Ellenville Regional Hospital 2019-2021
Community Service Plan

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www.ellenvilleregional.org

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2019-2021 Community Service Plan

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Executive Summary

As required by of the New York State Department of Health and IRS Ellenville, Regional Hospital (ERH) must every three-years conduct a thorough Community Health Assessment (CHA) and submit a Community Service Plans (CSP) outlining interventions designed to improve health outcomes in the service area. In recent years, the New York State Department of Health has encouraged local hospitals and health departments to collaborate in the creation of joint Community Health Improvement (CHIP)/CSP documents. Ulster County Department of Health and Mental Health (UCDOHMH) hosted a series of meetings with key stakeholder organizations in Ulster County to discuss the selection of priorities. ERH, with its partners UCDOHMH and HealthAlliance Hospital: Mary's Ave Campus (HA), have jointly selected Preventing Chronic Diseases and Promote Well-Being and Prevent Mental and Substance Use Disorders as the two priority areas for the 2019-2021 CHIP/CSP. Community based organizations, health care providers, a number of County of Ulster Departments, and Ulster County Coalitions were also involved in the decision making process and will work to support the selected initiatives.

In 2017, the seven Local Health Departments of the Mid-Hudson Region, including Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester Counties, and HealtheConnections created the Local Health Department Prevention Agenda Collaborative with the endeavor of creating the first Regional CHA for the Mid-Hudson Region. The Collaborative contracted the Siena College Research Institute (SCRI) to conduct a random digit dial regional community health survey to supplement the Regional CHA and to gauge the perception of residents surrounding health and resources in their communities. Responses from 5,372 residents of the Mid-Hudson Region were collected. To further supplement the data collected from the community, Collaborative members held focus groups with service providers to further understand the needs of specific communities and populations, and the barriers they face to achieving optimal health. The resulting Regional CHA document was used to inform key stakeholders during the county level meetings hosted by UCDOHMH.

ERH, with its service area composed predominantly of the Town of Wawarsing (population 13,157), and the surrounding areas, has through the health assessment process, identified cardiovascular disease and substance use disorder as two health conditions resulting in premature death and disparate impact in the service area. With the occurrence of cardiovascular disease, which has an age-adjusted county mortality rate higher than the state (223.3/220.2), also exists a high burden of co-occurring chronic diseases including obesity and diabetes, and a high rate of associated risk behavior such as tobacco and substance use. Substance use has had an immediate impact on the rate of premature death in Ulster County, with the highest number of fatal opioid overdoses in New York State occurring in Ulster County in 2018.

ERH reviewed multiple data sources during the assessment process, including but not limited to, New York State Community Health Indicator Reports (CHIRS) and New York State Prevention Agenda Dashboard, Student Weight Status Category Reporting System (SWSCR), New York State Education Department (NYSED), New York State Opioid Data Dashboard, 2014-2016 New York State Vital Statistics, the Expanded Behavioral Risk Factor Surveillance System (Expanded BRFSS), and the results of the SRI survey. Additionally, ERH conducted a series of community forums during 2018-2019, conducted two surveys in the Wawarsing area, focusing on perception of health priority and the perception of the opioid crisis (included as attachments).

Strategies included to address the selected priority areas are detailed in the attached work plan table. Interventions for the first priority area include the use of the evidence-based Community Health Worker Model and health education to reduce the occurrence of childhood obesity and adult cardiovascular disease, as well as opportunities for increase physical activity, and access to no-cost physical therapy. For the second priority area, the use of Certified Peer Recovery Advocates, Medication Assisted Recovery accessible 24/7 (buprenorphine induction), harm reduction, medication take back, law enforcement assisted diversion, and detox services are all among the evidence based interventions intended to reduce the morbidity and mortality rate of not only opioids, but other substances including alcohol.

As described above, 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 UCDOHMH in 2017 to address population health and housed as a department of ERH, a consortium of providers work together to collaborative 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), HealtheConnections, Ellenville Central School District (ECSD), Ellenville/Wawarsing Youth Commission, The Rose Women's Care Service: Community Resource Center, Inc., Rondout Valley Growers Association, Ellenville Public Library and Museum, Planned Parenthood of the Mid-Hudson Valley, Catholic Charities of Orange, Sullivan, and Ulster, Step One, and Ellenville First Aid and Rescue Squad.

The ERRHN consortium meets 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. The ERRHN holds multiple local, state, and federal grants, and as such has detailed methodologies for progress tracking and program evaluation.

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 has approximately 13,000 - 15,000 visits annually. In 2018, the hospital served 10,082 patients who made 19,955 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 13,157, of which 4,135 reside within the Village of Ellenville, the largest population center (2013-2017 American Community Survey 5-Year Estimates). The ERH service area includes the top ten zip codes serviced by the hospital. There has been no major change to the parameters of the Ellenville Regional Hospital Service Area since the 2018 CSP update was submitted.

Demographics		
	Town of Wawarsing	Village of Ellenville
Race / Ethnicity		
White	71.7%	65.1%
Black and African American	10%	10.5%
American Indian and Alaska Native	0.3%	0
Asian	2.2%	5.6%
Other Races	7.3%	9.3%
Two or more Races	8.6%	9.5%
Hispanic of any race	20.8%	28.4%
Median Age	41.5 years	37 years
Age 62 or older	18.5%	14.3%
Median Household Income	$46,889	$45,531
Income Below Poverty Level	17.9%	18.9%

(Data from 2013-2017 American Community Survey 5-Year Estimates)

ERH's catchment area includes an impoverished population borne out by some of the statistics listed above. For example, Ellenville and Warwarsing have median household incomes (shown in chart)

that are substantially lower than the Ulster County median household income of $61,652 and the NYS median household income of $62,765(ACS 2013-2017). In addition, the Town of Wawarsing is designated a Medically Underserved Population (MUA/P) (78828). Both of these factors create a significant barrier for the uninsured and underinsured to be able to access quality healthcare, other than by utilizing those health care services available through ERH. Compared to 2017 statistics for the overall population of Ulster County (8.1% African-American and 9.8% Hispanic), Ellenville and Warwarsing (statistics shown in chart) stand out as diverse rural communities made up of markedly higher percentages of African-American and Hispanic residents.

When looking at the health of the community in the Ellenville/Warwarsing area, it is important to note that the Ellenville Family Health Center (FHC), 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 FHC 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 FHC sees approximately 3,600 patients per year and offers same-day appointments. In 2018, the center provided 12,761 medical visits, 7,063 mental health visits and 8,383 dental visits to a largely indigent patient population: 39.73% of patients seen at the health center received Medicaid, 17.51% received Medicare, and 13.19% were uninsured.

Since the mid 1990's, the community has lost over 1,000 good paying jobs due in part to the closure of two major manufacturing industries and to a significant decline in the tourism industry. The Town and Village struggle with the issues that accompany poverty and unemployment in rural areas. Major employers that continue to support the residents of the region are the NYS Department of Corrections, Ellenville Central School District and Ellenville Regional Hospital.

An affordable Senior Housing project, which is a joint venture between the hospital and Warwick Properties, Inc., is located on the Ellenville Regional Hospital campus. All three phases of the project remain fully occupied, with approximately 156 senior citizens living independently in one-bedroom apartments. Funding was secured for the project from the New York State Division of Housing"s Community Renewal Housing Trust Fund. The Partnership sponsoring the housing project is developing plans to build additional affordable housing close to the Hospital, targeting seniors, special needs populations and possibly returning Vets.

Public Participation

To engage the community in the selection of health priorities for 2019 - 2021, the Ulster County Department of Health (UCDOH) took the lead, with partners HealthAlliance of the Hudson Valley and Ellenville Regional Hospital, in the organization and execution of a county-wide Community Health Assessment (CHA) as UCDOH did in 2016. A Community Health Needs Assessment Survey was used to confirm existing priorities and to help develop new evidence-based strategies. Conducted by Sienna Research Institute, a 13-minute, random dial survey (70% landline, 30% cell) was conducted across the seven counties of the Hudson valley. In Ulster County, 800 individuals were surveyed, with Spanish speaking interviewers available. The three organizations (UCDOHMH, HA, and ERH) continued to meet throughout 2019, 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.

Ellenville Regional Rural Health Network (ERRHN), a newly formed department of Ellenville Regional (ERHN) Hospital (2017), held community conversations (forums) on May 8, 2018, May 6, 2019, June 13, 2019, and December 4, 2019. Additionally, in 2019 ERRHN circulated two surveys. The first survey focused on community perception of the biggest risks to health and topics discussed during the community conversations. Prior to distribution, staff at the Nathan Kline Institute reviewed the second survey, which focused on the impact of the opioid epidemic on community residents and their families. *"As one of the nation's most respected research centers focused on mental health, investigators at the Nathan S. Kline Institute for Psychiatric Research (NKI) study the causes, treatment, prevention, and rehabilitation of severe and persistent mental illnesses. As a facility of the New York State Office of Mental Health, founded in 1952, NKI has earned a reputation for its landmark contributions in psychiatric research, especially in the areas of psychopharmacological treatments for schizophrenia and major mood disorders, dementia research, clinical trials methodology, neuroimaging, therapeutic drug monitoring, and the application of computer technology to mental health services."*

As a result of the forums and surveys collected, in 2019 ERRHN:

- expanded its harm reduction services to include Naloxone, syringe vouchers, safe use kits, fentanyl test strips, condoms, sharps containers, medication disposal pouches, etc.;
- hired a nutritionist to aid community residents in dietary counseling, lead a nutrition support group, and collaborate with Cornell Cooperative Extension (CCE) to expand the family cooking program;
- Met with Ellenville Central School District (ECSD) to begin working on new projects such as collaborating with CCE on a Smarter Lunchroom Movement, and new "Try it Tuesdays" initiative to increase students exposure to fresh vegetables

- Collaborated with a number of partners including CCE, ECSD, and the Rondout Valley Growers Association to pursue a farm to school planning project opportunity.

Additionally, the Healthy Ulster Council, a broad-based coalition formed by representatives from a variety of organizations and agencies in 2010, has been ongoing in its work of 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

A workgroup made up of key staff from UCDOH-MH, HealthAlliance of the Hudson Valley and Ellenville Regional Hospital met regularly to review local health data in conjunction with the existing Community Health Improvement Plan and the Community Service Plans for the two hospitals. This workgroup reviewed the status of existing community interventions and best practices, analyzed the results of the 2019 UC Community Health Needs Assessment, and presented findings to the three main community coalitions working in these priority areas. Following these efforts, the workgroup elected to continue working towards the two previously selected Priority Areas (PAs): Prevent Chronic Disease and Promote Well-Being and Prevent Mental and Substance Use Disorders for the next 2019-2021 years. The specific interventions selected for each hospital system will be jointly monitored by the workgroup and the larger coalitions.

With an emphasis on these two PAs, the partners are closely watching the upward trends in suicide rates, opioid overdose rates, adult smoking rates, exposure to secondhand smoke, tobacco marketing to youth, child poverty rates, food insecurity, teen pregnancy rates, child and adult obesity rates, hypertension rates, premature death rates, and preventable hospitalizations. At the same time, many positive programs to promote health are being developed or expanded by the partners, while they are also working on interventions and programs to prevent the development of chronic diseases.

For ERH specifically, the Focus Areas chosen within the two Prevention Agenda Priorities for the years 2019 – 2021 are to:

1) Prevent Chronic Diseases Focus Area 4: Preventive care and management
2) Promote Well-Being and Prevent Mental and Substance Use Disorders Focus Area 2: Prevent Mental and Substance User Disorders

For Prevent Chronic Diseases Focus Area 4, there will be continued development and implementation of the Ellenville Regional Rural Health Network (ERRHN) Wellness Program and

its educational programming. The Collaborative will work to increase participation in lifestyle changes including increased physical activity, improved diet, and improved health and wellbeing awareness, utilizing the evidence based Community Health Worker (CHW) model.

For Promote Well-Being and Prevent Mental and Substance Use Disorders Focus Area 2, ERH will continue to implement and expand Project RESCUE (24/7 buprenorphine induction with warm hand off to a Peer and treatment provider) and continue to supply harm reduction supplies and education on harm reduction to individuals seen in the ED and the community. Additionally ERH staff will continue to support the Ulster County Sheriffs ORACLE program (Opioid Response as County Law Enforcement) that aims to divert individuals from potential incarceration to detox and treatment services.

Data sources for this CSP include the NYS DOH Prevention Agenda Dashboard, the Community Health Indicator Reports, 2013-2017 American Community Survey 5-Year Estimates, the NYS 2015-2016 Expanded Behavioral Risk Factor Surveillance Survey, New York State Opioid Data Dashboard, NYS Department of Education, and various US Census data sources. We have also drawn on utilization data from Ellenville Regional Hospital and the Family Health Center, as well as results from the 2019 UC Community Health Needs Assessment Survey.

The New York State Community Health Indicator Reports (CHIRS) and New York State Prevention Agenda health indicators that are relevant to this local Community Service Plan and that support the need for chronic disease prevention in Ulster County include:

	Ulster County	**NYS**
Percentage of premature deaths (before age 65 years)	24.5%	24.0%
The percentage of adults who are obese (2016)	30.6%	25.5%
Percentage of children and adolescents who are obese (2014-2016)	19.9%	17.3%
Percentage of cigarette smoking among adults (2016)	15.2%	14.2%
Age-adjusted cardiovascular disease mortality rate per 100,000 (2014-16)	223.3	220.2
Age-adjusted heart attack hospitalization rate per 10,000 (2016)	15.8	13.9
Age-adjusted percentage of adults with physician diagnosed high blood pressure (2016)	29.4%	28.9%
Age-adjusted percentage of adults with physician diagnosed diabetes (2016)	6.7	9.5
Age-adjusted diabetes mortality rate per 100,000 (2014-2016)	17.6	17.0

Data indicating that Ellenville Regional Hospital is located in an economically depressed area with a high rate of cardiovascular disease and obesity, informed the decision-making that lead to the

selection interventions intended to prevent the onset of cardiovascular disease, and to reduce and prevent obesity.

While data is not available specifically for Wawarsing or Ellenville, 2014-2016 age-adjusted suicide mortality rate per 100,000 (UC – 11.8; NYS – 8.0), and the poor mental health condition of 14+ days (UC – 12.3%; NYS – 10.7%) are more prevalent in Ulster County than they are in New York State.

In 2016, there were 54 fatal overdoses in Ulster County. Data from the New York State Opioid Data Dashboard includes valuable information on Outpatient ED Visits and Opioids. For all 2016 emergency department visits (including outpatients and admitted patients) involving any drug overdose, in NYS the age-adjusted rate is 170.7 per 100,000 population, 210.4 for NYS excluding NYC, and significantly higher in Ulster County with a rate of 380. For ED visits (outpatients) and hospital discharges involving opioid misuse, dependence and unspecified use, the crude rate per 100,000 population of NYS in 2016 was 222.2, it was 206 in NYS excluding NYC , and in Ulster County, it was significantly higher with a rate of 808.

The Emergency Department (ED) has historically been a critical point of access for emergent trauma, overdoses, and other medical crisis's. In 2017 and 2018, the ED patient volume at ERH was 12,944 and 12,695 respectively. In 2017, the total number of ED opioid related visits was 134 and overdoses accounted for 38 of those visits, with 1 fatality. In 2018, the total number of ED opioid related visits was 105, 24 of which were overdoses, with 3 fatalities. Ellenville First Aid and Rescue Squad transported 24 overdose calls to Ellenville Regional Hospital in 2018. Ulster County had 202 opioid overdoses in 2017, 45 of which were fatal. As per the recent New York State County Opioid Quarterly Report (July 2019), Ulster County experienced 146 opioid overdose ED visits in 2018, 56 of which were fatal. Ulster County Medical Examiner data shows that there were 61 fatal opioid overdoses in 2018. Fentanyl was identified in 30 of the 61 fatal overdoses. In 2018, Ulster had the highest number of fatal overdoses in New York State. While the raw number of overdoses went down, fatalities increased over the two-year period.

Of the 73 individuals in the Town of Wawarsing who completed the opioid survey, 25 reported they knew someone in their immediate family who had misused opioids, 17 reported having someone in their immediate family who had an opioid overdose, 9 individuals reported having someone in their immediate family have a fatal overdose. Additionally, 18 individuals reported having a friend or extended family member who had an opioid overdose, and 25 reported an acquaintance having an overdose; with 23 reporting that they had a close friend or extended family member who had a fatal overdose, and 24 reporting an acquaintance having a fatal overdose.

The burden of impact the community has experienced because of the opioid crisis, highlighted by

the data presented, lead to the selection of preventing substance overdose and fatality as the second focus area.

Interventions

See attached work plan table for detailed description of interventions

Priority Area #1: Preventing Chronic Diseases

Focus Area 4: Preventive care and management

Goal 4.3: Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity

Intervention 1 Summary: ERH is working to identify and enroll 150 adults at risk of cardiovascular disease (determined by CDC Heart Age Calculator) in the RHN Wellness Program, to aid them in making lifestyle changes to reduce their risk of developing CVD.

Intervention 2 Summary: ERH is working to identify and enroll 45 families with children who are overweight or obese into the RHN Wellness Program, to aid them in making lifestyle changes to reduce their risk of developing chronic diseases and experiencing poor health outcomes.

Priority Area #2: Promote Well-Being and Prevent Mental and Substance Use Disorders

Focus Area 2: Prevent Mental and Substance User Disorders

Goal 2.2: Prevent opioid overdose deaths

Intervention 1 Summary: Implement Project RESCUE, a collaborative partnership between ERH and Catholic Charities of Orange, Sullivan, and Ulster. Medication Assisted Recovery (MAR) (Buprenorphine) will be available in the ED for induction 24/7 (with assessment for withdrawal symptoms) with a warm hand off to a certified recovery peer advocate (CRPA) and a referral to start treatment. MAR is available for up to three days in the ED, with a guaranteed treatment start day with partnering agencies of day four.

Intervention 2 Summary: Provide necessary harm reduction supplies and guidance to prevent fatal overdoses and the occurrence, and transmission of infectious complications (i.e. HepC, HIV, Endocarditis).

Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults

Intervention 3 Summary: Support Ulster County Sheriffs Project ORACLE to facilitate law enforcement assisted diversion for alcohol use disorder by providing detox services, peer support, and referral to treatment providers.

See attached work plan table for detailed description of interventions.

Attachments

Attachment 1: Community Survey

Ellenville Community Conversation Survey

1. What are your top four (4) concerns for Ellenville (please check top four)?
   - Alcohol and/or Drug Use _____
   - Crime _____
   - Domestic Violence _____
   - Employment _____
   - Healthcare (heart disease, obesity, diabetes, etc.) _____
   - Opportunities for Positive Youth Involvement _____
   - Poverty _____
   - Teen Pregnancy _____
   - Violence (outside of domestic violence, ex. gangs) _____
   - Other (*PLEASE WRITE IN OTHER ISSUES NOT LISTED*)

     _____

2. Do you have health insurance? Yes _____ No _____
3. Do you have a primary doctor? Yes _____ No _____
4. Name three positive qualities about Ellenville:

   _____

   _____
5. If you could change one thing about Ellenville, what would that be?

   _____

   _____
6. Do you have any other thoughts, concerns, ideas you would like to share?

   _____

   _____

Attachment 2: Opioid Survey

Please take our very brief survey to help us learn more about the state of health in Wawarsing. **Please do not write your name on the survey. Your answers are strictly confidential, and all paper surveys will be shredded once the data entry is complete.**

Please answer a few social determinants questions to help us understand the population of this area better.

1. What is your current employment status?

- ☐ Full-time employment currently
- ☐ Part-time employment currently
- ☐ Currently unemployed
- ☐ Self-employed

2. What is your annual income level?

- ☐ > $5,000/ year
- ☐ $5,000 - $15,000/ year
- ☐ $15,001 - $25,000/ year
- ☐ $25,001 - $35,000/ year
- ☐ > $35,000/ year

3. Have you ever been homeless ("Homeless" means you did not have your own place to sleep, not an apartment or house that you or your family owned or rented)?

- ☐ Yes, but I am no longer homeless
- ☐ Yes, and I am currently homeless
- ☐ No

4. What is your highest level of education?

- ☐ Less than high school
- ☐ High school diploma or equivalent
- ☐ Some college, no degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctoral or professional degree

5. Do you have health insurance?

- ☐ Yes, and I have a co-pay or deductible
- ☐ Yes, and I don't have a co-pay or deductible
- ☐ No, I don't have health insurance

Please check any of the following statements that are true for your family.

6. **My zip code:** _____

7. **How have you been affected by the opioid epidemic? Check all that apply:**

   ☐ I know someone in my immediate family who has misused opioids.

   ☐ I have a close friend or extended family member who has misused opioids.

   ☐ I am aware of an acquaintance, coworker, or classmate who have misused opioids.

   ☐ I am not aware of anyone who misuses or misused opioids.

8. **How have you been affected by opioid <u>overdose event(s)</u>? Check all that apply:**

   ☐ I know someone in my immediate family who has overdosed on opioids.

   ☐ I have a close friend or extended family member who has overdosed on opioids.

   ☐ I am aware of an acquaintance, coworker, or classmate who has overdosed on opioids.

   ☐ I am not aware of anyone who has overdosed on opioids.

9. **How have you been affected by an opioid <u>overdose death</u>? Check all that apply:**

   ☐ I know someone in our immediate family who has died from an opioid overdose.

   ☐ I have a close friend or extended family member who has died from an opioid overdose.

   ☐ I am aware of an acquaintance, coworker, or classmate who has died from an opioid overdose.

   ☐ I am not aware of anyone who has died from an opioid overdose.

10. **If you have a friend or family member (including yourself) that has misused opioids, how were opioids used?**

    ☐ Ingesting pills ☐ Injecting

    ☐ Sniffing/ snorting ☐ Smoking

11. **I know what Narcan/Naloxone is:**

    ☐ Yes ☐ No

12. **I know where to get Narcan/Naloxone:**

    ☐ Yes ☐ No

13. **I have been trained to administer Naloxone:**

    ☐ Yes (*If Yes: Go to #15*) ☐ No (*If No: Go to #14*)

14. I would like to be trained to administer Narcan/Naloxone:

☐ Yes ☐ No

15. In the past 12 months, I have administered Narcan/Naloxone on someone:

☐ Never (0) ☐ Two to four times (2-4)

☐ One time (1) ☐ Five or more times (5+)

16. In the past 12 months, a friend or family member has administered Narcan/Naloxone on someone:

☐ Never (0) ☐ Two to four times (2-4)

☐ One time (1) ☐ Five or more times (5+)

17. In the past 12 months, I have received a prescription for an opioid pain medication from a medical provider.

☐ Yes *(If Yes: Go to #18)* ☐ No *(If No: Go to #22)*

18. The opioid pills prescribed were taken more frequently than the doctor prescribed:

☐ Yes – I finished the prescription earlier ☐ No – I finished the prescription on time or later than prescribed

19. The prescribed medication was taken as prescribed by the doctor (as indicated on the pill container):

☐ Yes, and no medication was left over ☐ No, I had some medication left over

20. I have tried to get a refill since completing the first prescription:

☐ Yes *(If Yes: Go to # 21)* ☐ No *(If No: Go to #22)*

21. I was successful in refilling this prescription:

☐ Yes ☐ No

22. I know the proper way to dispose of medications, including opioid prescriptions, if there are any leftover:

☐ Yes ☐ No

23. I know where at least two prescription drop boxes are located in Wawarsing (to dispose of medications):

☐ Yes, and I have used a drop box in Wawarsing ☐ Yes, but I have never used the drop box in Wawarsing

☐ No, but I know where one drop box is located

☐ No, I don't know where any drop boxes are located in Wawarsing

24. In the past 12 months, I have used a prescription drop box located in Wawarsing (to dispose of medications):

☐ Yes

☐ No

25. In the past 12 months, I have:

☐ Tried to access treatment for opioids and been unsuccessful in finding treatment

☐ Tried to access treatment for opioids and been successful in finding treatment

☐ Received treatment for a substance use disorder including opiates

☐ Tried to access mental health counseling and been unable to find a counselor

☐ Tried to access mental health counselling and was able to find a counselor

☐ Received mental health counseling

26. If additional mental health counselors became available locally in Wawarsing, I would use the service:

☐ Yes

☐ No

27. What do you think should be done to address the opioid epidemic more effectively?

28. One thing I wish the local service providers understood about families in Wawarsing is:

Name of County - Organization(s) Ellenville Regional Hospital
2019 Work plan

Planning Report Liaison Victoria Reid
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Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	ERH is working to identify and enroll 150 adults at risk of cardiovascular disease (determined by CDC Heart Age Calculator) in the RHN Wellness Program, to aid them in making lifestyle changes to reduce their risk of developing CVD.	The age-adjusted cardiovascular disease hospitalization rate per 10,000 (CHRIS 2014-16) of 113.9 in Ulster County is slightly better than the state rate of 125.6, and comparable to the regional rate of 112.5. However, there is an disparate number of deaths in Ulster County. Heart Disease is the leading cause of all deaths in Ulster County, and the second leading cause of premature (<75) deaths. The age adjusted Cardiovascular disease mortality rate of 223.3 per 100,000 (CHRIS 2014-16), is higher than the NYS rate of 102.4 and the Mid-Hudson Region rate of 83.6. This indicator has significantly worsened from the 2011-2013 rates. Cardiovascular disease premature death (aged 35-64 years) rate (CHRIS 2014-16) is significantly higher than both the state (83.6) and region (102.4) at 120.4 per 100,000, and also significantly worsened from the 2011-2013 rates. Of Ulster adults, 33.2% (BRFSS 2016) of adults have diagnosed hypertension, compared to the state rate of 31.7%.	Individuals identified at risk in the community, at the ERH ED, or at a local PCP are referred to the RHN Wellness Program. Individuals who accept the referral are enrolled into the cohort, and complete an intake assessment with a community health worker (CHW) that includes collection of clinical metrics, a SDOH screening (PRAPARE), and health knowledge and behavior assessments. The CHW works with the individual to develop an action plan to begin making lifestyle changes that reduce their risk of developing CVD. The CHW provides support to the cohort by offering meetings at their house or a community location to eliminate transportation barriers, can assist them with obtaining blister packaging of medication from local pharmacy or arranging medication reconciliation with ERH Pharmacist, can meet them at the grocery store to help educate on shopping, etc. Additionally, the cohort is able to meet with a nutritionist on site or a site of their choosing (to overcome transportation) to make meal plans and have nutrition counseling. In addition to the support provided by the CHW and Nutritionist, there are a number of no cost health programs cohort members can attend, that focus on health education, nutrition (cooking demonstrations, support group, etc.), and physical activity classes.	Input Measures: Staff time, programing from partners calcium score CT, Carotid Ultrasound. Output Measures: Free classes for community members, action plans, dietary plans. Short-term Outcome: Dietary and physical behavior changes Intermediate Outcome: Reduction in BMI, Heart Risk, blood pressure. Increased management of blood sugar. Long-term Outcome: Community wide reduction in rate of CVD incident and hypertension rate.	Community Health Worker Calcium Scoring Carotid Ultrasound Nutritionist Nutrition Support Group Pill blister pack partnership with Pharmacy Farm-acy Smoking Cessation Group Grocery Store Tours Healthy Hearts Cooking Club Living Well Napanoch New Horizons (educational presentations for seniors) Chair Yoga Couch to 5k (for runners and walkers) Hiking Club Staff & Volunteer Garden on Campus	Community Health Worker Calcium Scoring Carotid Ultrasound Nutritionist Nutrition Support Group Weekly Meal Plan (with on sale ingredients) Pill blister pack partnership with Pharmacy Farm-acy Gardening Class Smoking Cessation Group Grocery Store Tours Healthy Hearts Cooking Club Living Well Napanoch New Horizons (educational presentations for seniors) Chair Yoga Couch to 5k (for runners and walkers) Hiking Club Staff & Volunteer Garden on Campus	Community Health Worker Calcium Scoring Carotid Ultrasound Nutritionist Nutrition Support Group Weekly Meal Plan (with on sale ingredients) Pill blister pack partnership with Pharmacy Farm-acy Gardening Class Smoking Cessation Group Grocery Store Tours Healthy Hearts Cooking Club Living Well Napanoch New Horizons (educational presentations for seniors) Chair Yoga Couch to 5k (for runners and walkers) Hiking Club Staff & Volunteer Garden on Campus	Community-based organizations	Cornell Cooperative Extension - Provide nutrition and cooking education with ERRHN staff at free programs (Family cooking classes Expanded Food and Nutrition Education Program (EFNEP); Nutrition Support Group, Grocery Store Tours, etc.)
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	ERH is working to identify and enroll 45 families with children who are over weight or obese, into the RHN Wellness Program, to aid them in making lifestyle changes to reduce their risk of developing chronic diseases and experiencing poor health outcomes.	In Ulster County, 30.6% of adults and 19.9% of children and adolescence are obese. These rates are, both higher than the NY State rate. Ellenville Central School District had 1,569 students enrolled for the 2017-18 school year, 70% of whom were economically disadvantaged, and 5% were reported as homeless. In the Town of Wawarsing 23% of children under the age of 18 live below the poverty line. During a need assessment conducted by ERRHN in 2019, it was identified that during the Ellenville Central School District 2017-18 school year, 18% female of students in grades pre-k, kindergarten, 2, and 4 were overweight or obese (12% obese), and 22% of males from the same grades were overweight or obese (15% obese). While these rates seem promising, county data indicates that as children age, these outcomes worse. A study of Institute patients during the same time period looking at all youth under the age of 18, indicated an alarmingly higher rate of 48% of male and 44% of female pediatric patients being overweight or obese (30% and 26% respectively obese). Additionally, a survey conducted in the school district with elementary age students (474 out of 701 students completed surveys), found that approximately 33% of children do not have daily fruit consumption, 50% do not have daily	Families identified at risk in the community, at the ERH ED, or at a local PCP are referred to the RHN Wellness Program. Families who accept the referral are enrolled into the cohort, and complete an intake assessment with a community health worker (CHW) that includes collection of clinical metrics, a SDOH screening (PRAPARE), and health knowledge and behavior assessments. The CHW works with the family to develop an action plan to begin making lifestyle changes that reduce obesity and improve health. The CHW provides support to the family by offering meetings at their house or a community location to eliminate transportation barriers, can meet them at the grocery store to help educate on shopping, etc. Additionally, the cohort is able to meet with a nutritionist on site or a site of their choosing (to overcome transportation) to make meal plans and have nutrition counseling. In addition to the support provided by the CHW and Nutritionist, there are a number of no cost health programs cohort members can attend, that focus on health education, nutrition (cooking demonstrations, support group, etc.), and physical activity classes.	Input Measures: Staff time, programing from partners Output Measures: Free classes for community members, action plans, dietary plans. Short-term Outcome: Dietary and physical behavior changes Intermediate Outcome: Reduction in BMI, Heart Risk, blood pressure. Increased management of blood sugar. Long-term Outcome: Community wide reduction in rate of CVD incident and hypertension rate.	Community Health Worker Caregivers and Kids Cooking Classes Nutritionist Gardening Class Grocery Store Tours Healthy Hearts Cooking Club Couch to 5k (for runners and walkers) Hiking Club Teen Life Skills & Sexual Health Education Classes	Community Health Worker Caregivers and Kids Cooking Classes Nutritionist Gardening Class Grocery Store Tours Healthy Hearts Cooking Club Couch to 5k (for runners and walkers) Hiking Club Teen Life Skills & Sexual Health Education Classes Weekly Meal Plan (with on sale ingredients)	Community Health Worker Caregivers and Kids Cooking Classes Nutritionist Gardening Class Grocery Store Tours Healthy Hearts Cooking Club Couch to 5k (for runners and walkers) Hiking Club Teen Life Skills & Sexual Health Education Classes Weekly Meal Plan (with on sale ingredients)	Community-based organizations	Planned Parenthood - offers Life-skills & Sex Education classes
			See above	See above	See above	See above	See above	See above	See above	Federally qualified health care center	The Institute for Family Health - serve as founding member of the Rural Health Network and provide Guidance and oversite to program implementation. Primary care providers refer eligible patients and families to be enrolled into the cohort.
			See above	See above	See above	See above	See above	See above	See above	Local health department	Ulster County Department of Health and Mental Health - serve as founding member of the Rural Health Network and provide Guidance and oversite to program implementation.
			See above	See above	See above	See above	See above	See above	See above	Pharmacies	Matthews Pharmacy - partner for blister packing pilot for cohort members who need additional support with medication management
			See above	See above	See above	See above	See above	See above	See above	K-12 School	Ellenville Central School District - partners and providers spaces for free programing for community families

Name of County - Organization(s) Ellenville Regional Hospital
2019 Work plan

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Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	Implement Project RESCUE a collaborative partnership between ERH and Catholic Charities of Orange, Sullivan, and Ulster. Medication Assisted Recovery (MAR) (Buprenorphine) will be available in the ED for induction 24/7 (with assessment for withdrawal symptoms) with a warm hand off to a certified recovery peer advocate (CRPA) and a referral to start treatment. MAR is available for up to three days in the ED, with a guaranteed treatment start day with partnering agencies of day 4.	In 2018, Ulster County had the highest number of fatal overdoses in New York State. In 2017 and 2018, the ED patient volume at Ellenville Regional Hospital (ERH) was 12,944 and 12,695 respectively. In 2017, the total number of ED opioid related visits was 134 and overdoses accounted for 38 of those visits, with 1 fatality. In 2018, the total number of ED opioid related visits was 105, 24 of which were overdoses, with 3 fatalities. While the raw number of overdoses went down, fatalities increased over the two-year period. In 2016, there were 54 fatal overdoses in Ulster County. Ulster County had 202 opioid overdoses in 2017, 45 of which were fatal. As per the recent New York State County Opioid Quarterly Report (July 2019), Ulster County had 146 opioid overdose ED visits in 2018. The Ulster County Medical Examiner data shows that there were 61 fatal opioid overdoses in 2018. Fentanyl was identified in 30 of the 61 fatal overdoses. When comparing the age and presence of fentanyl when examining fatality data, those under the age of 46 were substantially more likely to have fentanyl noted as present in the examiner's report than those age 46 and older.	Buprenorphine (MAR) available 24/7 in the Emergency Department, for patients presenting in withdrawal or immediately post overdose. Upon presentation ERH ED staff alert the CRPA from Catholic Charities, and provides a warm handoff in-person or over the phone to the patient. The CRPA arranges for the patient a referral into treatment, and if necessary transportation. Buprenorphine can be prescribed to the patient for up to three days in the ED. Local Treatment Partners have agreed to accommodate a treatment start date for patients referred by the ERH ED no later than day 4.	Input Measures: Staff time, Partners Staff time, pharmacist, buprenorphine. Output Measures: Buprenorphine induction, referrals to treatment, warm handoffs. Short-term Outcome: Increase in individuals receiving MAR induction in the ED. Intermediate Outcome: Increase in individuals who present for OUD related ED visit enrolling in OUD treatment. Long-term Outcome: Community wide reduction in morbidity and mortality of OUD.	Implemented PDSA for Project RESCUE. Studied and made necessary adjustments and launched Project Rescue in May 2019. Built work flows, policies, procedures, secured partners, and executed MOUs necessary to implement project rescue to offer buprenorphine induction with warm handoff to CRPA.	Buprenorphine (MAR) available 24/7 in the Emergency Department, for patients presenting in withdrawal or immediately post overdose. Upon presentation ERH ED staff alert the CRPA from Catholic Charities, and provides a warm handoff in-person or over the phone to the patient. The CRPA arranges for the patient a referral into treatment, and if necessary transportation. Buprenorphine can be prescribed to the patient for up to three days in the ED. Local Treatment Partners have agreed to accommodate a treatment start date for patients referred by the ERH ED no later than day 4.	Buprenorphine (MAR) available 24/7 in the Emergency Department, for patients presenting in withdrawal or immediately post overdose. Upon presentation ERH ED staff alert the CRPA from Catholic Charities, and provides a warm handoff in-person or over the phone to the patient. The CRPA arranges for the patient a referral into treatment, and if necessary transportation. Buprenorphine can be prescribed to the patient for up to three days in the ED. Local Treatment Partners have agreed to accommodate a treatment start date for patients referred by the ERH ED no later than day 4.	Providers	Catholic Charities of Orange, Sullivan, and Ulster provides CRPAs to make contact with individuals in the ED and generate referral to treatment, with transportation as needed. Catholic Charities also serves as a provider of OUD treatment, with guaranteed start date by day 4.
			See above	See above	See above	See above	See above	See above	See above	Providers	Step One serves as a provider of OUD treatment, with guaranteed start date by day 4.
			See above	See above	See above	See above	See above	See above	See above	Federally qualified health care center	The Institute for Family Health serves as a provider of OUD treatment, with guaranteed start date by day 4.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	Provide necessary harm reduction supplies and guidance to prevent fatal overdoses and the occurrence and transmission of infectious complications (i.e. HepC, HIV, Endocarditis).	See above	Staff must acknowledge that many patients seen in the ED are not ready to accept SUD treatment. Staff will provide harm reduction materials that are proven to prevent fatal overdoses and reduce the transmission of disease and development of infections. These materials will be provided in the ED and in the Community to at risk individuals and their family/friends. Naloxone trainings will be held regularly, and the use of N-Cap will be heavily promoted.	Input Measures: Staff time, Partners Staff time, naloxone, fentanyl test strips, safe use kits, condoms, syringe vouchers, disposal packets, N-CAP materials, etc. Output Measures: Individuals receiving harm reduction supplies, referrals to treatment, warm handoffs. Short-term Outcome: Increase in individuals equipped with Naloxone to prevent fatal overdoses. Intermediate Outcome: Reduction in the number of fatal overdoses. Long-term Outcome: Reduction in the number of newly diagnosed cases of HIV, HepC, Endocarditis, and injection related abscess.	Staff will provide the following harm reduction supplies in the ED, at trainings, at community events, and to individuals who request it through the SUD Program Coordinator or SUD CHW: Narcan/Naloxone (and instructions to use NCAP) Fentanyl Test Strips Safe Use Kit (including cooker, sterile water, gauze, towel, alcohol swab) Syringe Vouchers and Sharp Container Enrollment into mail order syringe program Medication disposal packets and information on local drop boxes Medication lock bags and education on safe storage to prevent diversion Condom Packets link to syringe access program (Hudson Valley Community Services) for additional harm reduction supplies and guidance	Staff will provide the following harm reduction supplies in the ED, at trainings, at community events, and to individuals who request it through the SUD Program Coordinator or SUD CHW: Narcan/Naloxone (and instructions to use NCAP) Fentanyl Test Strips Safe Use Kit (including cooker, sterile water, gauze, towel, alcohol swab) Syringe Vouchers and Sharp Container Enrollment into mail order syringe program Medication disposal packets and information on local drop boxes Medication lock bags and education on safe storage to prevent diversion Condom Packets link to syringe access program (Hudson Valley Community Services) for additional harm reduction supplies and guidance	Staff will provide the following harm reduction supplies in the ED, at trainings, at community events, and to individuals who request it through the SUD Program Coordinator or SUD CHW: Narcan/Naloxone (and instructions to use NCAP) Fentanyl Test Strips Safe Use Kit (including cooker, sterile water, gauze, towel, alcohol swab) Syringe Vouchers and Sharp Container Enrollment into mail order syringe program Medication disposal packets and information on local drop boxes Medication lock bags and education on safe storage to prevent diversion Condom Packets link to syringe access program (Hudson Valley Community Services) for additional harm reduction supplies and guidance	Community-based organizations	Hudson Valley Community Services is the syringe exchange program that providers ERH with syringe vouchers, safe use kits, condom packets, and sharps containers.
			See above	See above	See above	See above	See above	See above	See above	Other (please describe partner and role(s) in column D)	Ellenville First Aid and Rescue Squad - emergency medical services - provided ERH with Fentanyl test strips.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults	Support Ulster County Sheriffs Project ORACLE, to facilitate law enforcement assisted diversion for alcohol use disorder by providing detox services, peer support, and referral to treatment providers.	The (2016) age-adjusted percentage of adults with poor mental health for 14 or more days in the last month in Ulster County is 12.3%, higher than the state rate of 10.7% and the prevention agenda target of 10.1%. In the same year, the age-adjusted percentage of adults binge drinking during the past month in Ulster county is 11.8%, much higher than the state rate of 8%, and significantly above the Prevention agenda target of 5.9%. The Prevention Agenda metric for Ulster County adults who engaged in binge drinking in the past month (BRFSS), significantly worsened from 10.5% (2013-24) to 22.2% (2016).	The Ulster County Sheriffs Project ORACLE team brings individuals with Alcohol Use Disorder to the ERH ED for evaluation. Based on the evaluation, ERH admits the individual to the inpatient unit, during the medically supervised detox process. ERH staff work the Sheriffs Project ORACLE deputies, to arrange for the patient to be enrolled in a treatment program that provides the appropriate level of care. UC	Input Measures: Staff time, Sheriff Deputies time. Output Measures: Medically supervised detox, referrals to treatment, warm handoffs. Short-term Outcome: increase in AUD patients who are diverted to medically supervised detox rather than legal troubles (i.e. incarceration). Intermediate Outcome: Increase in	Built work flows, policies, procedures necessary to support the Ulster County Sheriffs Project ORACLE. UC Sherriff Deputy brings individuals with Alcohol Use Disorder to the ERH ED for evaluation. Based on the evaluation, ERH admits the individual to the inpatient unit, during the medically supervised detox process. ERH staff work the Sheriffs Project ORACLE deputies, to arrange for the patient to be enrolled in a treatment program that provides the appropriate level of care. UC Sheriffs deputies provide the patient transportation to	The Ulster County Sheriffs Project ORACLE team brings individuals with Alcohol Use Disorder to the ERH ED for evaluation. Based on the evaluation, ERH admits the individual to the inpatient unit, during the medically supervised detox process. ERH staff work the Sheriffs Project ORACLE deputies, to arrange for the patient to be enrolled in a treatment program that provides the appropriate level of care. UC Sheriffs deputies provide the patient transportation to the treatment facility upon discharge (when detox is completed).	The Ulster County Sheriffs Project ORACLE team brings individuals with Alcohol Use Disorder to the ERH ED for evaluation. Based on the evaluation, ERH admits the individual to the inpatient unit, during the medically supervised detox process. ERH staff work the Sheriffs Project ORACLE deputies, to arrange for the patient to be enrolled in a treatment program that provides the appropriate level of care. UC Sheriffs deputies provide the patient transportation to the treatment facility upon discharge (when detox is completed).	Law Enforcement	Ulster County Sheriffs Department runs Project ORACLE, in which individuals with SUD are diverted to medical treatment rather than incarceration. Deputies conduct assessments, transport to ED, arrange treatment facility, and provide transport to facility. ERH staff supports their project be providing ED services, medically supervised detox, and Peer support for individuals admitted.