Executive Summary

Purpose and Scope

This comprehensive assessment examined the health status, behaviors, and needs of residents in Good Shepherd Health Care System's service area, covering Morrow and Umatilla counties in Oregon (population: 92,044). The study serves as a follow-up to a 2021 assessment and utilized multiple data sources including community surveys (566 respondents), key informant surveys (76 participants), and secondary health data.

Key Community Characteristics

- Demographics: 25.1% children (0-17), 58.9% adults (18-64), 16.1% seniors (65+)
- Diversity: 29.4% Hispanic/Latino population, 75.5% White
- Geography: Predominantly urban (74.4%) with significant rural populations
- Socioeconomic: 12.4% living in poverty, 16.5% adults lack high school education

Significant Health Needs Identified (Priority Ranked)

- Mental Health - 85.3% of key informants rated as "major problem"
- Substance Use - 65.8% rated as "major problem"
- Social Determinants of Health - Housing, poverty, food access
- Diabetes - Higher mortality and prevalence than state/national averages
- Nutrition, Physical Activity & Weight - High obesity rates
- Access to Health Care Services - Provider shortages, transportation barriers

Critical Health Indicators

- Mental Health: 22.9% report "fair/poor" mental health; suicide rate (19.4 per 100,000) exceeds national average
- Substance Use: High alcohol-induced death rates; increasing illicit drug use
- Chronic Disease: 43.3% obesity rate; 17.3% diabetes prevalence
- Access Barriers: 44.6% experienced healthcare access difficulties; provider shortages

Social Determinants Challenges

- Food Security: 36.7% food insecure; 27.2% have low food access
- Housing: 31.9% worry about housing costs; 15.0% live in unsafe conditions
- Financial: 32.3% cannot afford $400 emergency expense

Implementation Strategy

Good Shepherd Health Care System will develop targeted interventions addressing the prioritized health needs, building on previous efforts in mental health, obesity prevention, women's/infant health, and behavioral health services.

Methodology

The assessment employed rigorous data collection including random-sample telephone and online surveys, key informant input from community leaders, and analysis of vital statistics and public health data, ensuring statistical validity with a ±4.0% margin of error at 95% confidence level.

Biggest Gaps in Service

Primary Care and Access Issues

1. Severe shortage of primary care physicians - Only 59.6 primary care physicians per 100,000 population (well below state rate of 138.8 and national rate of 121.1)
2. Long wait times for appointments - 28.5% of residents experienced difficulty getting doctor appointments in the past year
3. Lack of specific source of ongoing care - Only 72.1% have a specific source of ongoing medical care (fails to meet Healthy People 2030 objective of 84.0%)

4. High emergency room utilization - 19.5% used emergency rooms more than once in the past year, indicating inadequate primary care access

Mental Health Services

5. Critical shortage of mental health providers - Wait times of 6-8 months for mental health appointments at Community Counseling Solutions
6. Limited inpatient mental health facilities - Patients held in emergency departments for days awaiting placement
7. Inadequate crisis intervention services - No immediate mental health care available for crisis situations

Specialty Care Deficits

8. Limited specialty services - Residents must travel outside the area for:
    - Cardiology services (no stable cardiology in Hermiston)
    - Endocrinology (long wait times, limited access)
    - Dermatology (no services available despite high cancer rates)
    - Pediatric specialists (occupational therapy, physical therapy, audiology)
9. Cancer care limitations - Single doctor and small clinic insufficient for community needs; lack of radiation therapy and PET CT scanning locally

Substance Abuse Treatment

10. No local residential treatment facilities - Residents must travel elsewhere for inpatient substance abuse treatment
11. Limited detox services - Insufficient detox beds and long waiting lists
12. Inadequate follow-up care - No halfway houses or continuing treatment programs for post-treatment support

Geographic and Transportation Barriers

13. Rural access challenges - Limited transportation options affecting ability to reach medical appointments
14. Distance to specialized care - Many residents must travel to Portland, Spokane, or Tri-Cities for specialized services

Workforce and Infrastructure Issues

15. Overall provider shortage - Insufficient healthcare professionals across multiple specialties to meet growing community needs
16. Limited weekend/evening services - Most providers don't offer Friday services, forcing reliance on urgent care or emergency departments

Greatest Barriers to Care

Top Barriers Experienced by Residents

1. Getting doctor appointments - 28.5% of residents experienced difficulty getting appointments (the most common barrier)
2. Finding a physician - 21.2% had difficulty finding a doctor
3. Inconvenient office hours - 15.9% were prevented from getting care due to office hours
4. Cost of doctor visits - 13.3% couldn't afford physician visits
5. Cost of prescriptions - 11.8% couldn't afford needed medications
6. Lack of transportation - 11.4% couldn't get to appointments due to transportation issues

Systemic Provider Shortages

7. Severe shortage of primary care physicians - Only 59.6 per 100,000 population (well below state/national averages)
8. Mental health provider crisis - 6-8 month wait times for mental health appointments
9. Limited specialty care - Residents must travel long distances for specialized services

Geographic and Infrastructure Barriers

10. Rural location challenges - Distance to specialized care requiring travel to Portland, Spokane, or Tri-Cities
11. Limited weekend/Friday services - Most providers don't offer services on Fridays, forcing reliance on urgent care or emergency departments

Economic Barriers

12. Prescription cost management - 10.7% skip doses or stretch prescriptions to save money
13. High deductibles and out-of-pocket costs - Even insured residents struggle with healthcare expenses
14. Limited insurance coverage for specialty services - Some providers don't accept certain insurance plans (like EOCCO)

Systemic Access Issues

15. No same-day appointment availability - Forces non-emergency cases to use emergency departments
16. Complex healthcare navigation - Difficulty understanding and accessing available services
17. Language and cultural barriers - 1.7% prevented from getting care due to language/cultural issues (though this affects a significant absolute number given the 29.4% Hispanic population)

Key Informant Insights

Healthcare leaders identified these as the most critical barriers:

- "Provider availability, specialties availability, lack of specialists in the area that accept EOCCO, and transportation"
- "The lack of doctors, especially specialists. The remoteness of some communities, even with transportation, can impact the choice to get care"
- "Appointments are scheduled many weeks out, or the doctor is not available"

Impact on Care Utilization

These barriers result in:

- 44.6% of residents experiencing some type of difficulty accessing care in the past year
- High emergency room utilization (19.5% used ER more than once annually)
- Only 67.3% of adults had a routine checkup in the past year
- 21.9% rating local healthcare services as "fair" or "poor"

What the Hospital or CCO is Doing Well

Successful Implementation of Previous Strategies

Mental Health Initiatives

- Successfully launched the annual "You Are Not Alone Mental & Behavioral Health Awareness" event in 2023
- Formed new partnerships with Community Counseling Solutions to increase mental and behavioral health services
- Community Health & Outreach now provides substance use educational presentations at local schools

Nutrition and Physical Activity Programs

- Offered a 25% increase in education resources and programs related to Obesity, Nutrition and Physical Activity
- Classes are offered in-person at various locations with virtual options, all free of charge
- Recordings available for later viewing to increase accessibility

- Partnerships with multiple organizations including Oregon State University SNAP Ed, Hermiston Parks & Recreation, and local senior centers

Women's and Infant Health

- Launched free, virtual, on-demand Childbirth classes through partnership with Birthly
- Implemented ConneXions program referrals for all new OB patients at Good Shepherd Women's Center
- ConneXions assesses social determinants of health, education needs, and skill building for families

Strong Community Partnerships

The hospital has established extensive partnerships across multiple sectors:

Healthcare Collaborations:

- Local Communities Health Partnership (LCHP)
- Umatilla County Public Health
- Oregon Washington Health Network
- Community Counseling Solutions
- Greater Oregon Behavioral Health Inc. (GOBHI)
- Mirasol Family Health Center
- Columbia River Health

Community Organizations:

- Local school districts
- Law enforcement agencies
- Domestic Violence Services Inc.
- Local senior centers
- Parks and recreation departments

Healthcare Infrastructure Strengths

Specialized Services:

- Good Shepherd has expanded the Cancer Center
- Eastern Oregon Cancer Center provides local cancer treatment options
- Good Shepherd Diabetes and Nutrition Center offers specialized care
- Good Shepherd Women's Center provides comprehensive women's health services

Emergency and Acute Care:

- Hospital provides essential emergency services for the region
- Serves as a critical access point for urgent care needs

Educational and Outreach Programs

Community Health Education:

- Distributed 5,000+ pieces of mental health education materials
- Offered at least 5 mental health presentations using multimedia outlets
- Spanish-language options available for educational materials
- Diabetes education and self-management classes
- Living Well With Diabetes programs

Preventive Care Focus:

- Routine checkup rates improving (67.3% in 2024 vs. 55.5% in 2021)
- Dental insurance coverage rates high (78.2%, exceeding Healthy People 2030 objectives)
- Children's dental visits meeting national objectives (71.8%)

Addressing Social Determinants

ConneXions Program:

- Comprehensive assessment of social determinants of health
- Skill building for families

- Wraparound services approach

Community Grants and Support:

- Good Shepherd Denture Grant program
- Various community health initiatives

Areas of Positive Performance vs. Benchmarks

Better Than National Averages:

- Lower HIV prevalence (114.8 vs. 386.6 nationally)
- Lower STI rates (chlamydia and gonorrhea below national figures)
- Lower uninsured rates (5.7% vs. 8.1% nationally)
- Better food access difficulties (25.2% vs. 30.0% nationally)

Meeting Some Healthy People 2030 Objectives:

- Dental care visits (59.1%, exceeding 45.0% objective)
- Children's dental visits (71.8%, well above 45.0% objective)
- Health insurance coverage (5.7% uninsured, meeting 7.6% or lower objective)

Innovation and Adaptation

Technology Integration:

- Virtual and on-demand educational offerings
- Telemedicine options for some services
- Online educational resources with recorded sessions

Multilingual Services:

- Spanish-language educational materials and presentations
- Culturally appropriate service delivery

Priorities

1. Top Priority Health Needs (2024)

- Mental Health (top priority - 85.3% rated as "major problem")
- Substance Use (65.8% rated as "major problem")
- Social Determinants of Health
- Diabetes
- Nutrition, Physical Activity & Weight
- Access to Health Care Services

2. Specific Measurable Goals from Previous Strategy (2021-2024)

Mental Health

- Reduce suicide rate by 15%
- Decrease adults reporting "fair/poor" mental health by 4%

Obesity/Nutrition/Physical Activity

- Reduce overweight/obese adults by 4%
- Reduce overweight/obese children by 10%

Women's, Men's & Infant Health

- Reduce infant death rate by 15%
- Increase cervical cancer screenings to 73.8%
- Increase prostate cancer screenings to 63.2%

Behavioral Health

- Reduce cirrhosis/liver disease mortality by 15%
- Reduce tobacco use by 3%
- Decrease domestic/sexual violence reports

3. Three Overarching Organizational Goals

1. Improve health status - Increase life spans and quality of life
2. Reduce health disparities - Target at-risk populations
3. Increase access to preventive services - For all community residents

4. Implementation Approach
    - Develop focused Implementation Strategy based on 2024 assessment
    - Prioritize top community-identified needs
    - Leverage community partnerships
    - Align with hospital mission and available resources
    - Meet IRS nonprofit hospital requirements
5. Key Strategic Focus Areas
    - Workforce expansion - Recruit mental health providers and specialists
    - Community education - Multilingual health promotion campaigns
    - Partnership development - Collaborate with schools, public health, social services
    - Technology integration - Enhance Epic system for screening and prevention
    - Rural access - Address transportation and geographic barriers