

Yellowhawk Tribal Health Center – Community Health Improvement Plan: 2012

Goal of Community Health Improvement Plan

Goal of the Yellowhawk community health improvement plan is to assist CTUIR members lead happy and productive lives and enjoy maximum health. The guides for this process will be the Yellowhawk CEO annual work plan and the CTUIR Board of trustee focus on prevention and wellness.

Yellowhawk Tribal Health Center - Health Commission

Vision Statement

- That the Yellowhawk Tribal Health Center (YTHC) be recognized by the population that it serves as a provider of quality health education and services, and considered a model of excellence by the health care community.
- That CTUIR members and other Native Americans served by YTHC may lead happy and productive lives enjoy maximum health, experience quality of life, and take personal responsibility for managing their health and well being.

Mission Statement

- YTHC exists to ensure a high quality, accessible, responsive and well-coordinated delivery system of health education, promotion and health and wellness services, for the benefit of current and future CTUIR members and eligible members of the community

DATA

The Confederated Tribes of the Umatilla Indian Reservation (CTUIR) is located in the Northeast corner of Oregon in Umatilla County which borders the state of Washington. CTUIR is comprised of nearly 3,000 members of the Cayuse, Umatilla and Walla Walla tribes. The closest city, Pendleton is approximately 5 miles west and has a population of 16,000.

Yellowhawk Tribal Health Center (YTHC) is a federally funded, tribally run health clinic that provides and coordinates health care to CTUIR tribal members as well as members of other federally recognized tribes living on the reservation or within the Tribes catchment area. In order to develop a Community Health Improvement Plan (CHIP) for the YTHC Community Health Outreach Program (CHOP) both primary and secondary data for the County and the Tribe was needed.

According to County Health Rankings 2012¹ (Appendix A), Umatilla County is comprised predominantly of Non-Hispanic Whites, but has a higher percentage of both Hispanic and Native Americans (20% and 4%) as compared to the State (11% and 1%). The County also has a higher percentage of the population under the age of 18, 27% compared to 23% for the State. Umatilla County is 30% rural compared to 21% of the state and ranks 22nd out of 33 for Health Outcomes and 33rd for health behaviors. CTUIR is rural and comprised of 172,000 acres, which represents about 12% of Umatilla County. The County has higher rates of adult obesity (34% vs 26%), smoking (23% vs 18%), and physical inactivity (25% vs 18%) as compared to the State as a whole. a higher percentage of high school students graduate in Umatilla County as compared to the State (71%, 66%), but fewer students go on to college (48% VS 64%). Umatilla County also has a higher percentage of single parent households (33% vs 30%), more violent crime (328/100,000 compared to 271/100,000) and a teen birth rate that is 1.7 times higher than the State and nearly 3 times the national average.

In the fall of 2011, Umatilla County and YTHC completed a Community Health Assessment using a self-report survey instrument. The survey was mailed to a random sample of 800 County residents with a 45% response rate (n=342, CI=5.28%). YTHC mailed another 600 surveys to a random sample of CTUIR members with a response from 139 (> 5% of population surveyed). The low response rate from CTUIR was noted as a limitation in the study.

The Umatilla County Health Assessment² data specific to CTUIR members indicate that they experience higher rates of chronic disease and reported poor health than Umatilla County, the State of Oregon and the US general population (Appendix B). This survey also indicates that a higher percentage of CTUIR members are uninsured as compared to Umatilla County (27% VS 16%) residents. Although uninsured, these individuals rely almost exclusively on YTHC for direct health care services.

Government and Performance and Results Act (GPRA)³ measures collected from the YTHC Electronic Health Records, indicate a younger population than the county or the State for CTUIR (28% under the age of 18 and 8% over the age of 65 as compared to 13% for the county and 14% for the state). This data also indicates that for 2011, approximately 47% of the YTHC population obtained body mass index measurements between the ages of 2-5 years of age have a BMI greater the 85% and that the incidence rate of obesity for ages 6-74 ranges from 37% to 74% with the highest rates between 35-44 years of age.

Other data collected on the CTUIR in 2011 included an elder’s survey (Appendix C) conducted by the YTHC Senior Center which works under a Title VI grant. The data in this survey is consistent with data retrieved from the Community Health Assessment with the exception that CTUIR elders live more independent lives. A youth feasibility study was also conducted by the tribe and indicates that there are little resources and opportunities available to youth and adolescents living on the reservation.

Objectives -SMART Specific Measurable Attainable Realistic Time duration

YTHC CEO Priorities	Healthy people 2020 objectives
<p>Diabetes Prevention and Treatment</p> <p>CTUIR BOT Focus Area Promote wellness by encouraging healthy choices and lifestyle changes</p> <p>Explore ways to encourage consumption of more first foods and changing lifestyle/food choices to promote wellness</p>	<p>-Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education</p> <p>Increase prevention behaviors in persons at high risk for diabetes with pre-diabetes</p> <ul style="list-style-type: none"> • Increase the proportion of persons at high risk for diabetes with pre-diabetes who report increasing their levels of physical activity • Increase the proportion of persons at high risk for diabetes with pre-diabetes who report trying to lose weight • Increase the proportion of persons at high risk for diabetes with pre-diabetes who report reducing the amount of fat or calories in their diet • Increase the proportion of adults who are at a healthy weight • Increase the proportion of adults who engage in aerobic physical activity of at least moderate intensity for at least 150 minutes/week, or 75 minutes/week of vigorous intensity, or an equivalent combination

<p>Chronic Disease</p> <p>CTUIR BOT Focus Area Promote wellness by encouraging healthy choices and lifestyle changes</p> <p>identify and begin implementation of strategies for reducing Heart Disease and contributory risk factors for our community</p> <p>Tobacco prevention and education</p>	<p>Heart Disease and Stroke Reduce the proportion of persons in the population with hypertension Increase the proportion of adults with hypertension who meet the recommended guidelines</p> <ul style="list-style-type: none"> • BMI • Physical activity <p>Arthritis Reduce the proportion of adults with doctor-diagnosed arthritis who experience a limitation in activity due to arthritis or joint symptoms</p> <p>Reduce tobacco use by adults</p> <p>Reduce tobacco use by youths</p>
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Team: DM/Nutrition - Teresa Jones, Jean Farmer
 Adolescent – Jennifer Campbell, Robby Bill
 Arthritis – Turner Goin, Paula Wallis, Charlie Picard
 Tobacco – Jennifer Campbell, Kristi Yunker
 Medical/clinical team

Annual Work Plan Objectives: Increase participation in Diabetes programs and activities.

Activity: Establish a case management system that tracks persons with diabetes and assists in the management of their care increasing by 10% each quarter.

- Expand our multidisciplinary team to include providers, to provide formal diabetes education to the population with pre-diabetes and diabetes no later than 1 Sep 2012.
- Utilize I H S Best Practices,(DSME and Physical Activity) as guide for practice.
- Establish a policy for providers and/or team to make referrals to DSME at diagnosis of pre-diabetes, metabolic syndrome and/or diabetes to include Gestational DM or as needed for follow-up; increase our DSME referrals by 10% each quarter.
- Establish a policy for DSME at diagnosis, then every 6-12 months, or more as needed, no later than 1 Sep 2012.
- Establish a policy for MNT at diagnosis and at least yearly, or more as needed.
- Increase activities to at least twice monthly to identify persons who have pre-diabetes and diabetes such as offering random blood sugars at public events, schools with parental consent, Diabetes Awareness Day (held in Mar),and offering educational sessions at schools beginning 1 Sep 2012 .

Existing programs:

- Diabetes Program
- WIC/Nutrition
- Adolescent Services
- Sons & Daughters of tradition
- TPEP grant

- Fit & Strong

Resources needed

DM Wellness coach

Partners:

Execution plan how are resources acquired:

Continue implementation of DM Case Management

Life Coach/group trainer hired

Measure, Timeline, Barriers/overcome:

Increase of 10% participation in DM program through clinic referrals for one on one counseling by June 2013.

BOT objectives: Explore ways to encourage consumption of more first foods and changing lifestyle/food choices to promote wellness

Activity: expose all community health/behavioral health staff to the cultural concept of first foods through digging field trips, longhouse and museum activities.

- Integrate first food concept into wellness activities – community walking, food demonstrations, and community gardens

Existing programs:

- Diabetes Program
- WIC/Nutrition
- Adolescent Services
- Sons & Daughters of tradition
- Small community garden
- Fit & Strong program for elderly

Resources needed

Need to identify grant resources to expand community gardens throughout the community .housing developments

Partners: CTUIR wellness nurse, OSU

Execution plan how are resources acquired

Measure, Timeline, Barriers/overcome

YTHC CEO Priorities	Healthy people 2020 objectives
Youth Overweight/ Obesity CTUIR BOT Focus Area Healthy weight Explore ways to encourage consumption of more first foods and changing lifestyle/food choices to promote wellness	-Reduce the proportion of children and adolescents who are considered obese -Increase the proportion of adolescents who are connected to a parent or other positive adult caregiver -Increase the proportion of adolescents who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity -Increase the proportion of adolescents who participate in extracurricular and out-of-school activities

Team: Adolescent Team – Jennifer Campbell, Robby Bill
 Sons & Daughters of Tradition – Sara Frank, Dorothy
 Circles of Care: Dolores JImerson

Annual Work Plan Objectives: Recommend strategies; enact policies and environmental initiatives that support healthy eating and active living to reduce youth overweight/obesity in our community

Activity:

- Submit Application for Oregon Healthy Communities grant – Plan for extension of current walking path, begin community lead walking program
- Continue in our process of “Building Bridges,” a coalition between YTHC and NCS to establish improvement of healthy food options to the school lunch program and for purchase at Mission Store to begin fall 2012.
- Include healthy cooking class as part of elective curriculum for students to begin fall 2012.
- Collaborate with CTUIR language program to develop first foods message in community health wellness message

Existing programs:

- Circles of Care
- WIC/Nutrition Services
- Sons & Daughters of tradition

Resources needed

- Systems of Care
- Director
- Additional staff

Adolescent Services

- Health promotion specialist

Partners:

- CTUIR Youth Feasibility work group
- CTUIR language program

**Execution plan how are resources acquired
 Measure, Timeline, Barriers/overcome**

YTHC CEO Priorities	Healthy people 2020 objectives
Maternal Child Health	<p>Increase the proportion of pregnant women who receive early and adequate prenatal care</p> <ul style="list-style-type: none"> • Prenatal care beginning in first trimester • Early and adequate prenatal care <p>Increase the proportion of infants who are breastfed</p> <p>Increase the proportion of women giving birth who attend a postpartum care visit with a health worker</p> <p>Increase the proportion of women delivering a live birth who received preconception care services and practiced key recommended preconception health behaviors</p> <p>Discussed preconception health with a health care worker prior to pregnancy.</p>

	Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines
	Increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines

Team: MCH Team Karen Cook, Rita Campbell

Medical/Clinic

WIC – Jean Farmer, Alisa

Objectives: Increase proportion of women & children seeking care YTHC

Activity: Continue implementing MCH Title V grant – building capacity

Submit application for Tribal MCH home visiting grant to expand capacity

Contract with Pediatrician, OB/GYN providers for monthly clinic

Begin Mobile Mammogram Clinic every other month

Existing programs:

- Diabetes Program
- WIC/Nutrition
- Adolescent Services
- PHN/MCH PHN

Resources needed

Apply for Tribal maternal, child infant grant

- Additional PHN/CHR
- OB/GYN consultant

Partners

Execution plan how are resources acquired

Measure, Timeline, Barriers/overcome

YTHC CEO Priorities	Healthy people 2020 objectives
Elders Health Services	-“Implementation Plan for Improving Elders Services on the Umatilla Reservation” - Implementation of the GAP Analysis Matrix recommendations in report completed by American Indian Health Management and Policy (AIHMP) -GAP Issues needing addressed- Housing, Transportation, Elders status checks, Elder Abuse, Communication, Building of a newer Elder services program, Case Management, Training, Issues in home services, assisted living, reservation on health services
Part I-Fit & Strong! Part II-Healthy Living in Oregon	Fit & Strong! -Evidence based program that targets CTUIR elders with osteoarthritis (OA) Healthy Living in Oregon -Study conducted with 10 people to identify facilitators & barriers to healthy living in the CTUIR community

Team: Senior Services Program/Title VI Grant Program- All staff

CHR/Transport-Charlie Picard

Chronic Disease Prev. & Health Prevention-Jennifer Campbell

Health Services- Dr. Ehlers, Shana Alexander, YTHC

Elders Status Checks-Rhonda Craig, Alan Humphrey,

Elder Abuse-Desiree Cruz, Modesta Minthorn, Ray Denny, Alan Humphrey

Diabetes- Teresa Jones

Nutrition-Jean Farmer
Department of Children Family Services-Julie Taylor
Housing-Brook Kristovich, Josh Franken, Pamela Fisher
Public Safety-Ray Denny
Transportation-Jim Beard, Susan Johnson
Elders Services Coordinating Team-Debra Croswell

BOT objectives: Enhance the ease of services and information to the CTUIR elders so that they are able to gain access of resources in one area.

Activity: Develop and Implement Senior Services Program through Yellowhawk Tribal Health Organization

Existing Programs:

- Title VI Nutrition/Caregiving Program/First Food Development Program
- YTHC Health Promotion & Wellness
- Community Health Outreach Program-WIC/Nutrition/CHR-Transport/Out Reach Nurse/Chronic Disease & Health Prevention/Mental Health/Diabetes
- CTUIR Public Affairs
- Department of Children & Family Services/Elder Abuse
- CTUIR Transportation/Planning Office
- CTUIR Elder Housing
- CTUIR Public Safety
- CTUIR Finance/Elder Pension Checks
- CAPECO
- Public Health
- Umatilla County HUD Housing
- CTUIR/County Legal Department
- CTUIR HR/TERO/Workforce Development
- Cayuse Technologies

Resources needed:

- Increased Program Funding- Program development, Elder travel, transportation,
- Increase Title VI Senior Center Staff
- Senior Caregiver Coordinator/Caseworker
- Building to develop Senior Helping Senior Food Bank/Outreach
- Community Participation to engage in helping neighbor elders-yard work, hunting/fishing, housing cleaning
- Development of Partnership information highway so that the elders can be aware community programs, resources and trainings.

Partners: CTUIR BOT, Executive Directors, YTHC, NCOA, city, county, Federal and state partners

Execution plan how are resources acquired:

- Resources have been developed with partnership through CTUIR/YTHC organizations
- Grants need to be studied and defined with Finance/Grant Writer that will assist in the many areas of development for the program next 5 years
- Resourcing and outsourcing with other partner organizations that are already established in aging area population independence and quality of life programs and developed procedures
- Develop Care giving and case manager program that will allow for Medicare billing for services

Measure:

Timeline:

Short-Term-1st, 2nd year

- program research on BOT/YTHC development procedures
- Gain insight from other Title VI program and AOA on programmatic development and resourcing
- Review and make improvements to existing programs/grants if needed
- Complete Elder Assessment Survey/local survey needs
- Gain knowledge of needed resources for in home care/caregivers
- Develop policy and procedures to aide in equality and accountability for use of elder travel funds
- Begin planning sessions with elders for travel, dinners, and activity/physical programs
- Develop partnerships with CTUIR transportation for elder specific needs
- Educate Elders and staff on outsourcing partnerships with tribal, city, federal and state organizations
- Seniors helping Seniors workshops to aide in community elder caregiving, visiting, transportation and every independent needs
- Caregiving classes/workshops for family members, grandparents raising children for resources for respite and other needs for family member
- Develop Newsletter or coincide with YTHC in elders monthly elder calendar/information resource
- Develop Program brochure to share with elders on available resources and program structure to aide them in independent living both on and off reservation
- Development of community, BOT and HC report to share on program development annually

Long-Term 3rd, 4th, and 5th year

- Development of Elders working with First Foods program development to share with youth, community on traditional gathering practices, uses and medicinal use.
- Partner with educations, vocational and services to bring youth and elder's back together
- Partner with Horizon Project, United and HUD housing projects funding to aide the elders who live within the rural areas and own housing to fix and update and protect their homes
- Review and examine the need for apartment style house that could potentially be developed into assisted living
- Continual funding services structure reviews on new grants/partnerships and outsourcing the program has a deliverable piece with other tribal grants

Barriers/overcome:

- Gaining Trust of Elders after money transfer and division
- Program Funding level to begin program and early expectation of BOT deliverables in year time
- Reactive vs Proactive support for forward momentum of project with all elders vs. some elders
- Pulling the community into the program for support and elder family/neighbor independent living support
- Elders and youth engagement practices have diminished to the point where the program needs to reacclimate both parties culturally and traditionally

Part I-Fit & Strong!-Part II-Healthy Living in Oregon

Team: Senior Services/Activities/Title VI Programs

Paula Wallis, Turner Goins, Charlie Picard, Sonja Lloyd

Objective: Enhancing the quality of life for our Elders by fostering an environment of dignity, pride and independence while preserving the tribal culture and traditional values.

Activity: Implement Fit & Strong! grant and Healthy Living in Oregon programs

Existing programs:

- Senior Services/Activities/Title VI Programs

- Diabetes Program
- Fit & Strong! research program

Resources needed

- Senior Caregiver Coordinator/Case manager
- Identify and train two tribal members to deliver Fit & Strong program
- 10 participants to interview & record from a Healthy living questionnaire

Partners: OSU/Developers of Fit & Strong!

Execution plan how are resources acquired

- Initial funding coming from OSU/Turner Goins
- Examine cultural acceptability of Fit & Strong! and Identify any adaptations that could improve its cultural relevance and effectiveness with focus groups
- Adapt Fit & Strong! instructor and participant manuals based on focus group feedback
- Identify and train two tribal members to deliver Fit and Strong!
- Pilot test the translated Fit and Strong! program measuring relevant outcomes at baseline and at two and six months
- Identify the prominent health-related issues in the CTUIR in terms of their socio-cultural contexts
- Examine the factors that key informants in the community perceive as enabling or enhibiting healthy lifestyles of community residents
- Increase awareness among CTUIR leaders of the factors that enable and inhibit the health of their residents

Measure: OSU will develop measurable and data and share with Senior Services Program, YTHC YOT and HC. Data will remain YTHC data.

Timelines-8 months

Barriers Fit & Strong!-engaging elders to participate at the regimen the program may require per week, location/funding to sustain program

Barriers Healthy Living In Oregon-NA

YTHC CEO Priorities	Healthy people 2020 objectives
Behavioral Health Integration of services CTUIR BOT Focus Area Alcohol and drug prevention and education	Reduce suicide attempts by adolescents Increase depression screening by primary care providers

Team: MH/BH – Joe Streetman,
 Suicide Prevention Team
 Circles of Care
 Medical/Clinical staff
 A&D staff

Objectives: Integrate Behavioral Health and Medical Services

Activity:

Existing programs:

A& D treatment counselors
 Suicide prevention grant
 Circles of Care Planning grant

Resources needed

Systems of Care

- Director
- Additional staff

Partners

Execution plan how are resources acquired

Measure, Timeline, Barriers/overcome

YTHC CEO Priorities	Healthy people 2020 objectives
Work towards appropriate Accreditation	AAAHC accreditation achieved 2011, next survey 2014. Secure NACCHO planning grant Begin IHS IPC4 initiative develop patient centered medical home

Team: PHAT

Objective: AAAHC: Maintain accreditation status

Public Health: Work towards achieving accreditation demonstrated by compliance with the Public Health Accreditation Board (PHAB) standards and measures

Activity: Public Health Accreditation Team (PHAT) developed, Continue to work with county partners develop CHIP

Existing programs:

AAAHC accreditation through 2014
 QI/risk management program
 Accepted into IPC4
 NACCHO accreditation planning grant
 PHAT

Resources needed

Partners

Execution plan how are resources acquired

Measure, Timeline, Barriers/overcome

Appendix A

County Health Rankings 2012, Umatilla County

	Umatilla County	Oregon
Demographics		
Population	73,347	3,825,657
% below 18 years of age	27%	23%
% 65 and older	13%	14%
% African American	1%	2%
% American Indian and Alaskan Native	4%	1%
% Asian	1%	4%
% Native Hawaiian/Other Pacific Islander	0%	0%
% Hispanic	20%	11%
% not proficient in English	8%	6%
% Females	49%	51%
% Rural	30%	21%
Health Outcomes		
Diabetes	9%	8%
HIV prevalence rate	73	
Health Care		
Mental health providers	7,279:1	2,211:1
Health care costs	\$6,479	\$6,978
Uninsured adults	27%	23%
Could not see doctor due to cost	15%	15%
Dentists	4,642:1	2,360:1
Social & Economic Factors		
Median household income	\$43,691	\$46,536
High housing costs	28%	39%
Children eligible for free lunch	48%	42%
Illiteracy	14.2%	10.2%
Homicide rate	5	3
Physical Environment		
Commuting alone	80%	72%
Access to healthy foods	73%	61%

Appendix B

Umatilla County Health Assessment, comparison data

2011 Adult Comparisons	Umatilla County American Indians 2011	Umatilla County General Population 2011	Oregon General Population 2010	U.S. General Population 2010
Diagnosed with				
Diabetes	34%	13%	8%	10%
Asthma	27%	20%	16%	14%

Arthritis	50%	32%	27%*	26%*
Current Drinker	41%	51%	58%	55%
Current Smoker	28%	18%	15%	17%
Rated health as fair or poor	33%	15%	16%	15%
Rated physical health as not good on 4 or more days in the previous month	43%	24%		
Reported that poor mental health or physical health kept them from doing usual activities	26%	15%		
Uninsured	27%	16%	16%	15%

Appendix C

Table 2: Identifying our Needs: A survey of elders IV, comparison data

Comparison data	CTUIR data -55 and over	Aggregate Tribal data – 55 and over	National Data – 55 and over
Rated health as fair or poor	33%	29.7%	17.3%
Diagnosed with Asthma	15%	12.7%	12.1%
Diagnosed with Cataracts	31%	12.6%	40.2%
Diagnosed with HTN	65%	57.6%	56.7%
Diagnosed with Diabetes	32%	39.5%	16.8%
On Insulin	9.0%	13.1%	25.6%
On dialysis	0.0%	1.7%	NA
Diagnosed with Prostate cancer	9.4%	5.8%	7.9%
Diagnosed with Breast Cancer	5.0%	2.3%	2.7%
Difficulty bathing due to physical health	8.0%	15.9%	36.8%
Difficulty dressing due to physical health	5.0%	11.4%	36.8%
Smoke cigarettes daily	9.8%	18.0%	19.5%
Have family member that provides care	26.2%	39.2%	NA
Care for grandchildren	19.5%	30.0%	1.9%
Little or no level of functional limitation	61.7%	44.9%	
Live on the reservation	41.1%	69.8%	NA
Happy all of the time/a good bit of time	84.7%	82.2%	NA

Appendix D

YTHC GPRA indicators 2011/2012

age	2-5	6-11	12-19	20-24	25-34	35-44	45-54	55-74
% obese	24.8	32.7	36.0	47.4	60.7	73.6	65.3	58.5
Dashboard Report - YELLOWHAWK				2011 Final		2012		
Poor Glycemic Control >9.5				12.0				
Ideal Glycemic Control <7				40.7				
Controlled BP <130/80				32.0				
LDL Assessed				79.7				
Nephropathy Assessed				49.7				
Retinopathy Assessed				50.0				
Dental Access General				43.2				
# Sealants				627				
Topical Fluoride-# Pts				496				
Influenza 65+				57.2				
Pneumovax Ever 65+				89.9				
Pap Smear Rates 21-64				47.0				
Mammogram Rates 52-64				46.3				
Colorectal Cancer 51-80				41.7				
Tobacco Cessation Counsel				14.6				
FAS Prevention 15-44				70.5				
IPV/DV Screen 15-40				63.0				
Depression Screen 18+				69.9				
IHD: Comp CVD Assessment				12.0				
Prenatal HIV Testing				76.7				