GRANDE RONDE HOSPITAL

COMMUNITY BENEFIT

FY 2017 – FY 2019

Priority Health Needs

PROGRESS REPORT
May 1, 2018 through April 30, 2019

THREE-YEAR GOALS

1. GOAL: MENTAL HEALTH ~ ACCESS: Improve access to health care by removing barriers.

1.1 Objective: Improve availability and ease of obtaining mental health services.				
N/A	Balanced Scorecard	Baseline = no	Target = yes	Provide financial assistance with relocation expenses for Mental Health Provider(s) =
Achieved	Balanced Scorecard	Baseline = 0	Target = 1	Number of community education/information events surrounding mental/behavioral health supported by the Hospital = 2
Achieved	Balanced Scorecard	Baseline = 26	Target = 50	Increase the number of social service transportation assistance pathways for patients through GRH Community Health Workers = 18 pathways were completed this year bringing the total number to 71.
Achieved	Balanced Scorecard	Baseline = 900	Target = 1440	Total number of applications completed for individuals - Oregon Health Plan and Presumptive Medicaid Eligibility through GRH locations as of 4/30/19 = 2,231 + 1,048 + 85 = 3,364

Achieved	**Balanced Scorecard**	**Baseline =900**	**Target = 1220**	**Total number of financial assistance applications completed with Financial Counselor support as of 4/30/19 = 1,998.**
Achieved	**Balanced Scorecard**	**Baseline = 19**	**Target = 22**	**Number of new, employed primary care providers recruited as of 4/30/19? 5 were recruited totaling 27.**

	Comments
Benchmark 1: Support community recruitment of Mental Health Provider(s).	***Benchmark 1: Grande Ronde Hospital (GRH) offered relocation assistance to our community partners for recruitment of a Mental Health Provider. A template agreement was created. During fiscal year ending 04/30/18, the Center for Human Development (CHD) hired Lynn Willis, NP. Lynn lives in the local area so no relocation assistance was needed. No other Mental Health Providers have been recruited during FY17 – FY19.***
Benchmark 2: Support community education and information surrounding mental/behavioral health such as mental health first aid, adverse childhood experiences and trauma information care.	***Benchmark 2: GRH supported the following community education/information surrounding mental/behavioral health to date:*** • ***Trauma Informed Care Training & Workshop – 10/05/16 – community partners included: Greater Oregon Behavioral Health, Inc. (GOBHI), Oregon Health Authority, GRH, and Portland State University.*** • ***Eastern Oregon Coordinated Care Organization (EOCCO) Provider Forum on Chronic Non-Cancer Pain Management - 04/28/17 – provider forum for tips on talking to patients about addiction, the neuroanatomy and neurochemistry of addiction, the role of pain schools, nonpharmacological options in the treatment of chronic pain, and the role of buprenorphine in the treatment of opioid abuse.***
Benchmark 3: Support local transportation efforts such as the "Rides to Wellness" program.	***Benchmark 3: GRH Community Health Workers completed 18 social service transportation assistance pathways during the fiscal year bringing our total pathways to 71. In addition, GRH supported the Rides to Wellness (RTW) Program through Northeast Oregon Public Transit: Union County with a $10,001 donation in FY2019.***
Benchmark 4: Assist with Oregon Health Plan enrollment.	***Benchmark 4: GRH has Financial Counselors in four (4) locations at GRH including the Hospital lobby, Pavilion, Regional Medical Plaza and Regional Medical Clinic. The Financial Counselors work as a cohesive unit to provide patient education, direction to available resources and assistance obtaining Medicaid and Financial Assistance coverage. They also participate in monthly application assistor trainings, which include all local individuals certified to assist patients in enrolling for healthcare coverage. Our Financial Counselors***

	routinely network with key individuals in the community to keep abreast of all programs available to those in need. In addition, they provide ongoing education to GRH staff about our services. The Financial Counselors have built a strong support network in the community and at GRH, which has enabled them to exceed the target enrollment numbers.
Benchmark 5: Assist with financial assistance application support.	***Benchmark 5: Same as above.***
Benchmark 6: Recruit additional primary care providers.	***Benchmark 6: Five primary care providers were recruited during FYE 04/30/19. They include: Darryl Sandberg, NP; Meghan Brassine, NP; Eve Koltuv, MD; Zachary Spoehr-Labutta, MD; and Korrie Dubray, NP.***

2. GOAL: MENTAL HEALTH ~ SUBSTANCE ABUSE/ADDICTION: Promote and partner with community programs/agencies to reduce substance abuse.

2.1	**Objective: Improve patient mental health by building community partnerships.**			
Achieved	**Balanced Scorecard**	**Baseline = 0**	**Target = 4**	**Number of meetings held of the Multidisciplinary Case Management Team = 10, bringing the total number of meetings held as of 04/30/19 to 16.**
Achieved	**Balanced Scorecard**	**Baseline = 0**	**Target = 2**	**Number of community events/programs where GRH is partnering to promote youth substance abuse prevention programs = 2**
Achieved	**Balanced Scorecard**	**Baseline = 0**	**Target = 5**	**Number of qualified patients who successfully complete the CHARM (Children and Recovering Mothers) program = FYE 04/30/19 - 18 women. Grand total = 18 + 5 (FYE 04/30/18) equals 23 women who have successfully completed the CHARM Program since its inception.**

	Comments
Benchmark 1: Maintain an ongoing Multidisciplinary Case Management Team.	***Benchmark 1: The GRH Multidisciplinary Team consists of hospital case management, clinic case management, Mary Goldstein, LCSW, ER Manager and Luke Matteucci, who represents the Center for Human Development (CHD). Collaborative community partners are invited depending on the topic of discussion. The team had ten (10) meetings this year. Also a Behavioral Health Department was created with Jim Sheehy, LCSW, serving as the manager.***
Benchmark 2: Participation and support for youth substance abuse programs such as the "Union County Safe Communities Coalition" and "Drug Free Youth".	***Benchmark 2: For FYE 04/30/19, GRH Supported the Union County Safe Communities Coalition (UCSCC) Drug Free Run held on 08/25/18. The run had 54 participants in the 5K, 10K and one mile run/walk. The event raised $10,000 to support youth substance abuse prevention in Union County. Proceeds from the event were used for the following activities: safe & sober grad night trip;***

	ongoing parenting education and resilience building in collaboration with the Union County Juvenile Department; and childcare for community educational opportunities that relate to preventing youth substance abuse. UCSCC again partnered with Union County Community Access for Resource Effectiveness (CARE) Coordinator, GRH and the City of La Grande Parks and Recreation Department to sponsor at risk kids to attend "Spring Break Camp". During the week of March 25-29, 2019, 23 at risk kids from La Grande, Elgin and Union were selected by CARE Coordinators in collaboration with local schools. The group identified transportation and meals as being additional barriers to participation. Community partners were able to provide transportation, morning snacks and lunch for these kids. *On October 19, 2016, GRH committed to support the Drug Free Youth (D-FY) program through the La Grande Middle School in conjunction with La Grande Rotary Club by providing up to $7,500/year for FY17-FY19 for drug screening costs through Interpath Lab. GRH also worked with the La Grande Rotary Club to promote the D-FY program to outlying schools in Union County and pledged $2,500 for drug screening costs. As of the close of the fiscal year, none of the outlying schools has expressed interest in creating a program at this time. During FYE 04/30/19, La Grande Middle School chose not to perform drug screenings on any D-FY members due to a leave of absence by the coordinator.*
Benchmark 3: Institute a CHARMS program.	*Benchmark 3: In calendar year 2016, there were approximately 15 babies born at GRH unknowingly affected by drugs. The CHARM (CHildren And Recovery Mothers) program officially enrolled the first patient on 10/19/17. During FYE 04/30/19, 24 women enrolled in CHARM, with 18 women successfully completing the program.* *The workflow of the CHARM program has adjusted to accommodate growth. Community team partner participants contribute essential services developing phases/levels of care ensuring the best possible interventions and outcomes. Our community team partners include: GRH; OB floor Nurse Manager, Women's and Children's Clinic Behavioral Health Specialist, CHW and RN Case Manager. CHD; Babies First, Maternal Case Management, Addiction Counseling and mental health and Grande Ronde Recovery Addiction Counseling and mental health. This team meets monthly to review the progress of each participant. CHARM participants are addressed as a dual diagnosis*

	approach with both addiction counseling and mental health services. Weekly and sometimes daily interventions are provided to support our CHARM ladies. *The majority of CHARM participants fall short of social determinants needing extensive resource management often times basic needs such as housing.* *The following community partners have contributed to the success of this program:* *Northeast Oregon Network (NEON)* *Department of Human Services* *Center for Human Development* *Community Connection of Northeast Oregon* *Next Step Pregnancy* *Greater Oregon Behavioral Health* *Grande Ronde Recovery* *Blue Mountain Associates* *Eastern Oregon Coordinated Care Organization Local Community Action* *Shelter from the Storm* *Cribs for Kids* *State MDT team* *Dr. Mark Harris* *Union County Food Banks* *Moon Motel* *Soroptimist International* *Norco Medical Supplies* *Northeast Housing* *Local churches* *La Grande Police Department* *Neighbor to Neighbor* *People Helping People* *The Other Side of Heaven* *Narcotics Anonymous* *Early Intervention* *Baker House* *Eastern Oregon Alcoholism Foundation*

3. GOAL: PREVENTIVE CARE ~ CHRONIC ILLNESS: To reduce morbidity and mortality stemming from heart disease, diabetes and cancer.

3.1	Objective: Support the creation of a healthy community be engaging community partners, promoting education and screening programs, and increasing awareness of chronic illness management.			
Achieved	Balanced Scorecard	Baseline = 0	Target = 3	Number of community educational/screening event(s) held as of 04/30/19 = 7
Achieved	Balanced Scorecard	Baseline = 0%	Target = 40.6%	Meet the CY2018 EOCCO Incentive Measure target for EOCCO Adolescent Well Care Visits = GRH Regional Medical Clinic met the target at 45.7%, GRH Women's & Children's Clinic met the target at 48.9%, GRH Elgin Clinic met the target at 75.4% and GRH Union Clinic met the target at 53.6%.
Achieved	Balanced Scorecard	Baseline = 0	Target = 100	Increase the number of patients assisted by employed Community Health Workers (CHW) in the home = Total RMP patients assisted by CHWs = 204; Total RMC patients assisted by CHWs = 335; Grand total patients assisted by CHWs 204+335 = 539. Total pathways completed = 195.
Achieved	Balanced Scorecard	Baseline = 0	Target = 1	Number of wellness projects/partnerships supported within the community as of 4/30/19 = 5

	Comments
Benchmark 1: **Host education and screening events.**	***Benchmark 1: GRH hosted seven community education/screening events for the FYE 04/30/19.*** ***GRH held three Community Blood Draw events at the GRH Union Clinic in Union, Oregon (04/06/19), at the GRH Elgin Clinic in Elgin, Oregon (04/13/19), and at the GRH Pavilion in La Grande, Oregon (04/27/19). The following screenings were performed at each event: Hemoglobin & Hematocrit Red Blood Cell screening for Anemia/Polycythemia, Cardiac Lipid Panel (Cholesterol, HDL, LDL & Triglycerides) and Glucose (Blood Sugar Count). 220 people participated in the three events.*** ***GRH held three Health Screenings at the Farmer's Market in La Grande, Oregon, on 06/16/18, 07/07/18, and 08/04/18, providing free blood pressure checks, diabetes information, and answering general questions from the public. Between 85-100 people participated in the blood pressure checks depending on the date.*** ***GRH participated in the La Grande Middle School Resource Fair on 08/08/18 at the La Grande Middle School in La Grande, Oregon. Providers and Staff from the GRH Women's and Children's Clinic promoted colorectal screenings and***

	colon cancer prevention as well as promoted the GRH Financial Assistance Program through our Financial Assistance Counselors.
Benchmark 2: Promote annual wellness visits for Medicaid patients.	*Benchmark 2: Clinic staff review the EOCCO roster, contact and schedule all patients who meets the guidelines for an Adolescent Well Care visit. In addition, GRH offers free sports physicals. At the time of registration for these physicals, the patient's appointment history is reviewed. If the patient has not had an Adolescent Well Care Visit within the last year a visit is scheduled at that time.*
Benchmark 3: Manage patient care in the home.	*Benchmark 3: Total number of clinic patients assisted by Community Health Workers (CHWs) in FYE 04/30/19 was 539 and total number of pathways completed by CHWs in FYE 04/30/19 was 195. Patients may have more than one pathway. CHWs assist patients in many ways – pathways include:* *Initial Intake - This questioner is filled out during the first home visit. The questionnaire helps the CHW determine what the patient's socioeconomic needs are.* *Medication Interview – Medication interventions are usually completed during the first home visit if the patient is taking any medications prescribed by a provider. The CHW goes through all the patient's medications and documents how the patient takes their medication. This is given to the patient's primary care provider to review and determine if the patient understands how to take their medications as prescribed.* *Medication Management - This pathway is completed if the provider determines the patient is NOT taking their medication correctly. If this is determined, the CHW coordinates a follow-up visit so the patient can be given more education by the provider or nurse. Once education is completed, the CHW completes a second Medication Interview (within 3 business days) that is reviewed by the provider to determine if the patient has a better understanding.* *Social Services - This pathway is used when a CHW assists a patient with any of the following resources:* • *Child Assistance* • *Family Assistance* • *Housing Assistance* • *Insurance Assistance (other than health insurance)*

- *Financial Assistance*
- *Medication Assistance*
- *Transportation Assistance*
- *Job/Employment Assistance*
- *Education Assistance*
- *Medical Debt Assistance*
- *Legal Assistance*
- *Parent Education Assistance*
- *Domestic Violence Assistance*
- *Clothing Assistance*
- *Utilities Assistance*
- *Translation Assistance*

***Medical Referral** - This pathway is used when a CHW helps schedule or coordinate an appointment with any of the following:*

- *Primary Care*
- *Specialty Medical Care*
- *Dental*
- *Vision*
- *Hearing*
- *Family Planning*
- *Mental Health*
- *Substance Abuse*
- *Speech and Language*
- *Pharmacy*
- *Other*

***Medical Home** - This pathway is used if a CHW helps the patient find and establish care with a primary care provider*

***Health Insurance** - This pathway is used when a CHW connects the patient to the appropriate resources to apply for insurance. Generally, this is referring patients to the appropriate resources who qualify for EOCCO and need help completing the paperwork.*

***Tobacco Cessation** - This pathway is completed when the CHW helps the patient quit smoking for a total of 30 consecutive days. The CHW helps with this process by scheduling an appointment with the patient's provider so they*

<u>Benchmark 4:</u> Support community partnerships on a project-by-project basis that promote wellness e.g., wellness center, health foods, exercise, etc.	***can discuss their options, providing approved smoking cessation information and encouragement.*** ***<u>Benchmark 4</u>: GRH supported the following community partnerships in FYE 04/30/19:*** • ***Color the Blues Autism Walk & Family Day – 6/23/18*** • ***GRH Clinics – Free Sports Physicals 07/2018 – 8/2018 – provide sports physicals to students in Union County.*** • ***Wildflower Lodge – Forget Me Not Trot 5K & Memory Mile - 09/22/18 – community event supporting Alzheimer's Awareness.*** • ***Central Elementary School Third Grade Healthy Lifestyles Exercise 09/26/18 – outdoor circuit/fitness training promoting healthy activity utilizing pedometers.*** • ***Safe Kids Union County – Union County Safe Kids Safety Fair – 04/16/19 – 04/17/19***