Ellenville Regional Hospital
Community Health Needs Assessment
2019 – 2021 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), a Community Health Needs Assessment (CHNA) 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/CHNA 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/CHNA. 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 contacted 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 below. 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 and Process/Methods Used to Conduct the CHNA

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.

Description, Assessment and Selection of Significant Health Needs of the Community

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 PA's, 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 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.

Community Health Needs Assessment Implementation Plan

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.

Evaluation of Impact from Previous CHNA

Intervention 1: Diabetes and Pre-Diabetes Self-Management Collaborative
Priority Area #1: Preventing Chronic Diseases (Action Plan)
Focus Area 3 – Increase access to high quality chronic disease preventive care and management in both clinical and community settings.
Goal #3.3 Promote culturally relevant chronic disease self-management education.

ERH collaborated with the FHC to improve blood sugar, lipid and hypertension levels in patients with diabetes and pre-diabetes in an outpatient setting, focusing on improved self-management and adherence, healthy eating and increased physical activity.

Adult ERH Emergency Department patients presenting with symptoms of diabetes or pre-diabetes, such as an elevated blood sugar or hyperglycemia, were referred to FHC‟s on-site certified diabetes educators and health coaches (with the patient's permission) upon discharge. Patients with diabetes that were not patients of the FHC were invited to participate in the evidence-based Stanford University Diabetes Self- Management Program. Patients of FHC or patients without a primary care provider who also had diabetes were offered an appointment with a primary care provider and a diabetes educator. All patients with pre-diabetes were invited to participate in the National Diabetes Prevention Program. In addition, Emergency Department testing, such as blood work and EKG results, were sent to the FHC to assist in the continuity of care. For all other patients with long term illness, a referral to the Chronic Disease Self-Management Programs (CDSMP) was offered. In addition, all patients with elevated glucose levels that did not have diabetes were invited to participate in the National Diabetes Prevention Program (NDPP).

The Institute for Family Health implemented the Diabetes Self-Management/ Chronic Disease Programs (DSMP/CDSMP) at some of their other health center sites. These programs are both evidence-based in their approach and were developed by the Stanford University Medical School.

The Diabetes Self-Management workshop was given 2½ hours once a week for six weeks in community settings such as churches, community centers, libraries and hospitals. People with type 2 diabetes attended the workshop in groups of 12-16. Workshops were facilitated by two trained Leaders, one or both of whom were peer leaders with diabetes themselves. They followed a detailed manual for the class.

Subjects covered included: 1) techniques to deal with the symptoms of diabetes, fatigue, pain, hyper/hypoglycemia, stress, and emotional problems such as depression, anger, fear and frustration; 2) appropriate exercise for maintaining and improving strength and endurance; 3) healthy eating 4) appropriate use of medication; and 5) working more effectively with health care providers. Participants will made weekly action plans, shared experiences, and helped each other solve problems they encountered in creating and carrying out their self-management program.

Classes are designed to be highly participatory. Mutual support and success build the participant's confidence in their ability to manage their health and maintain active and fulfilling lives. In addition, the program did not conflict with existing programs or treatment.

Each participant in the workshop received a copy of the companion book, "Living a Healthy Life with Chronic Conditions", 4th Edition, and an audio relaxation tape.

Source: http://patienteducation.stanford.edu/programs/diabeteseng.html

The Chronic Disease Self-Management Program is a workshop given two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries and hospitals. People with different chronic health problems attended together. Workshops were facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves.

Subjects covered included: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation; 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance; 3) appropriate use of medications; 4) communicating effectively with family, friends, and health professionals; 5) nutrition; 6) decision making and 7) how to evaluate new treatments.

Classes are highly participatory. Mutual support and success build the participants' confidence in their ability to manage their health and maintain active and fulfilling lives. The classes are designed to enhance regular treatment and disease-specific education for other conditions such as Better Breathers, cardiac rehabilitation, or diabetes instruction. This is important since many patients had more than one chronic condition. Treatment is not altered.
Source: http://patienteducation.stanford.edu/programs/cdsmp.html

The CDC-led National Diabetes Prevention Program is an evidence-based lifestyle change program for preventing type 2 diabetes. It can help people cut their risk of developing type 2 diabetes in half. Modest behavior changes helped participants lose 5% to 7% of their body weight. Adopting these lifestyle changes have be shown to help individuals with pre-diabetes reduce the risk of developing type 2 diabetes by as much as 58%. Participants worked with a lifestyle coach in a group setting during a one year program that included 16 core sessions (usually 1 per week) and 6 post-core sessions (1 per month).

The National Diabetes Prevention Program teaches strategies to participants so that they can incorporate physical activity into their daily lives and learn to eat healthy. Lifestyle coaches work with participants to identify emotions and situations that can sabotage their success, and the group process encouraged participants to share strategies for dealing with challenging situations.
Source: http://www.cdc.gov/diabetes/prevention

Non- identifiable data captured by FHC was shared with ERH so that we could track the progress and effectiveness of the referral program. Shared data will included:

- The number of patients who had an in-person meeting with a health coach or diabetes educator
- The number of patients who successfully attended at least four out of the six DSMP sessions
- The number of patients who successfully attended at least four out of the six CDSMP sessions
- The number of patients who successfully attended the NDPP program and lost 5% to 7% of their body weight and reduced their hemoglobin A1C level.

Program Outcomes

In 2015, because of staffing issues at the FHC, the DSMP and CDSMP classes were not held. Recruitment for the essential staff members continued with a goal to begin classes again in the spring of 2016.

During 2016, the Diabetes Collaborative made some progress in reaching diabetes patients for

participation in the DSMP classes. Sixty of the 323 FHC patients contacted about diabetes education had one-on-one visits with the FHC health coach which included some diabetes self-management education. Ten of those 323 patients started the DSMP which was offered in July of 2016 in the ERH conference room. Six of those participants completed four out of the six sessions.

In 2017, IFH completed the hiring FHC staff (diabetes educator and health coaches) including Spanish speaker for Diabetes Collaborative. In 2018, ERH hired a Community Health Worker (CHW) who assists with recruiting and scheduling of classes for chronic disease prevention and/or improved management.

In June of 2018, a DSMP class was held with individuals identified through the collaborative process. There were 13 individuals at the start of the class, 7 female, and 6 male. The program had a 67% attendance rate, with 3 participants completing 100% of workshops, and 8 participants attending 50% or more workshops. In October and November of 2018, a CDSMP course was held, with 13 participants at the start, 9 female and 4 male. Three participants attended 5 or more classes and were considered to have successfully completed the course. Three additional participants attended at least half the classes, for a total of 6 participants attending 50% or more of the program.

Intervention 2: Continued Development of the MAX Series Program – Managing Care for Super Utilizers

Priority Area #1: Promote Mental Health and Prevent Substance Abuse (Action Plan).
Focus Area 2 – Prevent substance abuse and other Mental Emotional Behavioral Disorders.
Goal #2.2 Prevent and reduce occurrence of mental, emotional and behavioral disorders among youth and adults.

> *Note: Mental Emotional Behavioral (MEB) disorder prevention includes substance abuse prevention as well as other MEB disorder prevention.*

In the region of southern Ulster County served by Ellenville Regional Hospital, there is a small percentage of the population (6%) that accounts for a disproportionate level of ED visits (43%) and inpatient admissions (52%) – members of this portion of the population have been deemed Super Utilizers.

Within that small portion of the population, quantitative and qualitative analysis revealed a significant subpopulation that was driving hospital utilization due to chronic pain. These visits were often resulting in the administration and/or prescription of opiates, which reflected a rise of opioid abuse in Ulster and adjacent counties.

Specific analysis of patients who had been to the ED 5+ times from January 2015 to October 2015 revealed a patient population of 64 individuals that accounted for 418 ED visits in that time period.

ERH and the Institute for Family Health which oversees the Family Health Center adjacent to ERH assembled a multidisciplinary team to focus on this population to better manage their chronic pain and to address any underlying substance use issues:

- Hospital Based Providers
- Care Navigators
- Health Center Providers
- Hospital Administration

- Health Center Administration

Overview of the Super Utilizer Program

The approach to managing the care for this patient population can be examined using four main categories:

1. **Patient Identification** - The team leveraged a flag in the electronic medical record (EMR) system to identify members of their target population when they came to the hospital. The flag was seen upon registry and downstream providers were alerted of Super Utilizer status.

2. **Planning** - In the planning phase of how to improve the care of the target population presenting to the ED for the management of chronic pain, the ED staff and hospital administration embraced a practice policy change to decrease the use of opioid medications in the ED. The policy change was planned, approved, announced and implemented January 1, 2016.

   Following the policy change, the process for patients presenting to the ED who were known to have chronic pain syndromes changed. When a patient was flagged as a Super Utilizer, this signaled to the providers in the ED that it was necessary to fill out a Drivers of Utilization (DoU) form. The DoU form was used to capture the underlying reason(s) that the Super Utilizers were presenting to the hospital, including challenges beyond medical diagnosis. The DoU form was shared with the IFH and helped track utilization of the cohort and share information about each individual's needs.

3. **Management** - In addition to a DoU form, Super Utilizers presenting to the hospital were to meet with an IFH Care Navigator. The Care Navigator‟s role was to support the coordination of follow-up appointments for the Super Utilizer at their primary care physician and other community based services that may be needed to address the underlying drivers of utilization. The Care Navigator also performed post-discharge telephone follow-up, contributed to the organization of team case conferencing and proactive telephone outreach aimed at reducing anxiety.

4. **Follow-up** - The team developed an integrated workflow between ERH and FHC that included a pain contract between the provider and patient. Adherence to this contract may play a role in setting criteria that allows for a patient to be considered „stable‟ and therefore no longer in need of the increased level of provider involvement in care.

Program Outcomes

There were a number of key insights attained through the efforts of this collaborative effort that supported a change in approach to managing care for Super Utilizers:

- Care Navigation services should be offered 24/7 to provide a "warm hand-off" for this difficult and complex population to assist them with their medical, social and behavioral needs.
- Provider education is key to changing practice patterns; this project is creating a new alternative to traditional care delivery and therefore requires support from hospital and medical staff leadership.

- The MAX cohort displayed a variety of psycho-social issues which required more non-medical staff involvement. The team benefited from expansion to include hospital case management, including social workers and other non-traditional staff as they could be more effective in outreaching to and forming relationships with patients.
- Case conferences are an important aspect to holistic patient care and care coordination. It was found to be a successful strategy for persistent Super Utilizers. The format included input from the primary care provider, emergency room, psycho-social staff and care management.

In addition to the lessons learned above, there are some key findings that can be applied more broadly to Super Utilizer programs to support success, including:

The key element of the team's success has been the ongoing, open communication between ERH and the FHC as well the diligent work of the Care Navigator. Also, the team was comprised of a small team of representatives that engaged community providers around the MAX project. This included meeting with individual community primary care providers to inform them of the project's efforts and potential benefits to their patients.

The hospital also developed and implemented a standardized chronic pain policy, which avoids the use of opioid-based medications for patients presenting to the ED. The policy was approved unanimously by the Medical Staff and then disseminated to the community providers. The standardized practice guidelines led to early success deterring the administration of opioids in the ED and allowed providers to point to a standard policy for opioid decisions, improving morale.

This collaborative program began partnering with a local Village Justice who is offering an innovative approach to criminal justice for those suffering from opioid abuse. Individuals arrested in Ellenville for opioid use (misdemeanor offenders with drug addictions) were be referred by Judge Parker to the IFH's Family Health Center for next day medication assisted treatment, along with the opportunity to enroll in a one year drug treatment program at the FHC. They will remain on probation as long as they comply with the program and are regularly returning to court every two months for compliance checks. Clearly the impact of the MAX program on the community and its residents has continued to expand.

In 2017 a new Super Utilizer cohort was identified. Developing the new cohort included incorporating a risk-stratification model to identify the high utilizer population. Best practices as well as lessons learned were incorporated into the process to better support the Super Utilizer population in the community.

This project, which focused on preventing opioid misuse by chronic pain patients who over utilize the hospital Emergency Department (ED), saw excellent progress in 2017. Specifically, the percentage of the Super Utilizer cohort with 2+ ED visits dropped from 98% from the study baseline (May - October 2015) to 4.6% as of August 2017. Similarly, the percentage of the Super Utilizer cohort who presented with 1+ opioid orders in the ED per month dropped from 100% for the baseline period to 5% in August 2017. Of the cohort of 64 patients, there was a 97% reduction in opioid administration through our ED, and an 84% decrease in visits to our ED.

The Care Navigator at IFH referred patients to pain management agencies, health care specialists, and primary care providers. These referrals contributed to the 84% reduction in hospital ED visits. The Care Navigator made referrals to food pantries, organizations providing respite, and others that deal with social determinants that hinder cohort member's ability to manage their health successfully.

During 2018, ERH hired a new Rural Health Network Executive Director who is certified by OASAS to train staff on SBIRT. Administrative staff met to discuss protocol for universal screening which will began in 2019. During 2018 the MAX Project maintained its successful rate of reducing repeat ED visits for chronic pain. Analysis in 2018 indicated that less than 2% of ERH patients received a prescription for or were administered an opioid medication during their visits. Comparatively, in 2018 the age-adjusted opioid analgesics prescription rate per 1,000 was 531.9.

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. **Your answers are strictly confidential, and all paper surveys will be shredded once the data entry is complete. Please do not write your name on the survey.**
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?

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