

Bon Secours Community Hospital Community Health Needs Assessment

2019 - 2021

BON SECOURS COMMUNITY HOSPITAL
160 EAST MAIN STREET, PORT JERVIS, NY 12771

Bon Secours Community Hospital
A Member of the Westchester Medical Center Health Network

Community Health Needs Assessment 2019-2021

EXECUTIVE SUMMARY

Every three years, the New York State Department of Health requires Local Health Departments to submit Community Health Improvement Plans (CHIP) and hospitals to submit Community Service Plans (CSP) which require a thorough Community Health Assessment (CHA) to be completed. In addition, the IRS requires all non-profit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years and to adopt an implementation strategy to meet the identified community health needs. These assessments and subsequent action plans are meant to meet several requirements outlined by both New York State public health law and the Affordable Care Act.

In recent years, the New York State Department of Health has encouraged local hospitals and health departments to collaborate in the creation of joint CHIP/ CSP documents in order to better serve their communities. To that end, beginning in 2017, the seven Local Health Departments of the Mid-Hudson Region, including Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester Counties, along with HealthConnections (the Regional Health Information Organization covering the Hudson Valley of New York) created the Local Health Department Prevention Agenda Collaborative with the goal of creating the first regional Community Health Assessment for the Mid-Hudson Region.

Bon Secours Community Hospital contributed both funding and staff members to join the Collaborative in contract with Siena College Research Institute (SCRI). SCRI conducted a random digit dial regional community health survey to supplement the Regional Community Health Assessment. In order 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, members of the Collaborative held 12 focus groups with service providers to understand the needs of specific communities and populations, and the barriers they face to achieving optimal health.

As guidance for the Bon Secours Community Hospital Community Health Needs Assessment, all data gathered through the collaborative CHA process served as the required research and public input to identify public health needs and develop action plans necessary to address the specific needs of the communities we serve.

In this report we have identified both internal and community-wide resources that will work together to address the identified health needs of our community. The implementation plan included in this document outlines evidence-based interventions, resources, partners, and intended outcomes.

If you would like additional information on this CHNA, please email Barbara_Demundo@bshsi.org or call Bon Secours Community Hospital at 845-858-7000.

FACILITY DESCRIPTION AND VISION

Bon Secours Community Hospital:

Bon Secours Community Hospital, a member of the Westchester Medical Center Health Network, is geographically desirable for residents of New York, New Jersey and Pennsylvania alike; with 122 beds for acute care and medical/surgical services, including long-term care and behavioral health services. The hospital's Emergency Department features highly trained physicians, nurses and technicians, providing the Tri-State community with a vital, life-saving service.

Bon Secours Community Hospital offers the Bariatric Surgery Center of Excellence, a complete program dedicated to weight loss surgery, dietary counseling, and support groups to help the morbidly obese patients turn their life around. In addition to acute care services, Bon Secours Community Hospital houses a long term residential facility.

As a member of the Bon Secours Charity Health System, the Mission of Bon Secours Community Hospital is to make visible God's love and to be Good Help to Those in Need, especially those who are poor, vulnerable and dying. As a system of caregivers, we commit ourselves to help bring people and communities to health and wholeness as part of the healing ministry of Jesus Christ and the Catholic Church.

As a prophetic Catholic Health ministry, we will partner with our communities to create a more humane world, build health equity and social justice for all, and provide exceptional value for those we serve. We will continue to strive to be the leading provider of quality, compassionate and regional community health care services in the Hudson-Delaware Valley.

Westchester Medical Center Health Network:

The Westchester Medical Center Health Network (WMCHHealth) is a 1,700-bed healthcare system headquartered in Valhalla, New York, with 10 hospitals on eight campuses spanning 6,200 square miles of the Hudson Valley. WMCHHealth employs more than 12,000 people and has nearly 3,000 attending physicians. From Level 1, Level 2 and Pediatric Trauma Centers, the region's only acute care children's hospital, an academic medical center, several community hospitals, dozens of specialized institutes and centers, skilled nursing, assisted living facilities, homecare services and one of the largest mental health systems in New York State, today WMCHHealth is the pre-eminent provider of integrated healthcare in the Hudson Valley.

FACILITY SERVICE AREA AND DESCRIPTION OF COMMUNITY

Bon Secours Community Hospital is located in the City of Port Jervis, NY which is situated in the westernmost part of Orange County and bordered by the states of Pennsylvania and New Jersey. Orange County begins approximately 40 miles north of New York City, and is positioned between the Hudson River in the east and the Delaware River in the west, the only county in New York State to border both rivers. Ulster and Sullivan Counties border Orange County on the north, and Rockland County is located to the south. Orange County is 839 square miles and is a diverse mix of rural, farmland, suburban, and urban areas.

Orange County continues to experience steady population growth, with the 2010 Census indicating that Orange County grew 9.2% from 2000 to 2010 to now include 372,813 residents. The population of the City of Port Jervis is 8828.

Based on 2010 U.S. Census population estimates, the median age in Orange County has increased by more than 2 years since 2007, to 36.6 years; the largest cohort of residents is between the ages of 45 and 49. The number of residents ages 65-69 is forecasted to more than double from 2000-2020 primarily due to the entry of 'baby boomers' into these age ranges.

According to the U.S. Census, 11.1% of residents in Orange County were foreign born, with 22.3% of persons over the age of five speaking a language other than English at home.

Poverty rates in Orange County vary greatly based on municipality. Poverty rates exceeding 25% for families with related children under 18 are found in Orange County's three cities (Middletown, Newburgh, and Port Jervis), as well as in the town of Monroe.

Bon Secours Charity Health System, of which Bon Secours Community Hospital is a part, has defined a service area by zip codes within Orange, Rockland and Sullivan Counties based on the volume of inpatients receiving care at our acute care facilities.

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Bon Secours Charity Health System Service Area Zip Code Breakdown:

County	Zip-Code	Population	County	Zip-Code	Population
Rockland	10901	23,959	Rockland	10960	15,357
Orange	10916	4,265	Rockland	10965	15,149
Orange	10917	2,134	Orange	10969	1,403
Orange	10918	12,264	Rockland	10970	9,773
Rockland	10920	8,877	Orange	10973	2,322
Orange	10921	3,856	Rockland	10974	3,208
Rockland	10923	8,796	Orange	10975	291
Orange	10924	13,388	Rockland	10977	63,319
Orange	10925	4,061	Rockland	10980	13,997
Orange	10926	3,108	Rockland	10984	3,020
Rockland	10927	12,120	Orange	10987	3,280
Orange	10928	4,004	Rockland	10989	10,333
Orange	10930	8,784	Orange	10990	19,678
Rockland	10931	887	Rockland	10993	4,996
Orange	10940	49,194	Orange	10998	2,824
Orange	10941	13,242	Sullivan	12719	1,305
Orange	10950	49,712	Orange	12729	2,253
Rockland	10952	41,631	Sullivan	12737	2,074
Rockland	10954	23,226	Orange	12746	1,271
Rockland	10956	31,450	Orange	12771	14,061
Rockland	10960	15,357	Orange	12780	2,064

Bon Secours Charity Health System Service Area Patient Population Demographic Breakdown:

Population Demographic Characteristics			
	Population	Percentage of Mid-Hudson Region	Percentage of State
Orange	378,174	16.2	1.9
Rockland	325,027	14.0	1.6
Mid-Hudson	2,329,583	N/A	11.8
NYS	19,798,228	N/A	N/A

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Population Stratified by Sex				
	Male		Female	
	N	%	N	%
Orange	189,437	50.1	188,737	49.9
Rockland	159,227	49.0	165,800	51.0
Mid-Hudson	1,145,334	49.2	1,184,249	50.8
NYS	9,604,111	48.5	10,194,117	51.5

Population Stratified by Age										
	<5 years		5-19 years		20-34 years		35-64 years		≥65 years	
	N	%	N	%	N	%	N	%	N	%
Orange	24,827	6.6	84,117	22.2	71,658	18.9	148,560	39.2	49,012	12.9
Rockland	24,718	7.6	73,931	22.7	59,130	18.2	118,160	36.3	49,088	15.1
Mid-Hudson	135,754	5.8	467,151	20.1	422,422	18.1	941,303	40.4	362,953	15.6
NYS	1,176,877	5.9	3,554,995	18.0	4,288,714	21.7	7,769,291	39.3	3,008,351	15.2

Population Stratified by Race/Ethnicity											
	Non-Hispanic White		Non-Hispanic Black		Non-Hispanic Asian		Hispanic		Non-Hispanic Other*		
	N	%	N	%	N	%	N	%	N	%	
Orange	247,267	65.4	36,590	9.7	9,728	2.6	74,643	19.7	9,946	2.5	
Rockland	205,500	63.2	37,408	11.5	19,570	6.0	56,251	17.3	6,298	1.9	
Mid-Hudson	1,474,867	63.3	251,474	10.8	104,516	4.5	442,732	19.0	55,994	2.4	
NYS	11,071,563	55.9	2,842,869	14.4	1,639,345	8.3	3,726,238	18.8	518,213	2.5	

Population Stratified by Spoken Language												
	English		Language other than English		Spanish		Other Indo-European languages		Asian and Pacific Islander languages		Other languages	
	N	%	N	%	N	%	N	%	N	%	N	%
Orange	266,172	75.3	87,175	24.7	48,089	13.6	31,129	8.8	5,032	1.4	2,925	0.8
Rockland	185,140	61.6	115,169	38.4	40,495	13.5	58,243	19.4	11,489	3.8	4,942	1.6
Mid-Hudson	1,593,213	72.6	600,616	27.4	319,183	14.5	193,652	8.8	60,735	2.8	27,046	1.2
NYS	12,924,635	69.4	5,696,716	30.6	2,810,962	15.1	1,617,553	8.7	951,683	5.1	316,518	1.7

Source: U.S. Census Bureau, 2017 American Community Survey 5-year estimates

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Population 25 years and older	
	Population
Orange	240,447
Rockland	204,647
Mid-Hudson	1,570,660
NYS	13,660,809

Population Stratified by Educational Attainment								
	Less than High School Graduate		High School Graduate		Some college, no degree		Associate's degree or higher	
	N	%	N	%	N	%	N	%
Orange	24,494	10.2	71,195	29.6	49,182	20.5	95,576	39.7
Rockland	26,017	12.7	45,439	22.2	33,875	16.6	99,316	48.6
Mid-Hudson	177,335	11.3	377,325	24.0	262,838	16.7	753,162	48.0
NYS	1,895,439	13.9	3,591,287	26.3	2,169,152	15.9	6,004,931	44.0

Total Households	
	Households
Orange	126,460
Rockland	99,935
Mid-Hudson	811,321
NYS	7,302,710

Households Stratified by Income												
	<\$10,000		\$10,000-\$24,999		\$25,000-\$49,999		\$50,000-\$74,999		\$75,000-\$99,999		>\$100,000	
	N	%	N	%	N	%	N	%	N	%	N	%
Orange	5,981	4.7	14,904	11.8	22,560	17.8	19,693	15.6	16,470	13.0	46,852	37.1
Rockland	3,841	3.8	11,329	11.4	15,062	15.1	13,270	13.3	11,497	11.5	44,936	45.0
Mid-Hudson	36,649	4.5	91,125	11.2	135,356	16.7	119,400	14.7	95,259	11.7	333,532	41.1
NYS	516,085	7.1	1,055,677	14.4	1,440,269	19.8	1,160,508	15.9	865,640	11.9	2,264,531	31.1

Source: U.S. Census Bureau, 2017 American Community Survey 5-year estimates

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Population Stratified by Veteran Status			
	Civilian Population 18 years and older	Civilian Veterans	
	N	N	%
Orange	276,321	19,967	7.2
Rockland	234,951	9,180	3.9
Mid-Hudson	1,787,887	93,489	5.2
NYS	15,571,733	757,900	4.9

Source: U.S. Census Bureau, 2017 American Community Survey 5-year estimates

In New York State, nearly one in four adults, over 3.3 million people, have a disability. Adults with a disability typically have a higher rate of chronic conditions, such as obesity, heart disease, and diabetes. Structural and societal barriers can limit the ability to participate in work, recreation, and programs aimed at promoting healthy living for those living with a disability.

Various types of disabilities can affect an individual's quality of life. Types of disability include:

- Independent living disability – difficulty performing tasks or errands alone, such as visiting a doctor's office or shopping due to a physical, mental, or emotional condition
- Cognitive disability – serious difficulty concentrating, remembering, or making decisions due to a physical, mental, or emotional condition
- Self-care disability – difficulty handling tasks, such as dressing or bathing on one's own
- Mobility disability – difficulty moving around physically, such as walking or climbing stairs
- Hearing disability – deafness or serious difficulty hearing
- Vision disability – blindness or serious difficulty seeing (even when wearing glasses)

In the Mid-Hudson Region, Rockland County had the lowest percentage of adults living with a disability and Orange County had the highest percentage of adults living with a self-care disability.

Population Stratified by Type of Disability							
	Adults Living with Any Disability	Independent Living Disability	Cognitive Disability	Self-care Disability	Mobility Disability	Hearing Disability	Vision Disability
Orange	25.9%	7.0%	8.7%	4.8%	11.6%	6.6%	4.1%
Rockland	18.3%	5.1%	5.5%	4.0%	9.9%	2.6%	3.6%
NYS	22.9%	3.9%	8.7%	3.5%	13.3%	3.9%	3.7%

Source: NYSDOH Expanded Behavioral Risk Factor Surveillance System. 2018

CHNA METHODOLOGY AND COMMUNITY INPUT

Beginning in 2017, Bon Secours Community Hospital entered into a collaborative 7-County partnership to create a regional Community Health Assessment (CHA) which was directed by Orange County Epidemiologist Jackie Lawler and representatives from HealthConnections. This collaborative developed the Regional Community Health Assessment Survey (Appendix A) for the purposes of creating the CHA and to inform future health improvement efforts in the Mid-Hudson Region. This survey was designed to include questions to collect information around several initiatives and priorities put forward by the New York State Department of Health and the NYS Prevention Agenda 2019 -2024.

Survey data collection, analysis, and charting were provided by a team from Siena College Research Institute. SCRI administered a random digit dial survey by phone which took place between April and September of 2018, utilizing both landline and mobile phone numbers to reach respondents. Results were then weighted by gender, age, race, and region according to the U.S. Census 2010.

The Regional Community Health Assessment Survey collected responses from a randomized sample of over 5,000 Hudson Valley residents however, there were some populations that may not have been fully accounted for in the survey. Some of these underrepresented populations include those who are low-income, veterans, seniors, people experiencing homelessness, LGBTQ members, and people with a mental health diagnosis. In order to ensure that the needs of these populations were met, focus groups were conducted with providers that serve these populations by offering mental health support, vocational programs, nutritional and educational programs, and family and community support. Before these focus groups took place, a Stakeholder Interview Form (Appendix B) was sent out to these providers in order to supply additional insight around local factors influencing community health. This survey covered several topics, including the populations the providers serve; the issues that affect health in the communities they serve; barriers to people achieving better health; and interventions that are used to address social determinants of health. Throughout the seven counties in the Mid-Hudson Region, 285 surveys were completed by service providers. The answers to the survey varied throughout each county, and these differences were expanded upon in the focus groups.

The data from the CHA, Stakeholder Interview forms, and focus groups, along with BRFSS data, was presented at an Orange County Community Health Priority Selection Summit in June of 2019, where more than 100 local health/human services providers and CBOs assisted in the selection of each county's CHIP/CSP Focus Areas. At this Summit, 2 Priority Areas for the county were chosen within the framework of the 2019-2024 NYS Prevention Agenda.

For the purposes of aligning the county's collective resources to move towards achieving the NYS Prevention Agenda's goals, the chosen Priority Areas for Orange County are:

- Prevent Chronic Disease
- Prevent Communicable Disease

The Orange County Health Summary is presented in Appendix C.

IDENTIFIED COMMUNITY HEALTH NEEDS

To provide guidance for the Bon Secours Community Hospital CHNA, a Bon Secours Charity Health System Community Needs Steering Committee was formed to direct the CHNA process. This committee is responsible for prioritizing community needs and developing hospital-specific implementation plans to address the identified health needs. Committee members are also responsible for reporting outcomes on a yearly basis for the IRS 990 Schedule H.

Bon Secours Charity Health System Community Needs Steering Committee Members

Chief Executive Officer: Dr. Mary Leahy

Committee Co-chairs: Barbara Demundo and Jason Rashford

Executive Management Team Members: Sister Susan Evelyn, Patrick Schmincke

Finance Representative: David Albright

Population Health Representatives: Craig Dickman, Sapna Shah

Good Samaritan Hospital members: Dr. Adrienne Wasserman, Sheila Magee, Claudia Williams

Bon Secours Community Hospital members: Sophie Crawford, Mary Decker, Karen Murphy, Tobie Westward Milone

St. Anthony Community Hospital members: Anita Volpe, Dr. Mark Madis

The Bon Secours Community Hospital 2019 – 2021 CHNA Implementation Plan was developed by using evidence based interventions as recommended by the NYS Prevention Agenda 2019 – 2024. The overarching strategy of the NYS Prevention Agenda is to implement public health approaches that improve the health and well-being of entire populations and achieve health equity. This strategy includes an emphasis on social determinants of health, defined by Healthy People 2020 as the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The Prevention Agenda also forms the important framework through which community health needs are prioritized.

The Prevention Agenda's five Priority Areas serve as the blueprint for state and local action to improve the health of New Yorkers. As per the NYSDOH requirements, Bon Secours Community Hospital must choose a minimum of two health goals to address from among the following five priority areas:

- Prevent Chronic Diseases
- Promote a Healthy and Safe Environment
- Promote Healthy Women, Infants and Children
- Promote Well-Being and Prevent Mental and Substance Use Disorders
- Prevent Communicable Diseases

In partnership with the Orange County Health Department, Orange County hospitals, and health and human service agencies, Bon Secours Community Hospital has chosen the following Prevention Agenda goals to work towards over the next three years

- Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products by youth and young adults
- Promote tobacco use cessation
- Increase cancer screening rates for breast, cervical, and colorectal cancers
- Reduce the annual rate of growth for Sexually Transmitted Infections

COMMUNITY RESOURCES

Orange County, NY is resource-rich with an extensive network of health and human service agencies located throughout the county. In addition to these agencies, Orange County is home to five area hospitals, hundreds of medical providers, two-year and four-year colleges, a medical school and several large Federally Qualified Health Centers. Throughout the CHA process, these community partners assisted the Health Department to assess and prioritize health needs and many have made commitments to work towards the health goals of the county.

Bon Secours Community Hospital has chosen specific Prevention Agenda goals based on our internal expertise, resources, and the desire and commitment to improve the health and well-being of our community members. As no one entity can address all needs, community partners are essential to help achieve the Prevention Agenda goals. As a member of the Joint Membership of Health and Community Agencies (JMHC), Bon Secours Community Hospital works collectively with the member agencies to address the diverse needs within the county that the hospital could not do alone.

The following JMHC member agencies are uniquely positioned to serve as community resources to meet both specific and diverse community needs:

Access: Supports for Living	Legal Services of the Hudson Valley
Action Toward Independence	Maternal-Infant Services Network of Orange/Sullivan/Ulster
Alcoholism & Drug Abuse Council of Orange County	Mental Health Association of Orange County, Inc.
The ARC of Orange County, NYSARC, Inc.	Middletown Community Health Center
Catholic Charities of Orange and Sullivan	NAMI Orange
Cornerstone Family Healthcare	Orange County Department of Mental Health
CPI/Epilepsy Society of Southern New York	Orange County Housing Consortium
CRVI	People, Inc.
Dispute Resolution Center	RECAP, Inc.
Ezras Choilim Health Center	Rehabilitation Support Services, Inc.
Farmworkers Community Corp.	Restorative Management Corp.
Highland Rehabilitation and Nursing Center	Safe Harbors of the Hudson, Inc.
HONORehg, Inc.	Safe Homes of Orange County
Independent Living, Inc.	United Way of the Dutchess-Orange Region
Inspire	Youth Advocate Program
Jewish Family Service of Orange County	

EVALUATION OF IMPACT FROM PREVIOUS CHNA

Bon Secours Community Hospital's 2016 – 2018 CHNA had the following impact:

Goal:

Increase Access to High- Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings

Impact:

- BSCH completed onboarding use of Healthify to improve care coordination efforts with CBOs
- Construction of Medical Village began in Dec. 2018. Temporary ED will allow for a complete renovation of the current ED to include co-located Behavioral Health Services and an Observation unit.
- Investment in IT and internal BSCH Action Team to actively engage in the NYS MAX Series Project to reduce re-admission and provide steering to System work teams.
- BSCH has implemented Post Discharge Transition of Care 30 Day Telephonic Follow Up Program to reduce re-admissions.
- EHRs and data sharing services are utilized to provide patients with contact information of community partners to assist with access to preventive care and community resources.
- Ambulatory Care Managers work with Medical Group patients to ensure compliance with discharge instructions and to remove barriers.
- BSCH continues to utilize the Post Discharge Transition of Care Telephonic Follow Up Program to improve outcomes and reduce readmissions for post-discharge patients.

Goal:

Promote Mental, Emotional and Behavioral Well-Being in Communities

Impact:

- Behavioral Health Integration Coordinator is responsible for behavioral health integration into primary care by conducting clinical assessments and evaluations and delivering treatment services in individual and group formats. This role is designed to enhance screening, treatment and engagement within this population.
- Treatment and therapy is provided based upon the treatment plan developed by the multidisciplinary treatment team (PCP/LMHC/collaborating psychiatrist) and in partnership with the adult primary care practice.
- The Behavioral Health Integration Coordinator works with patients and their families/caregivers in creating effective psychiatric treatment plans and consults with community resources involved in patient's treatment plan.
- BSCH has continued the contract in with Access: Supports for Living to assist with care coordination and reduce re-admissions post Behavioral Health inpatient discharge. Peers are utilized to bridge gap during first 48 hours after discharge to help with medication pickup, connecting with provider and going to first appointment with provider.

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IMPLEMENTATION PLAN

NYS PREVENTION AGENDA PRIORITY AREA: PREVENT CHRONIC DISEASES

FOCUS AREA 3: Tobacco Prevention

PREVENTION AGENDA GOALS

3.1 Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products by youth and young adults

3.2: Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low SES; frequent mental distress/substance use disorder; and disability

OBJECTIVES: By December 31, 2021, decrease the prevalence of lifetime vaping product use by high school students by 20% from 25% to 22.5% and decrease the current tobacco use by high school students by 20% from 6.3% to 5.0%. (Data source: Orange County Youth Survey, 2016)

EVIDENCE BASED INTERVENTIONS

3.1.2: Use media and health communications to highlight the dangers of tobacco use and reshape social norms (Source: The Community Guide)

3.2.4: Promote Medicaid benefits for tobacco cessation services and free cessation classes available in Orange County particularly among target populations in Middletown and Port Jervis (Source: CDC)

DISPARITIES ADDRESSED: Adults with low SES, Adults living with a disability

Activities	Timeframe	Intermediate Level Evaluation Measures	Internal Staff and Resources	Community Implementation Partners	Intended Outcome/Product/Result
Create a media campaign including posters and advertisements through the County	January 2020-December 2021	Number of posters distributed	Bon Secours Charity Health System (BSCHS) Community Engagement	Orange County Health Dept., ADAC, Catholic Charities of Orange, Ulster and Sullivan Counties	Increased knowledge among youth regarding the dangers of vaping and combustible tobacco
Community presentations on the effects of smoking and vaping to high school age students	January 2019-December 2021	Number of presentations at schools and community events	BSCH Nursing and Respiratory departments	Port Jervis school districts, Operation PJ Pride, Orange County Health Dept.	Decrease in number of high school age students who begin smoking/vaping
Medicaid benefits promotion to target population Host Freedom from Smoking Classes	January 2020-December 2021	Number of persons completing Freedom from Smoking program	BSCH Nursing and Respiratory departments, BSCHS Community Engagement	Orange County Health Dept., Access: Supports for Living, Office for the Aging	Increased number of adults referred for tobacco cessation Increased number of individuals who quit smoking

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IMPLEMENTATION PLAN

NYS PREVENTION AGENDA PRIORITY AREA: PREVENT CHRONIC DISEASES

FOCUS AREA 4: Preventive Care and Management

PREVENTION AGENDA GOAL 4.1: Increase cancer screening rates for breast, cervical, and colorectal cancers, especially among disparate populations in the cities of Newburgh, Middletown and Port Jervis

OBJECTIVE: By 12/31/2021, increase % of adults receiving breast cancer, cervical, and colorectal cancer screenings based on the most recent screening guidelines by 5%. (Baselines: 75.9% Breast Cancer Screening; 76.1% Cervical Cancer Screening and 68.5% Colorectal Cancer Screening; Data Source: BRFSS, 2016)

EVIDENCE BASED INTERVENTIONS:

4.1.2: Conduct one-on-one (by phone or in person) and group education (presentation or other interactive session) in a church, home, senior center or other setting (Source: The Community Guide)

4.1.3: Use small media and health communications to build public awareness and demand (Source: The Community Guide)

DISPARITIES ADDRESSED: Low SES concentrated in areas with high racial/ethnic minorities; Education level

Activities	Timeframe	Intermediate Level Evaluation Measures	Internal Staff and Resources	Community Implementation Partners	Intended Outcome/Product/Result
Conduct community education sessions about need for cancer screenings at local libraries, senior centers, and community events	March 2020-December 2021	Number of individuals reached through one-on-one or group education that were referred to health providers for cancer screenings Change in awareness of the importance of cancer screenings as a preventative measure	Bon Secours Medical Group (BSMG) Breast Navigator, BSCHS Community Engagement	BSMG providers Orange County Health Dept.	Change in awareness of need for cancer screenings as part of preventative care Compliance with screening guidelines among individuals that were reached through one-on-one or group education Increase in the percentage of adults receiving cancer screenings

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<p>Develop consistent message across all entities to increase cancer screenings during awareness months for breast, cervical and colorectal cancers</p>	<p>June 2019- March 2020</p>	<p>Number and type of locations where posters were distributed</p> <p>Number of calls received about screening due to campaign</p>	<p>BSCH Radiology, BSCHS Community Engagement, BSMG</p>	<p>Orange County Health Dept.</p> <p>Orange County Cancer Prevention work group</p>	<p>Change in knowledge and awareness of need for cancer screenings</p>
<p>Evaluate how patients have found cancer screenings through surveys (i.e. newspaper, mailings, flyers, word of mouth, social media or other)</p>	<p>December 2019- December 2020</p>	<p>Number of community members surveyed at community events</p> <p>Percentages of how patients found cancer screenings by media type</p>	<p>BSCHS Community Engagement</p>	<p>Orange County Health Dept.</p> <p>Orange County Cancer Prevention work group</p>	<p>Increased knowledge of how patients are learning about cancer screening services</p> <p>Ability to target areas and markets for greater impact and community awareness</p>

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IMPLEMENTATION PLAN

NYS PREVENTION AGENDA PRIORITY AREA: PREVENT COMMUNICABLE DISEASES

FOCUS AREA 3: Sexually Transmitted Infections (STIs)

PREVENTION AGENDA GOAL 3.1: Reduce the annual rate of growth for STIs

OBJECTIVE #1: By December 31, 2021, reduce the annual rate of growth of chlamydia by 50% from 2.17% to 1.09%. (Baseline Data: 2016-2018 average 3-year percent change)

OBJECTIVE #2: By December 31, 2021, reduce the annual growth rate for gonorrhea by 50% from 4.0 to 2.0% (Baseline Data: 2016-2018 average 3-year percent change)

OBJECTIVE #3: By December 31, 2021, reduce the annual growth rate for early syphilis by 50% from 20% to 10% (Baseline Data: 2016-2018 average 3-year percent change)

(Data source: NYSDOH Communicable Disease Electronic Surveillance System (CDESS), 2016-2018)

EVIDENCE BASED INTERVENTION 3.1.2: Increase STI testing and treatment (Source: CDC)

DISPARITY ADDRESSED: People with low education level and/or low SES

Activities	Timeframe	Intermediate Level Evaluation Measures	Internal Staff and Resources	Community Implementation Partners	Intended Outcome/Product/Result
<p>OCDOH to provide in-person education to hospital Emergency Department Medical and Nursing staff</p> <p>Increase STI screening, testing and treatment in Emergency Department</p>	August 2019-December 2021	<p>Number of patients tested for chlamydia, gonorrhea, and syphilis</p> <p>Number of patients positive for chlamydia, gonorrhea, and/or syphilis</p> <p>Number of patients diagnosed with chlamydia, gonorrhea, and/or syphilis</p>	<p>BSCH Administration, BSCHS VP of Medical Affairs, BSCHS SVP of Mission, BSCH Medical Staff, Emergency Dept. staff, BSCHS Community Engagement</p>	<p>Orange County Health Dept.</p>	<p>Increased STI screening/testing in Emergency Department (ED)</p> <p>Increase in the number of patents with suspected STIs given prescription medication upon discharge from ED</p>

APPENDIX A

REGIONAL COMMUNITY HEALTH ASSESSMENT SURVEY

Hello, this is _____ for the Siena College Research Institute. We are working with local health departments and hospital systems to survey Hudson Valley residents to better understand the health status and health-related values of people who live in the community.

IF NEEDED:

You've been selected at random to be included in this survey. Your individual responses are confidential and no identifiable information about you will be shared with anyone—all responses are grouped together. The questions I am going to ask you to relate to your health and to your thoughts about health-related resources in your community. Again, your responses may really help to strengthen health policies and services.

IF NEEDED:

In total, the survey takes approximately _____ minutes to complete and you may refuse to answer any question that you do not want to answer. Are you able to help us with this important project? (NOW IS ALSO A TIME TO OFFER A CALL BACK AT A SPECIFIC, REQUESTED TIME AND PHONE NUMBER)

1. Overall, would you say that the quality of life in your community is excellent, good, fair or poor?
 - A. Excellent
 - B. Good
 - C. Fair
 - D. Poor

2. What State do you live in? [If not NY or CT, terminate]

3. What County do you live in? [If not Dutchess, Orange, Rockland, Putnam, Sullivan, Ulster Westchester or Litchfield CT (?), terminate]

4. What is your zip code? _____

5. How long have you lived in _____ County?
 - A. Less than 1 year
 - B. 1-5 years
 - C. More than 5 years

6. I'm going to read you a series of statements that some people make about the area around where they live, that is, their community. For each, tell me if that statement is completely true of your community, somewhat true, not very true or not at all true for your community.
 - A. There are enough jobs that pay a living wage.
 - B. Most people are able to access affordable food that is healthy and nutritious.
 - C. People may have a hard time finding a quality place to live due to the high cost of housing.
 - D. Parents struggle to find affordable, high-quality childcare.
 - E. There are sufficient, quality mental health providers.
 - F. Local government and/or local health departments, do a good job keeping citizens aware of potential public health threats.
 - G. There are places in this community where people just don't feel safe.
 - H. People can get to where they need using public transportation.

Bon Secours Community Hospital Community Health Needs Assessment

7. How important is it to you that the community where you live have the following?
- A. Accessible and convenient public transportation
 - B. Affordable public transportation
 - C. Well-maintained public transportation vehicles
 - D. Safe public transportation stops or waiting areas
 - E. Special transportation services for people with disabilities or older adults
8. Overall, how would you rate the community you live in as a place for people to live as they age?
- A. Excellent
 - B. Good
 - C. Fair
 - D. Poor
 - E. I don't know
9. For each of the following aspect of life, please rate it as excellent, good, fair, or poor in your community. Please let me know if you simply do not know enough to say.
- A. The availability of social/civic programs for seniors
 - B. The quality of health care services for seniors
 - C. The availability of programs and activities for youth outside school hours
 - D. The quality of information from county agencies during public emergencies, such as weather events or disease outbreaks
10. In general, how would you rate your health? Would you say that your health is excellent, good, fair or poor?
- A. Excellent
 - B. Good
 - C. Fair
 - D. Poor
11. Have you ever been told by a doctor or other health professional that you have any chronic health condition, such as high blood pressure, diabetes, high cholesterol, asthma or arthritis?
- A. Yes
 - B. No
12. If YES to 11--How confident are you that you can manage your physical health condition?
- A. Very Confident
 - B. Somewhat Confident
 - C. Not Very Confident
 - D. Not at all confident
13. Mental health involves emotional, psychological and social wellbeing. How would you rate your overall mental health? Would you say that your mental health is excellent, good, fair or poor?
AS NEEDED: This includes things like hopefulness, level of anxiety and depression.
- A. Excellent
 - B. Good
 - C. Fair
 - D. Poor
14. Have you ever experienced a mental health condition or substance or alcohol use disorder?
- A. Yes
 - B. No

15. If YES to 14--How confident are you that you can manage your mental health condition?

- A. Very Confident
- B. Somewhat Confident
- C. Not Very Confident
- D. Not at all confident

16. Thinking back over the past 12 months, for each of the following statements I read, tell me how many days in an AVERAGE WEEK you did each. Over the past 12 months how many days in an average week did you... (responses are 0 days, 1-3 days, 4-6 days or all 7 days)

- A. Ate a balanced, healthy diet
- B. Exercised for 30 minutes or more a day
- C. Got 7-9 hours of sleep in a night

17. On an average day, how stressed do you feel?

AS NEEDED: Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled.

- A. Not at all stressed
- B. Not very stressed
- C. Somewhat stressed
- D. Very stressed

18. In your everyday life, how often do you feel that you have quality encounters with friends, family, and neighbors that make you feel that people care about you? (IF NEEDED: For example, talking to friends on the phone, visiting friends or family, going to church or club meetings)

- A. Less than once a week
- B. 1-2 times a week
- C. 3-5 times a week
- D. More than 5 times a week

19. Have you smoked at least 100 cigarettes in your entire life?

- A. Yes
- B. No

20. If YES to 19, do you now smoke cigarettes every day, some days, or not at all?

- A. Everyday
- B. Some days
- C. Not at all

21. Pertaining to alcohol consumption, one drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. During the last 30 days, on the days when you drank, about how many drinks did you drink on average? [If respondent gives a range, ask for one whole number. Their best estimate is fine. If they do not drink, enter 0.] _____ drinks

22. [If Q21>0] Considering all types of alcoholic beverages, how many times during the past 30 days did you have **X [5 for men, 4 for women]** or more drinks on an occasion?

- A. _____ number of times
- B. None

Bon Secours Community Hospital Community Health Needs Assessment

23. How frequently in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

- A. Never
- B. Less than once per month
- C. More than once per month, but less than weekly
- D. More than once per week, but less than daily
- E. Daily

24. In the past 12 months, have you or any other member of your household been unable to get any of the following when it was really needed? Please answer yes or no for each item.

- A. Food
- B. Utilities, including heat and electric
- C. Medicine
- D. Any health care, including dental or vision
- E. Phone
- F. Transportation
- G. Housing
- H. Childcare

25. Have you visited a primary care physician for a routine physical or checkup within the last 12 months?

- A. Yes
- B. No

26. If NO to question 25, in the last 12 months, were any of the following reasons that you did not visit a primary care provider for a routine physical or checkup? (SELECT ALL THAT APPLY)

- A. I did not have insurance
- B. I did not have enough money (prompt if needed: for things like co-payments, medications)
- C. I did not have transportation
- D. I did not have time
- E. I chose not to go
- F. Other _____

27. Have you visited a dentist for a routine check-up or cleaning within the last 12 months?

- A. Yes
- B. No

If NO to question 27, in the last 12 months, were any of the following reasons that you did not visit a dentist for a routine check-up or cleaning? (SELECT ALL THAT APPLY)

- A. I did not have insurance
- B. I did not have enough money (prompt if needed: for things like co-payments, medications)
- C. I did not have transportation
- D. I did not have time
- E. I chose not to go
- F. Other _____

Sometimes people visit the emergency room for medical conditions or illnesses that are not emergencies; that is, for health-related issues that may be treatable in a doctor's office.

28. Have you visited an emergency room for a medical issue that was not an *emergency* in the last 12 months?

- A. Yes
- B. No

29. If YES to question 28, in the last 12 months, for which of the following reasons did you visit the emergency room for a non-health emergency rather than a doctor's office? (SELECT THE BEST OPTION)

- A. I do not have a regular doctor/primary care doctor
- B. The emergency room was more convenient because of the location
- C. The emergency room was more convenient because of the cost
- D. The emergency room was more convenient because of the hours of operation
- E. At the time I thought it was a health-related *emergency*, though I later learned it was **NOT** an emergency

If yes to 13 (behavioral health condition)

30. Have you visited a mental health provider, such as a psychiatrist, psychologist, social worker, therapist for 1-on-1 appointments or group-sessions, etc. within the last 12 months?

- A. Yes
- B. No

31. If NO to question 30, in the last 12 months, were any of the following reasons that you did not visit a mental health provider? (SELECT ALL THAT APPLY)

- A. I did not have insurance
- B. I did not have enough money (prompt if needed: for things like co-payments, medications)
- C. I did not have transportation
- D. I did not have time
- E. I chose not to go
- F. Other _____

32. How likely would you be to participate in the following types of programs aimed at improving your health? Would you be very likely, somewhat likely, not very likely or not at all likely?

- A. A mobile app based program on your smart phone
- B. An in person, one-on-one program
- C. An in person, group program
- D. An online, computer based, one-on-one program
- E. An online, computer based, group program

We are just about finished. These last few questions are about you.

33. Are you Hispanic?

- A. Yes
- B. No

34. What is your race?

- A. White
- B. Black
- C. Asian
- D. Other

35. Do you have health insurance?

- A. Yes
- B. No

36. What is your source of health insurance?

- A. Employer
- B. Spouse/Partner's employer
- C. NYS Health Insurance marketplace/Obamacare
- D. Medicaid
- E. Medicare
- F. None
- G. Other

37. What is your living arrangement? Do you...

- A. Rent an apartment or home
- B. Own your own
- C. Other living arrangement

38. What is your employment status?

- A. Employed full time
- B. Employed part-time
- C. Unemployed, looking for work
- D. Unemployed, not looking for work
- E. Retired

39. Are there children <18 living in your household?

- A. Yes
- B. No

40. Are you or anyone in your household a veteran or a member of active duty military service?

- A. Yes
- B. No

41. Do you or anyone in your household have a disability?

- A. Yes
- B. No

42. About how much is your total household income, before any taxes? Include your own income, as well as your spouse or partner, or any other income you may receive, such as through government benefit programs. (READ THE FOLLOWING OPTIONS)

- A. Less than \$25,000
- B. \$25,000 to \$49,999
- C. \$50,000 to \$99,999
- D. \$100,000 to \$149,999
- E. \$150,000 or more

43. What is your gender?

- A. Male
- B. Female
- C. Transgender/other gender

APPENDIX B

Stakeholder Interview Form

1. Name _____
2. Organization _____
3. Organization Website _____
4. Position _____

5. What is your service area?

- On website

6. Who do you serve? Please check all that apply

- Infants and toddlers
- Children
- Adolescents
- Adults
- Seniors
- Veterans
- English as a second language
- Women (services specifically for women)
- Men (services specifically for men)
- LGBTQ
- Those with a substance use disorder
- Those with a mental health diagnosis
- People with disabilities
- People experiencing homelessness
- Incarcerated or recently incarcerated
- Low income
- General population
- All the above

Bon Secours Community Hospital Community Health Needs Assessment

7. Thinking about the populations that you serve, what are the top 3 issues that affect health in the communities you serve?

- Access to affordable nutritious food
- Access to affordable, decent and safe housing
- Access to affordable, reliable transportation
- Access to affordable, reliable public transportation
- Access to culturally sensitive health care providers
- Access to affordable health insurances
- Access to clean water and non-polluted air
- Access to medical providers
- Access to mental health providers
- Access to high quality education
- Access to specialty services/providers

8. Which of the following are the top 3 barriers to people achieving better health in the communities you serve?

- Knowledge of existing resources
- Geographic location – living in an urban area
- Geographic location – living in a rural area
- Health literacy
- Having someone help them understand insurance
- Having someone to help them understand their medical condition
- Having a safe place to play and/or exercise
- Quality of education
- Attainment of education
- Drug and/or alcohol use
- Cultural Customs
- Other (specify) _____

9. Besides lack of money, what are the underlying factors and barriers to solving the top 3 issues you identified in the communities you serve?

10. What evidence-based interventions (if any) do you use that target your populations to address the social determinants of health?

11. As we go through the following list of health issues, please rate from 1 to 5 the impact of the health issues in your service area with 1 being very little and 5 being highly impacted.

Chronic Disease (e.g. heart disease, diabetes, asthma, obesity, cancer, etc.)

(Very Little) 1 2 3 4 5 (Highly Impacted)

Health Disparities

(Very Little) 1 2 3 4 5 (Highly Impacted)

Mental Health and Substance Use Issues

(Very Little) 1 2 3 4 5 (Highly Impacted)

Maternal and Child Health issues

(Very Little) 1 2 3 4 5 (Highly Impacted)

Environmental Factors (e.g. built environment, air/water quality, injuries, falls, food safety)

(Very Little) 1 2 3 4 5 (Highly Impacted)

Prevent Communicable diseases (e.g. sexually transmitted infections, hepatitis C, HIV, vaccine preventable disease, hospital acquired infections, etc.)

(Very Little) 1 2 3 4 5 (Highly Impacted)

APPENDIX C ORANGE COUNTY HEALTH SUMMARY

Orange County is located in the southeastern area of New York State, bounded on the east by the Hudson River and on the west by the Delaware River. It is located approximately 40 miles north of New York City with 40 municipalities and approximately 378,174 residents in 2017. Of Orange County residents, 50.1% are male, 68.5% are non-Hispanic White, 9.7% are non-Hispanic Black and 19.7% are Hispanic. Orange County is a mix of urban, suburban, farmland and rural areas. 24.0% of the population resides in rural areas, twice the average of New York State. Agriculture is a leading industry in Orange County and constitutes more than half of the County's open space. The availability of multiple modes of transportation, including bus, train and major highways, allow residents to travel to New York City, New Jersey, and Southern New York State for employment. Orange County also contains New York Stewart International Airport in Newburgh, NY and West Point Military Academy in Highland Falls, NY. At first glance, Orange County appears to be an affluent suburban community that enjoys a median household income above the New York State average (\$75,146 vs. \$62,765, respectively); a smaller percentage of individuals living below the poverty line (12.2% vs. 15.1% respectively); a smaller unemployment rate (5.6% vs. 6.6%, respectively); and boasts a higher percentage of high school graduates as compared to New York State (89.6% and 86.1%, respectively). However, aggregate county data are misleading and masks the disparities within the County. The urban areas of Orange County are characterized by severe socioeconomic and health inequities, with one-third of the population living below the poverty line and residing in the three major cities (Newburgh, Middletown, and Port Jervis).

AREA OF FOCUS

Heart disease and cancer are the leading causes of death and leading causes of premature death (death before age 75) by a large margin. Obesity is a leading contributor to these top causes of death, as well as diabetes, stroke, and hypertension, all of which can lead to premature death. According to 2016 BRFSS data, nearly 70% of Orange County adults are either overweight or obese. Data from 2016-2018 show that 36.8% of school-aged children and adolescents are overweight or obese. Over the past ten years, the rates of obesity have continually grown, as well as the subsequent morbidity of cardiovascular disease, prediabetes, and hypertension.

STIs are on the rise in Orange County. There has been a 75% increase in the average number of newly diagnosed HIV cases in Orange County from 17.2 per year (2011-2015) to 26.3 per year (2016-2018). Chlamydia rates among both males and females from 2014-2016 are higher in Orange County than rates in the Mid-Hudson Region, and have steadily increased or remained the same from 2011-2013 to 2014-2016. Additionally, Orange County had its first fetal demise in 2019 from congenital syphilis in over 25 years.

Emerging issues are STIs, Opioid burden, Youth-related electronic vaping, and Prediabetes among adults. Other health areas where Orange County is worse than New York State or getting worse since the last assessment include:

- Overdose deaths due to opioid and heroin use
- Premature births among non-Hispanic Black women and Hispanic women
- Preventable adult hospitalizations
- Youth-reported alcohol and electronic vaping product use
- Unintended pregnancy among non-Hispanic Black women and Hispanic women

COMMUNITY SURVEY DATA POINTS OF NOTE

As part of the Community Health Assessment Process, the Orange County Department of Health (OCDOH) participated in the Mid-Hudson Region Community Health Survey, in partnership with the six other Mid-Hudson Region local health departments, HealthConnections, and area hospitals, to collect data on 850 residents to help better characterize the needs of the community. Below are data points of note:

- 81% of Orange County respondents reported that accessible and convenient transportation was “very important” or “somewhat important” to them
- 80% of Orange County respondents reported that people may have a hard time finding a quality place to live due to the high cost of living
- 39% of Orange County respondents living in rural areas reported that places in Orange County did not feel safe vs. 54% of Orange County respondents living in urban zip codes
- 27% of Orange County respondents with <\$25K yearly income reported experiencing a mental health condition or substance or alcohol use disorder compared to 14% of total Orange County respondents
- 28% of Orange County respondents with <\$25K yearly income reported that in the past 12 months, they or any other member of their household has been unable to get food compared to 11% of total Orange County respondents
- 35% of Orange County respondents with <\$25K yearly income reported that in the past 12 months, they or any other member of their household has been unable to get medicine compared to 14% of total Orange County respondents

ASSETS AND RESOURCES

OCDOH has strong community partnerships with hundreds of organizations serving its residents, including five area hospitals, federally qualified health care centers, private medical providers, local two-year and four-year colleges, a medical school, community-based organizations, and regional organizations serving a broad variety of community needs. OCDOH has established multiple coalitions, including Healthy Orange, the Maternal and Infant Community Health Collaborative, Orange County Health Disparities Initiative Planning Committee, and the Orange County Cancer Screening Collaborative, in addition to co-leading and participating on a large number of countywide coalitions, such as changing the Orange County Addiction Treatment Ecosystem, WELCOME Orange, and the Resilience Project. These coalition partners will be mobilized to address the health areas of focus and emerging issues for the CHA/CHIP 2019-2021 cycle.

EFFORTS MOVING FORWARD

In addition to participating in the Mid-Hudson Region Community Health Survey, a service provider survey and subsequent focus group were conducted in March 2019, in partnership with the Joint Membership of Health and Community Agencies (JMCA), to collect data on underrepresented populations, including low-income, veterans, persons experiencing homelessness, the aging population, LGBTQ community, and people with a mental health diagnosis or those with a substance use disorder. 41 responses were collected and three underlying issues that impact the health of the populations served by their agencies were identified as follows: 1) Access to affordable, decent and safe housing; 2) Access to affordable, reliable public and personal transportation; and 3) Access to mental health providers.

OCDOH also created a Community Health Assessment Data Review Guide, as a review of 140 of the most current secondary data indicators available, stratified by the NYSDOH Prevention Agenda Areas for Orange County and New York State. Where available, trends from the previous year and comparison data from New York State were included. This document is available on the County website and was provided at the Orange County Health Summit on June 4, 2019. Over 100 partners, including hospitals, health care providers, community-based organizations, and academia, were in attendance to review the most current data; select the two Prevention Agenda Priorities for the 2019-2021 Community Health Improvement Plan (CHIP); and discuss both assets and barriers to addressing the two selected priority areas. Participants signed up to participate in ongoing strategic planning and implementation efforts for the 2019-2021 CHIP cycle. Each focus area chosen will have a corresponding workgroup co-led by OCDOH and area hospital staff. These workgroups will report out at the larger yearly Orange County Health Summit to share the ongoing efforts of the CHIP to other workgroups and the community.

