with abundant translation services available

Measures: Number of trainings offered, number of GSHCS employees trained, number of classes offered exclusively in Spanish, events hosted

Resources we hope to devote to these efforts: Staff time/financial resources to train Spanish speaking staff in health education curriculum, staff time to teach health education classes, staff time/financial resources to research and acquire health literacy and cultural humility curriculum, possibly room reservations for LCAC related events

Potential Partnerships: LCAC, Healthy Communities Coalition, Oregon Health Authority, Euvalcree

Obesity/Chronic Disease

Areas of concern (CHA Data):

1. Adult (42% of population obese), Low income (61% of population obese), Childhood Obesity (25% of children obese)
2. Sugar-sweetened beverage consumption (all ages) (impacts inflammation in chronic disease and contributes to obesity) (58% of adults drank one or more sugar-sweetened beverage per day) (47% of children drank one or more sugar-sweetened beverage per day)

Efforts we will continue: BMI measurements at community screening events, encouraging community partners to promote healthy gardening and food choices, continue to promote community-based exercise and fitness education opportunities

New Strategies/Action items:

1. Implement Northeast Oregon Prescription Trails Program
2. Sugar-sweetened beverage education at 75% of community outreach events
3. Feasibility analysis of metabolic and bariatric program

Goal(s):

1. Decrease in rates of obesity/chronic disease
2. Increase in rates of physical activity that meet CDC recommendations
3. Decrease in self-reported sugar-sweetened beverage consumption
4. Increasing promotion of the ACT Program

Outcome Objective(s): By the next Community Health Assessment (CHA), self-reported weekly consumption of sugar-sweetened beverages will decrease 10%

Process Objective(s):

1. By the end of the 2021 FY, the Northeast Oregon Prescription Trails (walkrxtrails.com) website and prescription program will be functional and available to the community
2. By the end of the 2021 FY, GSHCS will have recruited and trained at least 10 healthcare providers, to utilize exercise prescriptions with eligible patients
3. By the end of the 2021 FY, at least 200 exercise prescriptions will have been written for the prevention or treatment of obesity/chronic disease
4. By the end of the 2021 FY, the GSHCS Education Department will have educated at least 100 community members on the health risks associated with sugar-sweetened beverage consumption
5. Increase participation in the ACT program by 10% through promotion through newspaper, radio and Facebook by the end of the 2021 FY
6. By the end of the 2021 FY, GSHCS will conduct a feasibility analysis of a metabolic and bariatric program
7. By the end of the 2021 FY, the GSHCS Education department will have offered screening and education on BMI at (4) community events

Measures: Number of healthcare providers trained in Northeast Oregon Prescription Trails, website views, number of prescriptions distributed, attendance at events where sugar-sweetened beverage materials or models taken, feasibility analysis, events where BMI screening/education offered

Resources we hope to devote to these efforts: Staff time/financial resources to train healthcare providers in Northeast Oregon Prescription Trails, financial resources related to maintaining website, financial resources related to printing "prescription pads," staff time to provide sugar-sweetened beverage education, print materials and models

Potential Partnerships: LCAC, Healthy Communities Coalition, Umatilla County Public Health

Chronic Disease

Areas of concern (CHA Data):

1. Screening/Prevention
2. Percentage of adults who have had their cholesterol checked in the last 5 years

Efforts we will continue:

Offering free community screenings for A1c/Lipid and grant funded colorectal cancer screens at community events, Community education via social media, website, newspaper/mailing ads

New Strategies/Action items:

1. Integrate EOCCO incentive measure screenings into Epic
2. Voucher mailings for A1c/Lipid screenings
3. Creation of community cancer prevention strategic plan

Goal(s):

1. Increase in adults who have had their cholesterol checked in the last 5 years
2. Decrease in chronic disease and chronic disease-related morbidity/mortality

Process Objective(s):

1. By the end of the 2021 FY, GSHCS will utilize innovative approaches to offer at least (50) free A1c/Lipid screenings and health consultations, targeted towards those at increased risk
2. By the end of the 2021 FY, GSHCS will be actively collaborating with the Local Community Advisory Council metrics coordinator, to integrate EOCCO incentive measures (including screening/prevention efforts for chronic conditions) into Epic and clinical workflow at GSHCS

Measures: Number of vouchers distributed, number of events where vouchers are distributed, collaboration with Metrics Coordinator, Strategic Plan

Resources we hope to devote to these efforts: Staff time/financial resources to coordinate voucher screenings and health consultations, financial resources related to printing/mailing vouchers, staff time to integrate incentive measure screenings into Epic

Potential Partnerships: LCAC, Morrow County LCAC, Healthy Communities Coalition, Knight Cancer Institute, UCo Health

Violence

Areas of concern (CHA Data):

1. Adults (4%)/Hispanic+Latino adults (31%) threatened or abused in last year
2. Adults (8%)/Hispanic+Latino adults (14%) forced to have sexual intercourse when they did not want to (in lifetime)

Efforts we will continue:

Safe Communities Participation, "Start by Believing" campaign

New Strategies/Action items:

1. Collaborate with Domestic Violence Services to host one "In Her Shoes" event on site annually
2. Integrate abuse screening questionnaire into Epic
3. Expansion of awareness and scope of "Start by believing campaign" led by SANE team

Goal(s):

1. Increase community awareness of intimate partner/domestic violence, and sexual violence
2. Improve detection of abuse and referral to treatment
3. Change community norms and remove the stigma associated with being a victim of violence

Process Objective(s):

1. Contingent upon a continued partnership with Domestic Violence Services, GSHCS will host one "In Her Shoes" domestic violence awareness event annually, starting in 2020
2. Starting in 2020, GSHCS will integrate a systems model for intimate partner violence prevention; an Epic integration will prompt screening/referral to services for all patients at clinic appointments
3. By the end of the 2021 FY, GSHCS will expand community awareness of the "Start by Believing" campaign, by participating in at least (2) community events annually

Measures: Number of "In Her Shoes" trainings offered, number of events where "Start by Believing" has a display, integration of resources into "Start by Believing," integration of systems model for violence

Resources we hope to devote to these efforts: Staff time/financial resources to integrate systems model and screening into Epic, staff time/room reservations to host "In Her Shoes," staff time/financial resources to provide and expand scope of "Start by Believing"

Potential Partnerships: LCAC, Healthy Communities Coalition, Domestic Violence Services

Behavioral Health—Substance Abuse

Areas of concern (CHA Data):

1. Adults self-reporting misusing prescription medication to feel good/high or taking medication not prescribed to them (17%)
2. Adults who misused prescription medication reporting they obtained it from their PCP (94%)
3. Potential health impacts (to the individual and community) of adults using legal and illegal substances recreationally — adults who reported binge drinking (20%), adults who reported using marijuana (12%)

Efforts We Will Continue:

Safe Communities and Developmental Adolescent Residential Treatment (DART) participation, membership in the Local Community Advisory Council (LCAC) and support of LCAC objectives

New Strategies/Action items:

1. Ensuring uniform compliance with GSHCS policies regarding Prescription Drug Monitoring Program (PDMP) dashboard usage before prescribing opioids or other addictive prescriptions
2. Ensuring uniform compliance with GSHCS policies regarding requiring doctor/patient agreement when on long-term opioid prescriptions
3. Obtaining one GSHCS employed Medication Assisted Treatment (MAT) provider
4. Training select GSHCS staff in Naloxone administration
5. Creating on-site safe medication disposal site
6. Distributing accurate information on drugs at various community events

Goal(s):

1. Reduce rates of overdose and overdose-related death in the community
2. Reduce incidence and prevalence of substance use disorder in the community
3. Decrease gaps in service for those seeking treatment for substance use disorder
4. Increase community knowledge on the risks associated with using substances

Process Objective(s):

1. By the end of the 2021 FY, GSHCS will create system wide policies regarding PDMP dashboard use and Doctor-patient opioid agreements (PDMP use is described by the White House Office of National Drug Control Policy as "critical to improving public health." It can help curb access to multiple controlled substances which can be used as or transformed into street drugs like painkillers or meth.)
2. By the end of the 2021 FY, GSHCS will employ at least (1) Medication Assisted Treatment (MAT) provider
3. By the end of the 2021 FY, GSHCS will train at least (10) employees, who have positions requiring external community interaction, in lifesaving Naloxone administration (the National Institute on Drug abuse states, "Naloxone is an extremely safe medication that only has a noticeable effect in people with opioids in their systems." The CDC identified targeted Naloxone distribution as an evidence based overdose prevention strategy).
4. By the end of the 2021 FY, GSHCS will host a community training in life saving Naloxone administration
5. By the end of the 2021 FY, GSHCS will develop an on-site safe medication disposal location
6. By the end of the 2021 FY, GSHCS will have distributed (50) educational pamphlets on drug facts (including accurate information on the potential health impacts of alcohol and marijuana)

Measures: Creation of oversight plan, number of GSHCS MAT providers, number of GSHCS employees trained in Naloxone, community events hosted, safe medication disposal site creation, number of pamphlets distributed

Resources we hope to devote to these efforts: Staff time to create a compliance oversight plan for aforementioned policies, staff time to teach health education classes, staff time/financial resources associated with becoming certified and providing medication assisted treatment, possibly room reservations for Naloxone training, Financial resouces to acquire pamphlets

Potential Partnerships: Umatilla County Public Health, Oregon Washington health Network (OWhN)

Behavioral Health—Tobacco/Vaping

Areas of concern (CHA Data):

1. Smoking prevention (20% of adults former smokers)
2. Tobacco cessation for current smokers (8% of adults)
3. Lung cancer rates (lung and bronchus cancers are leading cause of cancer-related death in county)

Efforts we will continue:

Tobacco Treatment Specialist (TTS) Counseling , Community tobacco education and events

New Strategies/Action items:

1. Integrating tobacco use screening/referral into Epic
2. Disseminating information on vaping at community events

Goal(s):

1. Decrease in tobacco and nicotine-containing products use
2. Decrease in tobacco-related cancer rates

Process Objective(s):

1. By the end of the 2021 FY, GSHCS will integrate tobacco use screening and referral to treatment measures into Epic for all adolescent and adult clinic appointments
2. By the end of the 2021 FY, GSHCS will have distributed (50) educational pamphlets on vaping

Measures: Tobacco screening and referral integrated into Epic, Number of tobacco cessation referrals, Pamphlets distributed

Resources we hope to devote to these efforts: Staff time/financial resources to integrate tobacco screening and referrals, staff time/financial resources to provide tobacco cessation counseling and train more TTS counselors

Potential Partnerships: Umatilla County Public Health