COMMUNITY SERVICE PLAN 2014-2016
Hospital Mission

Ellenville Regional Hospital will provide quality health care services through the use of available resources, to meet the need of the people who live, work or visit our surrounding communities. This health care will be delivered with a compassionate and respectful attitude, for the patients, their families and friends.

Description of Community Served

Population and General Demographics:
Ellenville Regional Hospital (ERH) is located in the Town of Wawarsing, Ulster County NY. ERH also serves the Village of Ellenville. Based on 2010 census data, Wawarsing had a total population of 13,157 (including the Village of Ellenville). Ellenville’s total population was 4,135. The service area includes the top 10 zip codes serviced by ERH.

<table>
<thead>
<tr>
<th>Racial Makeup</th>
<th>Town of Wawarsing</th>
<th>Village of Ellenville</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>73.2%</td>
<td>68.1%</td>
</tr>
<tr>
<td>Black and African American</td>
<td>15.3%</td>
<td>13.7%</td>
</tr>
<tr>
<td>American Indian and Alaska Native</td>
<td>0.8%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Asian</td>
<td>1.4%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Other Races</td>
<td>5.4%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Two or more Races</td>
<td>4.0%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Hispanic of any race</td>
<td>19.3%</td>
<td>27.9%</td>
</tr>
<tr>
<td>Median Age</td>
<td>40.1 years</td>
<td>35.9 years</td>
</tr>
<tr>
<td>Age 62 or older</td>
<td>16.4%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Households with Individuals Age 65 or Older</td>
<td>29.7%</td>
<td>24.8%</td>
</tr>
<tr>
<td>Households with Children Under Age 18 years</td>
<td>31.9%</td>
<td>38.4%</td>
</tr>
<tr>
<td>Tenant-Occupied Housing</td>
<td>36.1%</td>
<td>52.6%</td>
</tr>
</tbody>
</table>

2009-2010 Data

- Median Household Income: Wawarsing $55,603, Village of Ellenville $40,233
- Median Individual Worker’s Income: Wawarsing $30,948, Village of Ellenville $24,167

2009 Data

- Income Below Poverty Level: Wawarsing 22.4%, Ellenville 30.3%, New York State 18.2%
- Income Below 50% of Poverty Level: Wawarsing 8.5%, Ellenville 8.3%, New York State 6.4%

Located on the Ellenville Regional Hospital Campus is an Affordable Senior Housing project, a joint venture between the hospital and Warwick Properties, Inc. All three phases remain fully occupied, with approximately 156 senior citizens living independent in their one bedroom apartments. Funding was secured for the project by the New York
State Division of Housing and Community Renewal Housing Trust Fund. The Partnership is developing plans to build additional affordable housing for seniors, special needs populations and possibly returning Vets in close proximity to the Hospital.

Also located on our campus is 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 in New York State. The Institute is committed to high-quality, affordable health care for all. They strive for excellence at each of their 26 practices, while accepting all patients regardless of their ability to pay. They offer primary care, mental health, dental care, social work and many other services to patients of all ages. As a federally-qualified community health center (FQHC) network, they meet national standards for affordable, accessible, comprehensive health care services. They are 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.

Major Employers:
Our major employers are the NYS Department of Corrections, Ellenville Central School District, & Ellenville Regional Hospital.

Primary Social and Healthcare Factors:
There is a vastly poor population living in ERH’s catchment area. ERH is located in a federally designated Health Professional Shortage Area (HPSA) and Medically Underserved Area (MUA). There is a significant problem with the uninsured & underinsured having access to quality healthcare without ERH. Since the mid 1990’s, our community has lost over 1,000 good paying jobs, due in part to the loss of two major manufacturing employers and a significant decline in its tourist industry. The Town and Village struggle with the issues that accompany poverty and unemployment in rural areas.

According to the 2009 NYS Department of Health Expanded Behavioral Risk Factor Surveillance System final report, the rate of cardiovascular disease among adults in Ulster County was 9%, while the NYS rate was 7.7%. The rate of physician diagnosed angina, heart attack or stroke was 8.5%, while the NYS rate was 7.6%. The percentage of obese adults (BMI 30 or higher) in Ulster County was 24.9%, while the NYS rate was 23.1%. There is no specific data available for Ellenville or Wawarsing.

There has been no major change to the parameters of the Ellenville Regional Hospital Service Area since the 2012 CSP update was submitted.
Public Participation

The Ulster County Department of Health (UCDOH) took the lead in the organization and execution of a county-wide Community Health Assessment (CHA) in 2013. Ellenville Regional Hospital collaborated with UCDOH in the planning stages of the CHA, along with other key community partners such as Health Alliance of the Hudson Valley, The Institute for Family Health, Hudson River Healthcare, Mid-Hudson Medical Group, Ulster Prevention Council and the SUNY New Paltz/Center for Research, Regional Engagement and Outreach (CRREO).

As an example of the collaborative process, on May 21, 2013, a focus group, “A New Era of Prevention: Assess, Plan and Connect for a Healthier Ulster County” was convened to explore chronic disease prevention and treatment in Ulster County. The participants came from various community stakeholders, including local non-profits, local community groups, local hospitals, fitness centers, Ulster County Government, healthcare providers and centers, UCDOH, human services agencies, health insurance providers, retirement communities, local schools and academia, mental health and substance abuse treatment services and the media. Six groups were formed, focusing on the areas of either Mental Health and Substance Abuse, Diabetes, Heart Disease, and Cancer, with each group relating their area of focus to obesity. The diversity in the attendees helped to assure that varied populations were represented and able to participate in the focus group process. The data collected at the focus group revealed that community awareness is a priority in educating those in need of services and those who deliver services in Ulster County. However, community members face challenges and impediments in seeking such care due to economic difficulties and access to quality healthcare based on the rural nature of many of the communities where they reside.

Assessment and Selection of Public Health Priorities

The UDOH engaged CCREO to complete a comprehensive Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). In completing this process, CCREO utilized the results of the aforementioned focus groups, vital statistics, hospitalization data, behavioral risk surveys and locally generated research. While CCREO examined 39 health indicators, they identified 16 whose data revealed poorer outcomes as compared to a 2010 Ulster County CHA, current NY State averages, and current USA averages.
A focus group was convened on September 10, 2013 to discuss the findings of the CHA and to select the Prevention Agenda items to focus on as a County. The group employed the Hanlon Method, a quality Basic Priority Rating System to prioritize the 16 identified health indicators. The Hanlon Method considers the following criteria: the magnitude of the problem, the severity of the problem, the predicted effectiveness of the intervention, and the feasibility of intervening to address the problem. The larger focus group broke into smaller groups in order to score the 16 indicators in order of priority. The larger group then reconvened and the scores from the smaller groups were averaged out to arrive at a consensus for on each indicator.

The results of this process are as follows:

<table>
<thead>
<tr>
<th>Health Indicator</th>
<th>Size Rating</th>
<th>Seriousness Rating</th>
<th>Effectiveness Rating</th>
<th>TOTAL SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Use Among Children</td>
<td>8</td>
<td>9</td>
<td>9</td>
<td>234</td>
</tr>
<tr>
<td>Childhood Obesity</td>
<td>8</td>
<td>9</td>
<td>9</td>
<td>234</td>
</tr>
<tr>
<td>Asthma Hospitalizations (Child)</td>
<td>9</td>
<td>8</td>
<td>8</td>
<td>200</td>
</tr>
<tr>
<td>Unplanned Pregnancy</td>
<td>9</td>
<td>8</td>
<td>8</td>
<td>200</td>
</tr>
<tr>
<td>Tobacco Use Among Adults</td>
<td>8</td>
<td>9</td>
<td>8</td>
<td>200</td>
</tr>
<tr>
<td>Suicide Deaths</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td>184</td>
</tr>
</tbody>
</table>
As a result of these findings, the UCDOH has identified the NYS DOH Prevention Agenda areas of Chronic Disease and Mental Health & Substance Abuse as its focus for the next three years.

Results from the Hudson Valley Region Health Planning Initiative HEAL Phase 9 Final Report of March 2010 reveal that almost 25% of the population who earn less than $50,000 per year will be diagnosed with diabetes, with over 60% being obese or overweight. Given that Ellenville Regional Hospital is located in an economically-depressed area, with a high rate of cardiovascular disease and obesity, we chose to focus on diabetic and pre-diabetic condition under the Chronic Disease Prevention Agenda area.

### Diabetes & Overweight Incidence
#### Varies by Sex, Age and Income

<table>
<thead>
<tr>
<th>Income:</th>
<th>Diabetes</th>
<th>Overweight/Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$25,000</td>
<td>13%</td>
<td>61%</td>
</tr>
<tr>
<td>$25,000-$49,999</td>
<td>11%</td>
<td>70%</td>
</tr>
<tr>
<td>$50,000-$74,999</td>
<td>7%</td>
<td>58%</td>
</tr>
<tr>
<td>$75,000-$99,999</td>
<td>10%</td>
<td>65%</td>
</tr>
<tr>
<td>&gt;$100,000</td>
<td>7%</td>
<td>64%</td>
</tr>
<tr>
<td>Total</td>
<td>9%</td>
<td>63%</td>
</tr>
</tbody>
</table>

Source: Hudson Valley Region Health Planning Initiative HEAL Phase 9 Final Report March 2010
Depression and mental health issues are also of concern to the residents of Ulster County. While data is not available specifically for Wawarsing or Ellenville, data from the NY State Department of Health website reveals that the suicide mortality rate and poor mental health conditions indicators are more prevalent in Ulster County than they are in New York State, or in the United States as a whole.

**Ulster County Indicators For Tracking Public Health Priority Areas**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Prevention Agenda 2013 Objective</th>
<th>US</th>
<th>NYS</th>
<th>Ulster County</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENTAL HEALTH/SUBSTANCE ABUSE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide mortality rate (per 100,000)</td>
<td>4.8+ (2010)</td>
<td>11.9*</td>
<td>7.5*</td>
<td>11.0* (2008-2010)</td>
</tr>
<tr>
<td>% adults reporting 14 or more days with poor mental health in last month</td>
<td>7.8%</td>
<td>10.8%*</td>
<td>11.2%</td>
<td>13.6%* (2009)</td>
</tr>
</tbody>
</table>

*Source: http://www.health.ny.gov/prevention/prevention_agenda/indicators/county/ulster.htm*

In addition, data garnered from the NY State Expanded Behavioral Risk Factor Surveillance System, Ulster County, Final Report July 2008 - June 2009 reveals that Ulster County residents earning less than $50,000 show a higher reporting of poor mental health 14 or more days within the past month among adults than those in NY State as a whole.
Three Year Plan of Action

Diabetes and Pre-Diabetes Self-Management Collaborative

ERH will collaborate 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, will be referred to FHC’s on-site certified diabetes educators and health coaches (with patient’s permission) upon discharge. Patients with diabetes that are not patients of the FHC will
be invited to participate in the evidence-based Stanford University Diabetes Self-Management Program. Patients of FHC, or patients who have no primary care provider, with diabetes will be offered an appointment with a primary care provider and a diabetes educator. All patients with pre-diabetes will be invited to participate in the National Diabetes Prevention Program, a CDC evidence-based workshop. In addition, Emergency Department testing, such as blood work and EKG results, will be sent to 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) will be offered. In addition, all patients with elevated glucose levels that do not have diabetes will be invited to participate in the National Diabetes Prevention Program (NDPP).

The Chronic Disease/Diabetes Self-Management Programs (CDSMP/DSMP) are evidence-based programs developed by the Medical School at Stanford University and have been implemented by The Institute for Family Health at other selected health center sites.

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 attend together. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves.

Subjects covered include: 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.


It is the process in which the program is taught that makes it effective. Classes are highly participative, where mutual support and success build the participants’ confidence in their ability to manage their health and maintain active and fulfilling lives. It is designed to enhance regular treatment and disease-specific education such as Better Breathers, cardiac rehabilitation, or diabetes instruction. In addition, many patients have more than one chronic condition.

The Self-Management Program will not conflict with existing programs or treatment. It is designed to enhance regular treatment and disease-specific education such as Better Breathers, cardiac rehabilitation, or diabetes instruction. In addition, many patients
have more than one chronic condition. The program is especially helpful for these people, as it gives them the skills to coordinate all the things needed to manage their health, as well as to help them keep active in their lives.

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

The Diabetes Self-Management workshop is 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 attend the workshop in groups of 12-16. Workshops are facilitated from a highly detailed manual by two trained Leaders, one or both of whom are peer leaders with diabetes themselves.

Subjects covered include: 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 make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their self-management program. Physicians, diabetes educators, dietitians, and other health professionals both at Stanford and in the community have reviewed all materials in the workshop.


It is the process in which the program is taught that makes it effective. Classes are highly participative, where mutual support and success build the participants' confidence in their ability to manage their health and maintain active and fulfilling lives.

The program does not conflict with existing programs or treatment. Treatment is not altered. For medical questions, participants are referred to their physicians or diabetes educators. If the content of the workshop conflicts with instructions they receive elsewhere, they are advised to follow their physicians' orders and discuss discrepancies with the physician.

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

The National Diabetes Prevention Program (NDPP) encourages collaboration among federal agencies, community-based organizations, employers, insurers, health care professionals, academia, and other stakeholders to prevent or delay the onset of type 2 diabetes among people with pre-diabetes in the United States.
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.
- The Diabetes Prevention Program research study showed that making modest behavior changes helped participants lose 5% to 7% of their body weight—that is 10 to 14 pounds for a 200-pound person.
- These lifestyle changes reduced the risk of developing type 2 diabetes by 58% in people with pre-diabetes.
- Participants work with a lifestyle coach in a group setting to receive a 1-year lifestyle change program that includes 16 core sessions (usually 1 per week) and 6 post-core sessions (1 per month).

The National Diabetes Prevention Program teaches participants strategies for incorporating physical activity into daily life and eating healthy. Lifestyle coaches work with participants to identify emotions and situations that can sabotage their success, and the group process encourages participants to share strategies for dealing with challenging situations.

Source: [http://www.cdc.gov/diabetes/prevention/about.htm](http://www.cdc.gov/diabetes/prevention/about.htm)

Non identifiable data captured by FHC will be shared with ERH so that we may track the progress and effectiveness of referral program. Shared data will include:

- 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 CDSMP sessions
- The number of patients who successfully attended at least four out of the six DSMP 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.

After the program has successfully been implemented, we will seek to include other community partners, such as local pharmacies, senior centers and houses of worship, for referrals of at-risk community members into the program.

As part of the collaborative process, the program will be marketed by both ERH and FHC. The CDSMP/DSMP and NDPP programs will be facilitated by FHC and hosted at
ERH. Representatives from FHC and ERH will meet twice a year to track the progress of the program, and to make mid-course corrections as warranted.

Mental Health Collaborative

Access to health care services is very limited, particularly for behavioral health in the Ellenville area. The FHC is the only federally-qualified health center in the area, and the only facility which accepts patients regardless of ability to pay. There are a number of private group practices and hospital-based clinics, but very few providers offer behavioral health services or a sliding-fee scale. Most do not care for the uninsured, and few have links to the many social supports that patients require. County behavioral health services are particularly limited, focusing primarily on the seriously and persistently mentally impaired. Very few facilities in the area accept Medicaid; though Medicaid recipients comprise about 17% of the total county population, and over 40% of Ellenville’s FHC patients have Medicaid. Another 15% of patients are uninsured, though some may become eligible in 2014. Limited community awareness about behavioral health diagnoses and treatment also creates a barrier to seeking care.

National estimates show that nearly 40% of primary care patients present with at least one behavioral diagnosis; and that these conditions are more prevalent among older adults, those with chronic illnesses, and low-income individuals. These figures suggest that Ellenville service area residents are at an increased risk for these diagnoses, based on the higher prevalence of these groups at Ellenville FHC.

As a way to address the ongoing mental health conditions facing our community, ERH will collaborate with FHC on referrals from our Emergency Department for mental health counseling and treatment. ERH Emergency Department clinicians will make a direct referral to clinicians at FHC. FHC’s Psycho-social staff, who will be available 24-hours a day, will evaluate patients identified and referred by emergency room staff. The evaluation will be completed by a licensed social worker and/or psychiatric provider and will consist of a bio-psychosocial assessment that looks at a patient’s psychiatric history, risk factors, strengths, treatment history and other psychosocial stressors and current situation. The Psychosocial staff at FHC is trained to provide evidence based treatment for depression and have been trained in Problem Solving Treatment in Primary Care (PST-PC), Behavioral Activation (BA) and Motivational Interviewing (MI). These short term evidence based treatments will be provided to patients seeking individual treatment. Additionally Wellness Self-Management (WSM) Groups will be offered to patients where group treatment would be beneficial. FHC also has behavioral health providers who are trained to treat patients with co-occurring depression and addiction disorders.
Patients who are uninsured, or whose income falls under 200% of the federal poverty level, will be offered services at FHC under a sliding fee scale.

The tool used to assist Emergency Department clinicians in identifying patients who have depressive or suicidal tendencies will be the Patient Health Questionnaire (PHQ). The PHQ is a new instrument for making criteria-based diagnoses of depressive and other mental disorders commonly encountered in primary care. The PHQ is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The diagnostic validity of the PHQ has recently been established in 2 studies involving 3,000 patients in 8 primary care clinics and 3,000 patients in 7 obstetrics-gynecology clinics. The PHQ-9 is the depression module, which scores each of the 9 DSM-V criteria as “0” (not at all) to “3” (nearly every day). As a severity measure, the PHQ-9 score can range from 0 to 27, since each of the 9 items can be scored from zero to three. In addition to making criteria-based diagnoses of depressive disorders, the PHQ-9 is also a reliable and valid measure of depression severity. These characteristics plus its brevity make the PHQ-9 a useful clinical and research tool. The clinician scans the completed questionnaire, verifies positive responses, and applies diagnostic algorithms that are abbreviated at the bottom of each page. The PHQ assesses 8 diagnoses, divided into threshold disorders (disorders that correspond to specific DSM-IV diagnoses: major depressive disorder, panic disorder, other anxiety disorder, and bulimia nervosa), and sub-threshold disorders (disorders whose criteria encompass fewer symptoms than are required for any specific DSM-V diagnoses: other depressive disorder, probable alcohol abuse/dependence, somatoform, and binge eating disorder).

The PHQ-9 is available in many languages, such as English, Spanish and Chinese, as well as in an adolescent version.

Emergency Department patient’s ages 12 years or old who score higher than 10 on the PHQ-9, or who answer “yes” to question #9 will be immediately referred to the Behavioral Health Unit at FHC for evaluation and care as indicated above. Patients with pre-natal or post-natal depression will also be connected with the Healthy Families program at FHC.

Medicare patients diagnosed with major depressive disorder may also be eligible for a referral to a Health Home program. A Health Home is a care management service model whereby all of an individual’s caregivers communicate with one another so that all of a patient’s needs are addressed in a comprehensive manner. This is done primarily through a “care manager” who oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared among providers so that services are not duplicated or neglected. The health home services
are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual "Health Home."

Non identifiable data captured by FHC will be shared with ERH so that we may track the progress and effectiveness of referral program. Shared date will include:

- The number of patients who were referred to FHC based on their PHQ-9 scores
- The number of referred patients who scheduled and attended follow-up appointments with a Psycho-social staff
- The number of referred patients who treated with a Psychiatrist
- The number of patients who saw a decrease of 50% or 10 points on their PHQ-9 scores within 90-days of treatment
- The number of patients who participated in at least 3 forms of depression care treatment such as problem solving treatment, behavioral activation, or cognitive behavioral therapy.

**Dissemination of the Plan to the Public**

The Community Service plan will be printed and made available in all waiting rooms in the hospital. In addition, it will be available on www.ellenvilleregional.org and distributed to all members of our Board of Trustees.