Ellenville Regional Hospital 2025-2027
Individual Community Service Plan

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Ellenville Regional Hospital
2025-2027 Community Service Plan

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Ellenville Regional Hospital
2025-2027 Community Service Plan

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Executive Summary

Ellenville Regional Hospital (ERH) has strategically focused its 2025-2027 Community Service Plan (CSP) on four critical priorities identified through local data and reflecting an acute understanding of the needs within its primary service area, the Town of Wawarsing. Each priority is supported by targeted, evidence-based interventions designed to move the needle on community health outcomes. As required by the New York State Department of Health and the IRS, Ellenville Regional Hospital (ERH) must every three years conduct a thorough Community Health Assessment (CHA) and submit a Community Service Plan (CSP) outlining interventions designed to improve health outcomes in the service area, with the current plan covering 2025-2027. For the CHA, ERH staff attended multiple meetings with the Ulster County Department of Health (UCDOH) and other community stakeholders to create a new assessment that was designed with an easy-to-answer format to encourage broader public participation. To ensure a decent sample size for the Ellenville service area, ERH partnered with UCDOH staff to attend community events to conduct survey outreach, in addition to directly surveying patients at the hospital. Although encouraged to collaborate on a single document, ERH is submitting a separate CSP from the UCDOH's Community Health Improvement Plan (CHIP); however, the hospital and the local department are actively collaborating and working together to support each other's work, having previously co-developed and jointly executed the public-facing CHA in previous years. For the 2025-2027 CSP, ERH has selected four distinct priority areas: Nutrition Security, Healthy Eating, Substance Misuse and Overdose Prevention, and Preventative Services for Chronic Disease Prevention and Control. ERH reviewed multiple data sources during the assessment process, including but not limited to, New York State Prevention Agenda Dashboard, New York State Opioid Data Dashboard, New York State Vital Statistics, the Expanded Behavioral Risk Factor Surveillance System (Expanded BRFSS), and the results of the CHA survey.

ERH, whose service area is predominantly composed of the Town of Wawarsing (population 12,771 according to the 2020 US Census) and surrounding areas, has selected its four distinct priority areas based on a comprehensive review of local health data and patient needs. The selection of Preventative Services for Chronic Disease Prevention and Control is directly supported by the New York State Prevention Agenda Dashboard, 2016 Behavioral Risk Factor Surveillance System (BRFSS), Information for Action (IFA) Reports, and CHA results, which identify elevated rates of diabetes, hypertension, and colorectal cancer as areas of high concern. Furthermore, data from the New York State Prevention Agenda Dashboard, Local Law Enforcement, and The HIDTA OD Map confirms that the effects of the opioid epidemic persist locally, with Ellenville specifically reported as the 3rd highest town in Ulster County for overdoses, leading to the selection of Substance Misuse and Overdose Prevention. Finally, a review of the social care needs screening performed through ERH's EMR system (in partnership with RIO and HIXNY)

highlighted food insecurity as the most pressing need among the patient population, which has led to the selection of the final two priorities: Healthy Eating and Nutrition Security. Strategies included to address the selected priority areas are detailed in the attached work plan table.

The Community Service Plan (CSP) for Ellenville Regional Hospital (ERH) is founded on four distinct, data-driven priorities, each supported by a set of targeted interventions designed to address critical local health disparities.

The first two priorities, Nutrition Security and Healthy Eating, stem from the finding that food insecurity is the most pressing social care need among ERH's patient population. Interventions focus on improving consistent household food security and decreasing the percentage of adults who consume no daily fruits or vegetables. To achieve this, the hospital will implement a Food as Medicine approach, including expanding medically tailored meals and produce prescription programs (FVRx) in partnership with the Regional Food Bank and Cornell Cooperative Extension. Simultaneously, ERH will promote healthier eating choices by working with local businesses to offer nutrition coaching and public awareness activities in workplace settings, addressing the diet-related chronic disease disparity directly at its source.

The priority of Substance Misuse and Overdose Prevention directly addresses the crisis highlighted by Ellenville's designation as the 3rd highest town in Ulster County for reported overdoses. The central intervention is to expand community-based harm reduction and life-saving services. ERH will actively promote and distribute Naloxone (Narcan) kits across the community, in partnership with local organizations, to increase the ability of the public and first responders to prevent fatal overdoses, thereby reducing the disparity in life expectancy and mortality rates. This initiative is coupled with broader primary prevention efforts aimed at reducing substance use across the lifespan.

Finally, Preventative Services for Chronic Disease Prevention and Control is a crucial priority in response to elevated community rates of diabetes, hypertension, and colorectal cancer. Interventions focus on increasing preventative health behaviors and access to screenings. ERH plans to increase the percentage of adults up to date on their colorectal cancer screenings through targeted small media campaigns that promote early detection. Furthermore, the hospital will conduct mobile or community-based screenings for cardiovascular risk factors like high blood pressure, specifically targeting hard-to-reach populations who may lack consistent primary care access. This multi-pronged approach aims to reduce morbidity and mortality associated with these severe, yet preventable, chronic conditions.

Many partners worked together to assess the health needs of residents of Ulster County. Locally, under the umbrella of the Ellenville Regional Rural Health Network, a consortium jointly founded by ERH, the Institute for Family Health (Institute), and The Ulster County Departments of Health

and Mental Health in 2017 to address population health and housed as a department of ERH, work together to collaboratively address health priorities. In addition to the three founding members, consortium partners who aid in program implementation include Cornell Cooperative Extension of Ulster County (CCE), Ellenville Public Library and Museum, Catholic Charities of Orange, Sullivan, and Ulster, Step One, and The Ulster County Sheriff's Office ORACLE Team.

The ERRHN consortium meets bi-monthly to review work plan and deliverables, and ERRHN staff continuously monitor project goals, presents monthly updates to partners, and annually evaluates program sustainability, workforce issues, emerging health disparities, and program impact.

Hospital Mission & Vision

ERH provides exceptional health care services to all people who live in, work in and visit the surrounding communities. This health care is delivered with compassion and respect based on our commitment to improving our community health through excellence, innovation, and state-of-the-art technologies.

Description of Community Served

Ellenville Regional Hospital (ERH) is a 25-bed rural critical access hospital that is also a teaching facility, located in the Village of Ellenville in the Town of Wawarsing, Ulster County NY. In terms of hospital patient volume, the Emergency Department had approximately 16,232 visits annually. In 2024, the hospital served a total of 13,577 unique patients who made 33,933 visits. Located within Ulster County, the Town of Wawarsing is situated in the Mid-Hudson Valley, approximately 90 miles northwest of New York City. The Town of Wawarsing has a population of 12,771 of which 4,167 reside within the Village of Ellenville, the largest population center (2020 U.S. Census).

Demographics		
	Town of Wawarsing	Village of Ellenville
Race / Ethnicity		
White	64%	71.6%
Black or African American	8%	4.9%
American Indian and Alaska Native	0%	0%
Asian	0%	0%
Other Races	1%	13.2%
Two or more Races	2%	9.4%

Hispanic of any race	24%	40%
Median Age	45.7 years	39.5 years
Age 62 or older	29%	11%
Median Household Income	$68,482	$82,181
Income Below Poverty Level	16.8%	23.7%

(Data from 2019-2023 American Community Survey 5-Year Estimates)

Based on the 2019-2023 American Community Survey (ACS) 5-Year Estimates, the Town of Wawarsing and the Village of Ellenville present as economically vulnerable and demographically distinct areas within Ulster County. Economically, both communities have median household incomes that fall below both the Ulster County and New York State medians, with Wawarsing at $68,482 and Ellenville at $82,181. This economic hardship is further evidenced by significant poverty levels, reaching 23.7% in Ellenville and 16.8% in Wawarsing. Compounding this, Wawarsing is designated a Medically Underserved Population (MUA/P), indicating that these factors collectively create a major barrier to accessing quality healthcare, emphasizing the necessity of services like those offered by ERH. Demographically, both communities are notably diverse compared to the overall Ulster County population, featuring a high percentage of Hispanic or Latino residents (40.6% in Ellenville and 24% in Wawarsing) and a significant Black or African American population (8% in Wawarsing). Furthermore, Wawarsing has an older median age of 45.7 years, with approximately 29% of the population aged 60 or older, while Ellenville's median age is 39.5 years.

The significantly higher poverty in the Village of Ellenville and the Town of Wawarsing, NY, compared to the wider Ulster County and New York State (NYS) figures, is a direct result of a historical economic collapse that stripped the area of high-wage jobs. Data from the U.S. Census Bureau's American Community Survey (ACS) highlights the severity of the issue: the Village of Ellenville's poverty rate is approximately 23.7% (2023 estimate, Data USA), and the Town of Wawarsing's rate is 16.8% (Census Reporter), both starkly higher than the Ulster County average (12.2%–14.3%) (Cornell Program on Applied Demographics; Census Reporter) and the New York State rate (~12.7%–13.7%) (US Census Bureau SAIPE; Census Reporter). This concentrated poverty is driven by the fact that the area's two main economic engines—the manufacturing/industrial sector and the "Borscht Belt" tourism/resort industry (e.g., the Nevele Hotel)—shuttered or relocated in the late 20th and early 21st centuries. The resulting scarcity of high-paying local employment opportunities forces residents into lower-wage service or retail jobs, or requires long commutes, which contributes to a much lower Median Household Income in the Wawarsing/Ellenville area compared to the rest of the region. This economic instability is

particularly severe among vulnerable populations, with one report noting that over 70% of single-mother families in the Village of Ellenville previously lived in poverty (Food Insecurity in Ulster County, SUNY New Paltz).

When looking at the health of the community in the Ellenville/Warwarsing area, it is important to note that the Ellenville Family Health Center (IFH), a primary care health center which is operated by The Institute for Family Health, one of the largest Federally Qualified Health Centers (FQHC) in New York State, is also located on the ERH campus. The Institute is committed to providing high-quality, affordable health care for all. It strives for excellence at each of its 26 practices, while accepting all patients regardless of their ability to pay. The Ellenville IFH offers primary care, mental health care, dental, and social work services, along with many other health services for patients of all ages. As part of a federally qualified community health center network, it meets national standards for affordable, accessible and comprehensive health care services. The Center is accredited by the Joint Commission and recognized by the National Committee for Quality Assurance as a Level 3 patient-centered medical home, the highest recognition available. The IFH sees approximately 3,600 patients per year and offers same-day appointments. According to the Institute of Family Health, a Federally Qualified Healthcare Center's Ellenville Site data, nearly 59% of health center patients residing in the 12428-zip code receive Medicaid or other public insurance, and 7.6% are uninsured. Furthermore, roughly 10% of adults in the zip code have no usual source of care. The same percentage of adults have delayed or not sought care due to high cost.

The affordable Senior Housing project, a joint venture between Ellenville Regional Hospital and Warwick Properties, Inc., is located on the hospital campus and has all three phases fully occupied, providing independent living in one-bedroom apartments for approximately 156 senior citizens. Funding for the project was secured from the New York State Division of Housing's Community Renewal Housing Trust Fund. The Partnership sponsoring the housing is now developing plans to build additional affordable housing close to the Hospital, targeting seniors, special needs populations, and possibly returning Veterans. Since the completion of the housing project, the Ellenville Regional Rural Health Network (ERRHN), a Community Wellness Program of Ellenville Regional Hospital, has been actively supporting the residents by providing monthly educational seminars on various health topics, offering fitness class opportunities, and managing food distribution to aid in the health and wellness of the residents.

Public Participation

To engage the community in the selection of health priorities for 2025-2027, the Ulster County Department of Health (UCDOH) took the lead, with partners including Ellenville Regional Hospital, in the organization and execution of a county-wide Community Health Assessment

(CHA). A Community Health Needs Assessment Survey was used to confirm existing priorities and to help develop new evidence-based strategies. The organizations will continue to meet throughout 2025, with additional representatives from organizations in the county including the Institute for Family Health, Cornell Cooperative Extension of Ulster County, and staff from other County departments, to continue the conversation around health priorities and initiatives to be included in the CHIP/CSP.

The community health survey received a total of 356 responses overall, with 73 specifically from the Ellenville Regional Hospital (ERH) Catchment area, revealing a demographic profile primarily consisting of older, non-Hispanic white females. Within the ERH Catchment area, the respondents were overwhelmingly female (86.3%) and predominantly Non-Hispanic White (81.9%), with 9.7% identifying as Hispanic/Latino. The population surveyed skews older, with 58.9% of all respondents aged 47 or older, including a significant 43.8% in the 65+ age group. Regarding general living conditions across the total survey population (N=356), the majority of households reported stability, with 64.3% owning their home (and only 2.3% reporting housing insecurity), high rates of technological access (95.5% with a cell phone and 91.4% with home internet), and strong access to transportation, as 77.2% of drivers have their own car, though 7.2% report having no car access. Finally, 26.7% of overall households indicated having 1-2 children present.

The Ellenville Regional Rural Health Network (ERRHN), a program of Ellenville Regional Hospital (2017), is dedicated to establishing and operationalizing a formalized entity to enhance local resource availability and address critical service gaps in the rural healthcare service area. This initiative is driven by two main goals. The first is Institutional Formalization, which involves restructuring the existing steering committee into a formal Board of Directors (BoD) by Year 1, Quarter 2, establishing a strategic plan with a documented accountability mechanism by the end of Year 1, and securing formal affiliations with at least five partner organizations. This strategic plan will align with the existing Steering Committee's 4 Pillars (Enhance Resource Availability and Collaborative Partnerships; Promote Nutritional Wellness; Increase Physical Activity Levels for Adults, Seniors, and Youth; Reduce Health Risks), specific rural health challenges, the New York Health Equity Reform (NYHER) implementation, and the NYS Prevention Agenda and Healthy People 2030 goals. The second goal is Targeted Data Collection and Activities, which includes conducting a comprehensive community health needs assessment (starting Year 2, Quarter 1) and, starting in Year 1, Quarter 3, promoting opportunities to strengthen the rural health workforce, increase knowledge of local services, and foster locally generated, innovative solutions across all age demographics. Ultimately, this project is poised to transition the ERRHN into a strategically guided, formalized entity capable of making measurable, positive impacts on rural health outcomes.

Additionally, the Healthy Ulster Council, a broad-based coalition formed by representatives from a variety of organizations and agencies, has been focusing on health problems in Ulster County and ways to improve health outcomes. Regular meetings of the Coalition, along with presentations and discussions, have kept the larger community, including Ellenville and the Town of Warwarsing, involved in the process of tracking health concerns and solutions.

Assessment and Selection of Public Health Priorities

The Ulster County Community Health Assessment Strategic Team is made up of key staff from UCDOH, UCDOMH, Westchester Medical Center, Ellenville Regional Hospital, Ulster County Office for the Aging, Ulster County Youth Bureau, and The Institute for Family Health met to create the Community Health Assessment (CHA). The survey begins with Demographics and Socioeconomic Status questions that establish the respondent's profile, covering gender, age group, race/ethnicity, and family structure, alongside critical Social Determinants of Health (SDOH) such as housing security, frequency of food insecurity, and access to resources like a car and the internet. The second section, Health Status and Impact, asks respondents to rate the level of impact ("No," "Some," or "High") that a specific list of chronic health conditions (e.g., High Blood Pressure, Cancer) and risk factors (e.g., Smoking/Vaping, Inability to Exercise) has on their family. Following this, the Health Behaviors and Barriers section measures self-reported engagement in key health maintenance actions (like Regular Doctor Visits, Exercise, and Regular Cancer Screening) using a comparative scale: "I do this now" versus "I WISH I did this," specifically structured to identify the gap between perceived importance and actual behavior, followed by questions on specific barriers to maintaining health (e.g., hard to access healthy food, lack of motivation). Finally, the survey concludes with questions on Priorities and Trusted Messengers, asking respondents to identify the areas that should be the HIGHEST priority for the county health department (e.g., Preventing Stroke, Improving Access to Health Care) and who they consider to be trusted messengers related to health information. This team will continue to meet along with additional community partners in the Health Ulster Coalition to continue to finalize priorities and to monitor the interventions for the CSP and the CHIP for Ulster County.

For the CSP for ERH, our primary sources of data were the Ulster County CHA, NYS Prevention Agenda Dashboard, and the Social Care Needs Screening from the patients at Ellenville Regional Hospital were used to select our priorities. The top health needs identified by the Ellenville Regional Hospital (ERH) Catchment in the CHA survey are rooted in unmanaged chronic disease, critical behavioral gaps, and profound socioeconomic barriers. The primary health threats are High Blood Pressure (20.6% high impact) and Asthma/Respiratory Illness (15.6% high impact). These clinical challenges are amplified by two major behavioral deficits: Inability to Exercise (8.8% high impact), which is the most desired change (31.5% wish they exercised more),

and poor adherence to Regular Cancer Screening (lowest compliance at 53.4%). Underlying these issues is a stark need for support in the area of Social Determinants of Health, particularly Food Insecurity, which affects 38.3% of residents, and lack of access to fundamental resources, with 11.1% having no car access and 11.1% having no internet access.

The NYS Prevention Agenda 2025–2030 Dashboard for Health Care Access and Quality shows that Ulster County continues to face significant challenges in preventative health services and chronic disease management compared to New York State (NYS) averages. According to the latest Prevention Agenda data, Ulster County faces continued challenges in hypertension control, with only 77.0% of adults with hypertension reporting the use of medication to manage their condition (Indicator 32.0). This rate remains below the New York State average of 80.2% and fails to meet the state's Prevention Agenda objective of 81.7%. The status of this indicator for the county is currently classified as "Unmet," highlighting a persistent gap in chronic disease management and a pressing need for enhanced clinical outreach and patient adherence support to reduce the risk of secondary cardiovascular complications.

According to the 2016 Behavioral Risk Factor Surveillance System (BRFSS) report, colorectal cancer screening outreach is a critical necessity for Ulster County because the disease remains the third leading cause of cancer death in New York State, with approximately 9,000 new cases and 3,130 deaths occurring annually. While regular screening can prevent the disease by removing precancerous polyps or improving survival through early detection, Ulster County's 2016 screening rate of 63.8% fell significantly below top-performing counties like Tompkins at 84.3% and missed the national goal of 80%. Outreach is specifically required to address disparities among at-risk subpopulations, including adults aged 50–64, low-income residents, and the uninsured, who report much lower screening rates than their counterparts. Furthermore, because the vast majority of unscreened individuals have health insurance and a regular provider, targeted outreach is essential to overcome non-financial barriers such as lack of awareness or motivation. By utilizing county-level data to identify these gaps, local health departments can better educate decision-makers and implement program interventions that align with the NYS Prevention Agenda to reduce the local burden of colorectal cancer.

The 2021 BRFSS data strongly demonstrates a continued need for A1C testing in Ulster County as a vital prevention and management measure, particularly as diagnosed prediabetes rates rose from 7.4% to 10.3% between 2016 and 2021 despite a slight decrease in overall diabetes prevalence. Because A1C testing serves as the primary tool for identifying prediabetes, it is essential for enabling early lifestyle interventions that can reverse the condition before it progresses to type 2 diabetes. Significant testing gaps persist, with 2021 BRFSS data revealing that only 48.5% of Ulster County adults—less than half the population—had been screened for

high blood sugar in the previous three years, leaving many at risk for undiagnosed conditions. Furthermore, with 61% of New York adults with diabetes lacking formal self-management education, regular A1C testing remains a cornerstone for providing the "big picture" of blood sugar control needed to adjust treatment plans and prevent severe complications like heart disease or kidney failure. By using high A1C levels as triggers for clinical intervention, health providers can reduce preventable hospitalizations, making expanded testing essential for improving the long-term health of Ulster County residents.

The NYS Prevention Agenda for Promoting Well-Being and Prevention of Mental and Substance Use Disorders indicates that Ulster County continues to bear a disproportionately high burden of the opioid crisis compared to the rest of the state. According to the latest data, the crude rate of overdose deaths involving drugs (Indicator 12.0) is 36.2 per 100,000 population in Ulster County, surpassing the New York State rate of 32.3 per 100,000. The disparity is even more pronounced among specific demographics, with the county recording a staggering 90.7 per 100,000 overdose death rate among Black, non-Hispanic residents (Indicator 12.1), compared to the state rate of 59.2.

The severity of the crisis is further reflected in the high utilization of treatment and prescription services. Ulster County reports a rate of 557.3 per 100,000 unique individuals enrolled in OASAS treatment programs for opioid use (Indicator 10.1), significantly higher than the NYS rate of 465.2. Additionally, the county has a notably high rate of patients receiving buprenorphine prescriptions for opioid use disorder at 1,009.1 per 100,000 (Indicator 11.0), more than double the state average of 446.0. Furthermore, Ulster County sees higher rates of initial opioid prescriptions given to opioid-naive patients (109.0 per 1,000) compared to the state (86.5 per 1,000). These figures underscore the urgent need for expanded harm reduction and treatment services. Locally, data from the Ulster County Sheriff’s Office reinforces these concerns, identifying Ellenville as the municipality with the third-highest number of reported overdoses in the county.

The determination of final priorities was corroborated and refined using patient-level Social Care Screening Data, which represents a crucial, localized data source. This information was systematically collected from Ellenville Regional Hospital patients through the hospital's collaboration with HIXNY, the designated Regional Information Organization (RIO), ensuring robust, patient-centric insights into the social needs of the hospital's specific patient population. A total of 995 patients responded to the core social needs questions, providing insight into the most urgent barriers to health. The data confirms that the most widespread and urgent social needs within the screened population are food insecurity (affecting nearly 1 in 5 patients) and transportation barriers (affecting 1 in 10 patients). Specifically, 197 patients (19.9%) reported that food they bought didn't last and they didn't have money to get more, with 5.9% indicating this was

"Often true," while 106 patients (10.7%) reported that a lack of reliable transportation kept them from medical appointments, work, or getting necessary daily items. Financial strain is also a core issue, with 150 patients (15.1%) reporting that it was "Hard" or "Very hard" to pay for necessities like food, housing, and medical care, and 57 patients (5.7%) reporting a recent threat of utility shut-off. In terms of living environment, the most common issues reported by patients were Pests (74 patients) and Mold (70 patients). Finally, a significant number of patients expressed an interest in education and employment support, including 55 patients (5.5%) seeking help with school or job training and 50 patients (5.0%) explicitly requesting help finding work. Overall, the data concludes that a robust resource referral system focusing on connecting patients to local food banks, transportation vouchers, and subsidized housing support is critical to mitigating these health-related social needs.

Ellenville Regional Hospital (ERH) has selected Nutrition Security, Healthy Eating, Substance Misuse and Overdose Prevention, and Preventative Services for Chronic Disease Prevention and Control as its top Community Service Plan (CSP) priorities based on converging data from key sources: the Ulster County Community Health Assessment (CHA) Survey, the NYS Prevention Agenda Dashboard, and the hospital's patient-level Social Care Needs Screening.

The most compelling justification for action centers on the acute need for Nutrition Security and Healthy Eating. The CHA survey shows a dual threat: 38.3% of ERH catchment residents face food insecurity, and High Blood Pressure (20.6% high impact) remains the primary chronic health concern. This clinical-social link is solidified by patient screenings, where 19.9% of patients reported food budget constraints and 20.5% of survey respondents wished for a healthier diet.

The NYS Prevention Agenda 2025–2030 data confirms these challenges, showing that 31.4% of Ulster County adults consume fewer than one fruit and fewer than one vegetable daily (Indicator 19.0). This rate is worse than the New York State average (34.4%) is not the goal; rather, the county is currently failing to meet the state's objective of 27.0%.

The priority of Substance Misuse and Overdose Prevention is mandatory due to the severe opioid crisis in Ulster County, where rates continue to drastically exceed state averages. The NYS Prevention Agenda 2025–2030 Dashboard reveals that Ulster County's crude rate for overdose deaths involving drugs is 36.2 per 100,000 (Indicator 12.0), which is higher than the New York State rate of 32.3 per 100,000.

The severity of the crisis is further underscored by the high volume of residents seeking care; the county reports 557.3 per 100,000 unique individuals enrolled in OASAS treatment programs for opioid use (Indicator 10.1), far surpassing the state rate of 465.2. Furthermore, Ulster's rate of patients receiving buprenorphine prescriptions for opioid use disorder (1,009.1 per 100,000) is more than double the state average. Crucially, local data from the Ulster County Sheriff's Office

continues to identify Ellenville as the 3rd highest municipality in the county for reported overdoses, underscoring the urgent need for expanded harm reduction, prevention, and treatment services directly within the hospital's service area.

Finally, Preventative Services for Chronic Disease Prevention and Control are justified by widespread systemic failures in health maintenance. The CHA survey highlighted that the community struggles with Inability to Exercise (8.8% high impact) and exhibits poor adherence to Regular Cancer Screening (only 53.4% compliance), despite the high impact of Cancer and High Blood Pressure. The NYS Prevention Agenda 2025–2030 data further validates this gap in control, showing that Ulster County's rate for Hypertension Management (Indicator 32.0) is 77.0%, which remains below the New York State average of 80.2% and fails to meet the state's 81.7% objective. This indicates a persistent need for improved clinical adherence and management support within the county. Therefore, this priority is essential for improving early detection, promoting preventative behaviors like exercise, and ensuring effective medication adherence for the high-impact chronic conditions that plague the community.

Interventions

The selected interventions are strategically designed to address the specific, data-driven challenges identified in the Ulster County Community Health Assessment (CHA), the NYS Prevention Agenda, and the Ellenville Regional Hospital (ERH) Social Care Screenings. These interventions focus on integrating clinical care with social support to mitigate the root causes of poor health outcomes.

The proposed interventions for the Nutrition Security priority, aimed at increasing consistent household food security from 71.1% to 75.9% (in alignment with Healthy People 2030 guidelines), are multifaceted and designed to address both the identification of need and the provision of resources.

The first intervention is a foundational strategy focused on identifying individuals who are or are at risk of food insecurity through standardized screening. This will be accomplished in partnership with HIXNY (the Regional Information Organization, or RIO), ensuring data integration and seamless referral to resources via the Hudson Valley Social Care Network Medicaid waiver program.

The second and third interventions focus on enhancing direct access to nutritious food. The second intervention is to expand or create access points for affordable, high-quality, nutritious food. This will be executed in partnership with local community organizations, specifically Ulster County Community Action and Family of Woodstock's Farm to Pantry Program, to establish a

recurring community resource by providing free produce distribution at least once per month. Complementing this, the third intervention is to promote and expand the availability of fruit and vegetable incentive programs. Through a collaboration with Cornell Cooperative Extension's Eat Smart Fruit and Vegetable Prescription Program (FVRx), ERH will continue to host and promote this initiative, with a goal of engaging at least two co-horts annually, directly addressing the financial barrier to healthy eating.

The final and most clinically focused intervention is to expand Food as Medicine approaches across the lifespan, specifically targeting populations at a higher risk of nutrition-related health disparities. To achieve this, ERH will create and execute a new "Food as Medicine Program". This program is designed for individuals who are food insecure and have specific, complex nutritional needs due to a chronic condition, and it will provide participants with nutrition-tailored food boxes to support better management of their health and adherence to necessary dietary regimes.

The interventions for the Healthy Eating priority are specifically designed to decrease the percentage of adults consuming no fruits or vegetables daily from 28.4% to 27.0%, directly supporting the Healthy People 2030 objective and addressing high rates of diet-related chronic conditions like hypertension. This strategy centers on promoting healthier eating choices through education and public awareness activities in workplace settings. The hospital will achieve this by collaborating with local community-based organizations, faith-based institutions, and various businesses to encourage the implementation of employee wellness programs. These programs will feature practical, direct support, including offering nutrition education workshops and personalized nutrition coaching to employees, thereby improving nutritional literacy and empowering individuals to make sustained dietary changes where they spend the majority of their time.

The two interventions for the Substance Misuse and Overdose Prevention priority are focused on both immediate harm reduction and sustained access to care, directly addressing the objective to significantly reduce the crude rate of drug-related overdose deaths. The first intervention is to provide or expand access to Food and Drug Administration (FDA)-approved medications for Opioid Use Disorder (OUD), such as buprenorphine, to reduce overdose fatalities while encouraging continuous treatment. Through partnerships with agencies like the Ulster County Sheriff's Office ORACLE Team and Hope Not Handcuffs, ERH will serve as a vital access point for eligible patients, facilitating buprenorphine induction to start treatment or offering bridge scripts to maintain continuity of care. The second intervention focuses on a widespread harm-reduction strategy: to provide or expand access to naloxone (Narcan) to reduce overdose fatalities. ERH will achieve this expansion through increased outreach at public events, initiating an EMS Narcan Leave Behind Program with local agencies, and maintaining community nalox-boxes. Both interventions are designed to reduce drug-related overdose deaths by increasing survival rates and

supporting recovery through medication-assisted treatment.

The priority of Preventative Services for Chronic Disease Prevention and Control is addressed through a unified set of interventions designed to aggressively close critical gaps in screening and disease management across the community, aiming to achieve key Healthy People 2030 objectives. Recognizing the intertwined issues of low compliance for cancer screening and poorly managed hypertension and diabetes, ERH will launch a major mobile health initiative: The HEAL (Health Screenings, Education, Access, and Linkages to Care) Mobile RV in 2026. This mobile unit will be used to conduct comprehensive community screenings to detect and address hypertension (via blood pressure checks), diabetes (via A1C testing), and to check for cancer screening completion. This integrated approach is designed to: 1) Increase the percentage of adults aged 35 years and older who had a test for high blood sugar in the past year (from 78.1% to 82.4%), 2) Increase the percentage of adult Medicaid members aged 18 years and older with hypertension who are currently taking medication (from 66.9% to 75.5%), and 3) Increase the percentage of adults aged 45 to 75 years who are up to date on their colorectal cancer screening (from 73.7% to 82.3%). By integrating these intervention points into a single mobile access program, ERH maximizes its reach to underserved populations and effectively targets the low screening and adherence rates identified in the community data. Complementing the mobile unit's direct screening efforts, ERH will also use media to promote cancer screenings to ensure continuous public awareness and drive-up overall compliance rates.

Conclusion

The Ellenville Regional Hospital (ERH) Community Service Plan for 2025–2027 is a data-driven strategy directly addressing the most urgent, high-impact health and social needs identified within the ERH catchment area of Ulster County. The comprehensive assessment, leveraging the Ulster County CHA, NYS Prevention Agenda, and localized patient Social Care Screenings, revealed a community struggling with pervasive Socioeconomic Disparities (especially food insecurity), an Acute Opioid Crisis, and a critical lack of Chronic Disease Management and Preventative Services.

The four selected priorities—Nutrition Security, Healthy Eating, Substance Misuse and Overdose Prevention, and Preventative Services for Chronic Disease Prevention and Control—are strategically aligned to mitigate these root causes. Interventions are designed for maximum impact: utilizing mobile health services like The HEAL Mobile to close screening and adherence gaps for conditions like hypertension and diabetes; employing Food as Medicine programs and produce incentives to transform the food environment and improve nutrition security; and establishing partnerships with law enforcement and community agencies to expand buprenorphine access and Naloxone distribution to reduce overdose mortality.

By moving beyond traditional clinical boundaries and focusing on the social determinants of health (SDOH), this CSP commits ERH to achieving measurable improvements in chronic disease control, enhancing community well-being, and ultimately reducing health disparities to fulfill the objectives of the Prevention Agenda and Healthy People 2030. The success of this plan relies on the continued collaboration with the Health Ulster Coalition and local partners to transform these identified needs into sustained, community-wide health equity.

Attachments

Attachment 1: New York State Prevention Agenda Dashboard

(Open attachments from attachment pane)

Prevention Agenda 2025-2030 Health Care Access and Quality Domain

Prevention Agenda 2025-2030 Social and Community Context Domain

Based on the **NYS Prevention Agenda 2025–2030 Dashboards**, here is a summary of the current health landscape for Ulster County across the two provided domains.

1. Health Care Access and Quality

This domain focuses on clinical preventative services, maternal and child health outcomes, and chronic disease management.

- **Chronic Disease Management:** Hypertension management is a primary area of concern; **77.0%** of adults report using medication for management, which is below the 81.7% state objective. Conversely, the county performs well in pediatric asthma management, meeting its target for reduced ER visits.

2. Social and Community Context

This domain examines behavioral health, the opioid crisis, and social determinants of health like nutrition and safety.

- **The Opioid Crisis:** Ulster County shows an intense burden regarding substance use. It currently **exceeds the state crude rate for overdose deaths (36.2 per 100,000)** and shows extreme disparities in outcomes for Black residents (90.7 deaths per 100,000). While the county has high enrollment in treatment programs and buprenorphine prescriptions (exceeding state targets), the high rate of initial opioid prescriptions to naive patients (109.0 per 1,000) remains a systemic challenge.
- **Mental Health:** The county is currently failing to meet goals for **mental distress (15.7%)** and **suicide mortality (12.5 per 100,000)**, both of which are higher than state objectives.
- **Nutrition & Lifestyle:** A significant portion of the population (**31.4%**) consumes fewer than one fruit and vegetable daily, missing the state's nutritional goal. Additionally, while overall smoking rates are slightly better than the state average, they still exceed the target of 7.9%.

Attachment 2: Ulster County Department of Health Community Health Assessment (CHA)
(Open attachments from attachment pane)

This summary analyzes the key findings from the Community Survey results focused on the Ellenville Regional Hospital (ERH) catchment area (N=73 respondents).

1. Population Profile and Social Determinants of Health (SDOH)

The typical respondent in the ERH catchment is an older adult, predominantly female, and non-Hispanic White. While **housing security is high** (67.1% own their home), two key social factors present significant barriers to health:

- **Food Insecurity:** Over one-third of respondents (**38.4%**) reported worrying about running out of food either "sometimes" (34.2%) or "often" (4.1%).
- **Transportation Access:** Nearly one-third of respondents (**30.1%**) reported sharing a car or never having a car, suggesting **significant transportation barriers** that could impact access to care.

2. Top Health Conditions and Risk Factors

When asked which health issues have the **highest impact** on their family today, respondents ranked the following conditions and risks as most critical:

Top 3 Health Conditions	% High Impact	Top 3 Risk Factors	% High Impact
High Blood Pressure	**20.6%**	**Inability to Exercise**	**8.8%**
Asthma/Respiratory Illness	15.6%	Smoking/Vaping	7.2%
Cancer	12.1%	Lack of Access to Health Care	4.5%

The top risk factor, **Inability to Exercise**, strongly aligns with aspirations for better health (see below).

3. Health Maintenance and Behaviors

Respondents reported strong engagement in foundational health practices, yet identified clear areas for improvement:

- **Positive Behaviors:** The majority report they **"do this now"** for **Regular Doctor Visits (82.2%)** and **Taking Medication (75.3%)**, indicating good adherence to routine medical care.
- **Key Aspiration Gap:** The single largest area where respondents **"wish I did this"** is **Exercise (31.5%)**, reinforcing that the "Inability to Exercise" is the most prominent perceived barrier to health maintenance.

- **Screening Gap:** While general doctor visits are high, participation in **Regular Cancer Screening** is lower, with only **53.4%** reporting they "do this now."

Conclusion

The data indicates that while the ERH catchment is generally engaged in primary care (doctor visits/medication), interventions should prioritize **addressing food and transportation insecurity**, and developing programs focused on **improving access to and motivation for physical exercise** to address the community's top self-identified risk factor. Cancer screening rates also represent a clear target for outreach.

Attachment 3: Ellenville Regional Hospital Social Care Screening

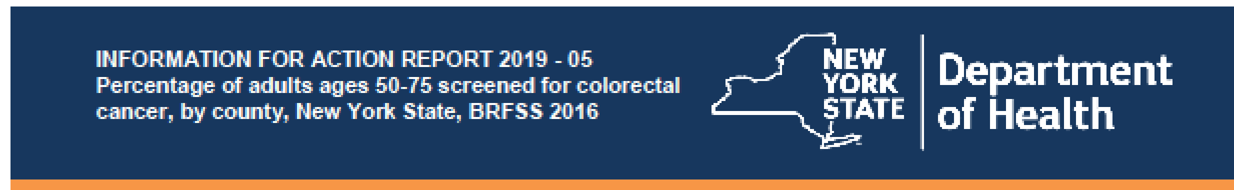
(Open attachments from attachment pane)

ERH Social Needs Screenings Jan-Sept

This report summarizes the social needs screenings conducted at Ellenville Regional Hospital between January and September 2025 using the NYS Screening Tool, where 995 patients provided actionable insights into the most pressing barriers to health. The data identifies food insecurity as the most acute challenge, affecting nearly 1 in 5 patients (19.9%), followed by significant transportation barriers that hindered 10.7% of respondents from reaching medical appointments or daily necessities. Financial strain further complicates these outcomes, with 15.1% of patients reporting difficulty paying for basics like food, medical care, and heating.

Housing also emerged as a critical concern, with 5.4% of patients worried about losing their residence and 1.6% lacking a steady place to live entirely. Beyond general stability, environmental quality within the home remains a risk; of the 1,105 responses regarding living conditions, the most frequent issues cited were pests (74 patients) and mold (70 patients), alongside utility threats where 5.7% of respondents faced service shut-off notices. Finally, the screenings revealed a desire for economic mobility, as 5.5% of patients sought help with education or training and 5.0% requested assistance in finding work. Collectively, these findings underscore that a robust referral system focusing on food security, transportation vouchers, and subsidized housing support is essential to mitigating the health-related social needs of the Ellenville community.

Attachment 4: 2019 NYS Department of Health Information for Action (IFA) Report # 2019-05

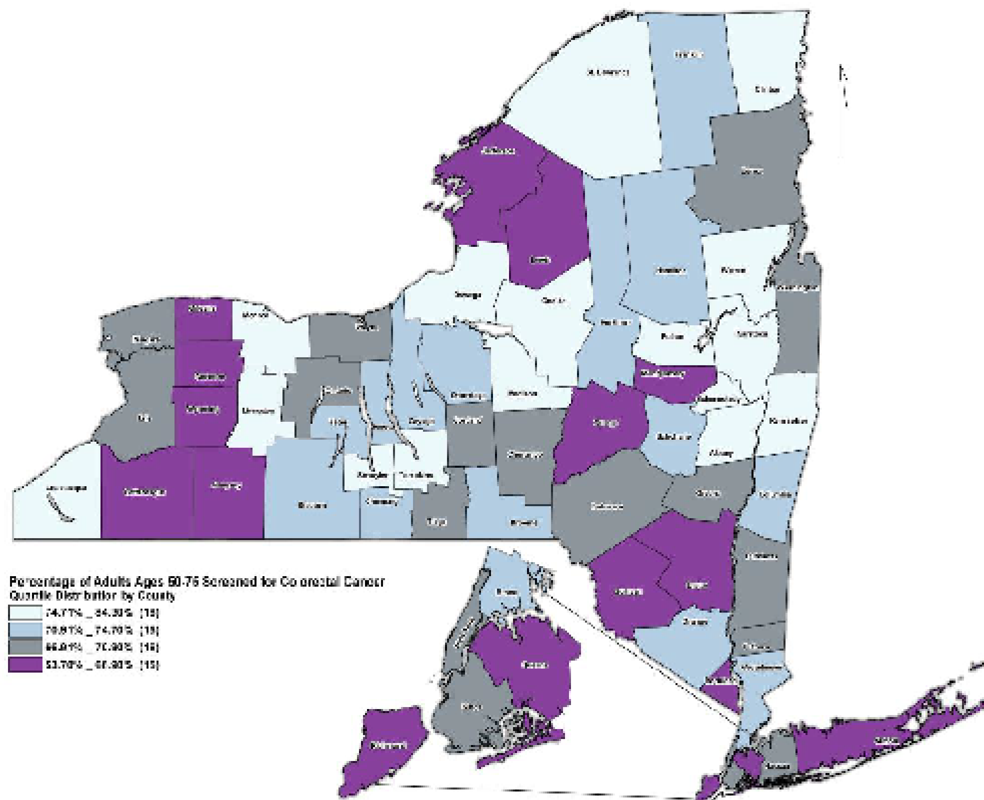


Colorectal cancer (cancer that starts in the colon or rectum) is the third leading cause of cancer death for men and women in New York State (NYS). There are approximately 9,000 new cases of colorectal cancer diagnosed each year in NYS, and about 3,130 NYS adults die from the disease annually.[1] Early detection of colorectal cancer through regular screening can improve survival rates. According to data from the 2016 NYS Behavioral Risk Factor Surveillance System (BRFSS), the percentage of adults ages 50-75 screened for colorectal cancer ranged from 53.7% in Sullivan County to 84.3% in Tompkins County. The five counties with the lowest percentage of adults screened were: Sullivan (53.7%), Lewis (56.8%), Suffolk (60.0%), Queens (61.3%), and Montgomery (61.4%). The counties with the highest percentage of adults screened in 2016 were: Tompkins (84.3%), Livingston (81.4%), Oswego (80.6%), St. Lawrence (79.5%), and Albany (79.0%).

Public Health Opportunity: County-level estimates can be used to identify geographic areas with low screening rates and to inform and evaluate the effectiveness and impact of program interventions and cancer screening activities. Local health departments and their partners can use this information to educate local decision-makers and support NYS Prevention Agenda planning.

[1] New York State Cancer Registry, 2011-2015

Percentage of adults ages 50-75 screened for colorectal cancer, New York State, BRFSS 2016



Note - some counties with high screening rates may still have a large number of adults who aren't screened due to the county's population size.
Information - for other reports about cancer screening in NYS visit: https://www.health.ny.gov/statistics/brfss/
Contact- Bureau of Chronic Disease Evaluation and Research, New York State Department of Health, by phone (518) 473- 0673 or by email bcder@health.ny.gov

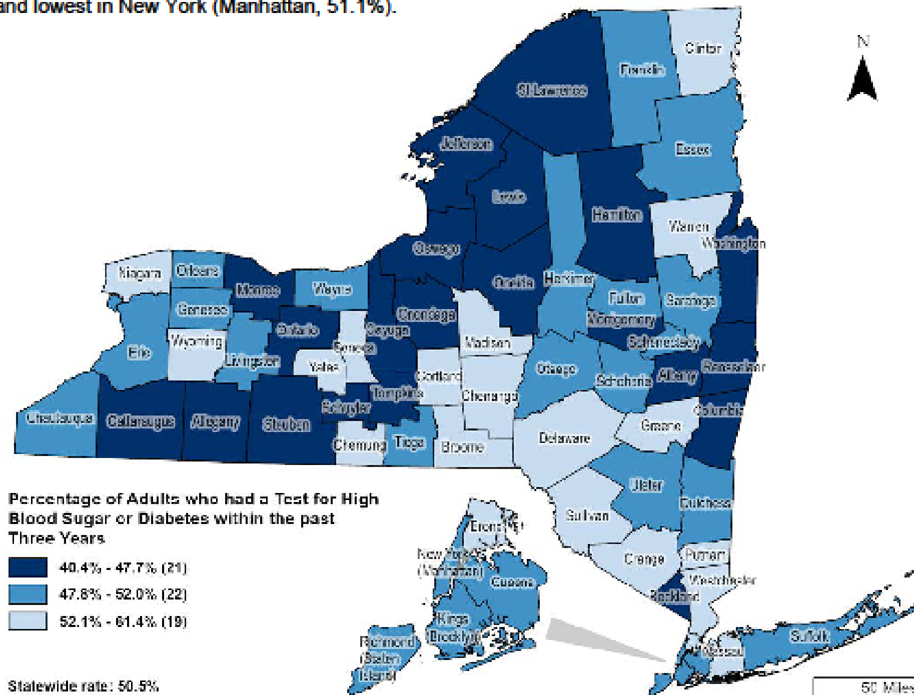
Attachment 5: 2023 NYS Department of Health Information for Action (IFA) Report # 2023-11

INFORMATION FOR ACTION # 2023-11
RELEASE DATE: 11/13/2023

Percentage of New York State Adults Tested for High Blood Sugar, by County, BRFSS 2021

Promoting routine screening for high blood sugar (or blood glucose testing) is a public health action that can help prevent or delay the onset of diabetes within a community. County-level percentages of adults tested for high blood sugar[1] in the past three years were obtained from the 2021 NYS Behavioral Risk Factor Surveillance System (BRFSS). About one-half (50.5%) of NYS adults had a test for high blood sugar or diabetes in the past three years. The percentage of adults tested for high blood sugar varies by county, from 40.4% in Columbia County to 61.4% in Greene County.

- For counties outside New York City (NYC), the percentage of adults tested for high blood sugar was highest in Greene (61.4%), Niagara (59.8%), and Cortland (59.5%) counties.
- For counties outside NYC, the percentage of adults tested for high blood sugar was lowest in Columbia (40.4%), Allegany (41.5%), and Hamilton (41.7%) counties.
- Among NYC boroughs, the percentage of adults tested for high blood sugar was highest in Bronx (53.5%) and lowest in New York (Manhattan, 51.1%).



Public Health Opportunity

To help identify, prevent, and manage diabetes in NYS, the Prevention Agenda focuses on creating clinical and community environments that support the prevention, early detection, and management of diabetes, especially for populations at greatest risk due to social determinants of health. Relevant goals include promoting routine testing, reducing obesity, supporting evidence-based care in health care systems to prevent and manage diabetes, and increasing referrals to evidence-based community programs to support individuals with and at risk for developing diabetes. County-level estimates can be used to identify areas of concern, track progress for program interventions, and evaluate the effectiveness of blood sugar testing activities. Monitoring county-level rates can be helpful towards the development of future program interventions in clinical and community settings. Local health departments and their partners can use this information to educate local decision-makers and support NYS Prevention Agenda reporting.