2019 EOCCO Community Health Plan (CHP)
For Umatilla County

PRIORITY ISSUE #1:Obesity

Angie, Amy Hendrix, Lourdes, TBD

PROBLEM IDENTIFIED:

State and national data indicate that low income households are more likely to experience obesity and other chronic disease and have lower fruit and vegetable (F/V) intake. Umatilla County obesity rates exceed state and national rates. Barriers to F/V intake include cost, knowledge, quality, variety, limited cooking skills and transportation (Tobey et al., 2016).

DATA AVAILABLE:

- Health Behaviors: 2017 data shows adult obesity at 33.2% compared to state rate of 26.9%
- 2018 Umatilla County CHA indicates that 42% of adults are obese; this jumps to 61% for those with incomes less than $25K
- Less than 1/3 of adults and children were eating 5 or more servings of fruits and vegetables per day (2018 Umatilla County CHA)
- Focus group report cites concern for children making poor eating choices.

GOALS:

Enroll at least 200 EOCCO members (adults and children) in Umatilla County in the Fruits and Veggies for Families produce distribution and nutrition education program.

Employ the SNAP match program to encourage SNAP participants to use their benefits for Farmer’s Market produce as measured by at least 150 SNAP transactions at the Pendleton Farmer’s Market.

Explore and report on feasibility of an EBT machine at the Hermiston Farmer’s Market to allow for a SNAP match program there by summer of 2020.

ACTION PLAN:

Prevention

- Address barriers to F/V consumption identified in program statement through the Fruits and Veggies for Families(FAVFF) Program.

- FAVFF served 140 participants in 2018 in Hermiston, >90% EOCCO members, pre/post increases in child vegetable consumption, ability to afford F/V and use of OSU Extension Food Hero resources to prepare F/V in the home.
- In 2019, continue FAVFF in Hermiston and expand to Pendleton (supported by LCAC Community Benefit Reinvestment funds).
- Formalize produce distribution agreement with CAPECO (Oregon Food Bank regional partner) to facilitate future sustainability.
- Apply for external funding by July 2019 to expand FAVFF program to Milton-Freewater.
- Partner with Pendleton Farmer's Market Board to implement SNAP match program (supported by LCAC Community Benefit Reinvestment funds).
- Encourage SNAP match at the market through Food Hero recipe tastings.
- Meet with Hermiston Farmer's Market manager by June 2019 and present case for EBT machine to make SNAP match possible at that market by 2020.
- Have metrics coordinator explore potential communication flow with health care providers that would allow FAVFF participation to be recorded in patient's medical record as nutrition education and weight assessment (addresses incentive measure)

***Fruits and Vegetables for Families (FAVFF) is a produce distribution and nutrition education program serving low income WIC participants with targeted food security and health risk factors.**

Reference:

Tobey, L. N., Koenig, H .F., Brown, N. A., & Manore, M.M. (2016). Reaching Low-Income Mothers to Improve Family Fruit and Vegetable Intake: Food Hero Social Marketing Campaign—Research Steps, Development and Testing. *Nutrients, 8(9),* 562.

ESTIMATED BUDGET NEEDED:

$25,000 for Milton-Freewater start up, $50,000 for Hermiston/Pendleton, expect decreasing costs each year as we work toward sustainability.

POTENTIAL FUNDING SOURCES:

LCAC community benefit funds
Moore Family Center Healthy Community Outreach
OCF oral health grant

PRIORITY ISSUE #2: Chronic Disease Prevention (Diabetes, asthma, and Cancer)

Jamie, TBD

PROBLEM IDENTIFIED:

Diabetes
Cancer
Arthritis
Trauma
(asthma…work group decisions)

DATA AVAILABLE:

diabetes (32.7-27.3 for state), Ever been told by doctor they have diabetes (9% 2018 and 14% 2015 UCo, 10% OR 2017, 11% US 2017)[2018 CHA, P.25]

Percentage of Diabetic Medicare Enrollees ages 65-75 that received HbA1C monitoring (35% UCo, 34%OR, 49% US) [county health rankings, 2018 CHA, p.131]

asthma (2015 rate 47.3-2.9% for state), (7% UCo 2018 and 24% Uco 2015, 17% OR 2017, 14% US 2017) [2018 CHA, P.25]

Cancer (195.7-189.7 for state)(Age adjusted mortality rate 174 UCo 2015-2017, 157 OR 2015-2017, 156 US 2015-2017) [CHA 2018, p. 70]

Arthritis (34% UCo, 27% OR 2017, 25% US 2017) [2018 CHA, p. 72]

Adults screened for high cholesterol in the last 5 yrs (66% Uco 2018, 85% OR 2017, 86% US 2017) [2018 CHA, p. 64]

Enter Metrics Not Met-TBD

GOALS:

The LCAC will work collaboratively with member organizations to create and support efforts that help the community prevent, detect, and manage chronic diseases.

Incentive measures addressed: Possibly all except #2

ACTION PLAN:

- Treatment and Management Prevention integrationRespiratory therapy program out of Good Shepherd to help with COPD.

- Families for fruits and vegetables will help obesity and diabetes by focusing on eating Within 1 year of beginning work, the metrics coordinator will have met with all local healthcare clinic managers.

- Within 1 year of beginning work, the metrics coordinator will have identified at least 1 potential EHR improvement/integration that could impact metrics collection at each hospital.

- Within 1 year, the LCAC will collaboratively create a health information and resource packet for distribution to LCAC member clients at appointments; information will be provided on current community events, screenings, and health improvement opportunities.

- Within 2 years, health literacy and cultural humility training will be integrated into hospital's organizational priorities.

ESTIMATED BUDGET NEEDED:
Metrics coordinator $XXXXX
$10,000 annually for printing

POTENTIAL FUNDING SOURCES:
UCO HPV grant
GSHF grants
CBI funds
Wildhorse Foundation

PRIORITY ISSUE #3: Behavioral Health
Amy Ashton Williams, Catie, TBD

PROBLEM IDENTIFIED:
Through consumer and partner feedback:
Improve access to behavioral services, no place for people to go
Substance Abuse
Tobacco
Vaping
Trauma
Mental Health - Adult and Youth
Maternal Depression

DATA AVAILABLE:
Suicidal ideation 18.0 compared to state at 18.2, 2018 UCO CHA

ED utilization for MH
Oregon Health Teen data
ACEs
State and county health rankings for tobacco use

GOALS:

- Lower wait times appointments to mental health services by 10%
- Identify Primary Prevention efforts for Substance Abuse Disorder that are culturally appropriate and inclusive.
- Identify and make list available TTS facilitators and of populations served for Tobacco Cessation treatment.
- Parent Education and Family Engagement - Provide Conscious Discipline Parent education and Positive Parenting Program for parents through Group and home visiting settings to 100 primary caregivers throughout Umatilla County
- Continue Narcan education and distribution – distribute Narcan with appropriate education to Home visitors, effected Families and service providers increase current distribution by 5% throughout the county

ACTION PLAN:

- Work on coordination of services, Identify comprehensive prevention efforts Within Umatilla County
- Support and Continue Hermiston Safe communities' partnership efforts to address and reduce Opioid prevention in Umatilla County
- Umatilla County Opioid Efforts
- Tobacco Retail licensing ordinance – Support Umatilla County Public Health Efforts
- Tobacco cessation – collaborate with trained cessation counselors within Umatilla County. Identify and make list available of populations served for Tobacco Cessation treatment.
- Continued partnership with the Early Learning HUB
- Narran Education and distribution

- Continue efforts with GOBHI and Lifeways to improve time to appointment for members

ESTIMATED BUDGET NEEDED:
TBD

POTENTIAL FUNDING SOURCES: TBD
Good Shepherd Health Foundation
Wildhorse Foundation
HRSA
Title 1 school funds
Title 9 school funds
GOBHI Early Childhood Funding
Community Benefit Reinvestment funds

PRIORITY ISSUE #4: Violence and Safety
Catie, TBD

PROBLEM IDENTIFIED:
Violence (Child Abuse, Intimate Partner Violence, Sexual Abuse, and others)
Personal and Community Safety
Trauma

DATA AVAILABLE:
5.5 per 1,000 compared to state at 12.8
UCO CHA – Seatbelt data, health disparities from GP to L/H pop

GOALS:

- Parent Education and Family Engagement –
  - Provide Conscious Discipline Parent education and Positive Parenting Program for parents through Group and home visiting settings to 100 primary caregivers throughout Umatilla County.
  - Increase Parent education and Engagement efforts to historically underserved populations within Umatilla county – provide 6 parent education and engagement activities within these communities.

- Increase Primary Prevention Efforts through a media campaign throughout Umatilla County through print and Radio by June 2020

- Align prevention efforts with CDC dosage guidelines for effective prevention.

ACTION PLAN:

- Continue to partner and work with early child hood partners

- Parent Education and Family Engagement – Parent education menu and calendar

- Continue support of Home Visiting efforts throughout Umatilla County

- Continue partnership and efforts of DVS

ESTIMATED BUDGET NEEDED:
$15,000

POTENTIAL FUNDING SOURCES:
Wildhorse Foundation
Other to be identified grants
Current Home visiting programs
Oregon Parenting Education Collaborative
Churches

PRIORITY ISSUE #5: Access to services
Trish, Sharron, Cathy, TBD

PROBLEM IDENTIFIED:
Providers/Integrated Care
Transportation
Prevention and Screening
Nutritional Services
Housing
Trauma

****Group prioritized the problems and opted to work on the top 3, highlighted above, in the effort to create a pertinent, focused goal and plan to improve access to services.***

DATA AVAILABLE:

UCO CHA
County and state
EOCCO enrollment
Advantage

GOALS:
Increase access to care by 10%, by June 30, 2021.

ACTION PLAN:
Provider/Integrated Health:

1. Utilize Metrics Coordinator to do outreach to local providers (primary care, mental health and dental health), regarding measures that are not being met and the incentives available.
2. Utilize CHWs to assist members to engage with primary care, dental, mental health and specialists as needed.
3. Utilize assisters at UMCHS, Mirasol, Euvalcree, to enroll eligible community members in OHP.
4. Utilize SB 558 to ensure any child, not born in the US, gets enrolled for OHP and a provider.
5. Collaborate with local Regional Health Equity Alliance to educate consumers on health access.

Transportation

1. Provide education to consumers on availability and usage of GOBHI Non-emergent medical transportation(Brokerage).
2. Collaborate with Community Development Coordinator (Transportation liaison) to discuss extension of Brokerage services, availability, etc.
3. Educate consumers on availability of low cost local transportation options: buses and taxi vouchers.
4. Educate Good Shepherd utilizers on the availability of Care Van.
5. Utilize CHWs to provide education to consumers on all the transportation options.

Prevention and Screening

1. Collaborate with EOCCO, regarding acceptable forms of documentation, other than billing codes, to be utilized to track completed screening procedures.
2. Collaborate with community partners to offer screening events at alternative venues and times, that are more convenient for working families.
3. Utilize Metrics Coordinator to do outreach to local providers (primary care, mental health and dental health), regarding measures that are not being met and the incentives available.

ESTIMATED BUDGET NEEDED:
$60,000 (Metric Coordinator salary/food and rental for events)

POTENTIAL FUNDING SOURCES:
Umatilla LCAC/EOCCO incentives
OHA
GSHF
Wildhorse Foundation
Pendleton Trust
CHI Foundation

PRIORITY ISSUE #6: Health Equity / SDOH
Jamie, TBD

PROBLEM IDENTIFIED:
Housing Homelessness
Food insecurity
Trauma
Hispanic/Latino Health Equity, Disparities, Access
poverty

DATA AVAILABLE:
1 in 65 children experience homelessness, 1 in 6 renters are paying more than 50% of income on rent

56% Hispanic/ Latino adults uninsured compared to 7% of general pop [2018 CHA, p.84]
53% Hispanic/ Latino parents reported healthcare provider always explained things in a way they could understand [2018 CHA, P.115]
GOBHI
OR State
PIT Count
CHA
Home 4 Hope

GOALS:
HOUSING:
Members of the LCAC will work collaboratively with the Home- 4- Hope Coalition to plan and

develop a tiny-home village that utilizes a housing first or harm reduction model to connect patients to wraparound services.

Incentive measures addressed: Numbers 6, 7, 8, 12, 13, 14, 15, 18, 19

Hispanic/Latino Health Equity, Disparities, Access:
To increase insurance rates, education on insurance and health issues, and points of access for Hispanic/Latino community members.

Incentive measures addressed: Possibly all except #2

ACTION PLAN:
HOUSING-

- Within 1 year, the Home -4- Hope coalition will have written a proposal for the tiny home village in both Pendleton and Hermiston.
- Within 1 year, Home- 4- Hope will have identified and applied to at least 3 funding sources for the tiny home village.
- Within 1 year, at least 2 qualified volunteers will be recruited to build tiny homes.

Hispanic/Latino Health Equity, Disparities, Access:

- By July 1, 2020, the LCAC will work collaboratively with the OHA to acquire at least 1 more certified OHP assister in each community (Hermiston, Pendleton, and Milton-Freewater).
- Within 1 year, the LCAC will offer 1 community OHP enrollment, health screening/information, and resource event targeted towards Spanish speakers.
- Within 2 years, the LCAC metrics coordinator will be actively collaborating with hospital/clinic administration and providers to integrate incentive measures into electronic health record systems and standard workflow.
- Within 1 year, existing information/resource packets from the OHA will be provided at all OHP application appointments.
- Within 2 years, health literacy and cultural humility training will be integrated into hospital's organizational priorities.

ESTIMATED BUDGET NEEDED:
HOUSING-

- Budget required for developing homes:
  - $81,000 (2,700/tiny home * 30 tiny homes, land donated) (Additional items needed to make village functional)

Hispanic/Latino Health Equity, Disparities, Access:

- Metrics Coordinator $XXXXX, training curriculum $10,000 (some trainings like health literacy available free or low cost online through resources like CDC Train)
- other expenses (assister salary and info packets provided by OHA)

POTENTIAL FUNDING SOURCES:

LCAC
Good Shepherd Foundation
Wildhorse Foundation
Governmental Grants
Faith Based Organizations
OHA
Governmental health equity grants