

Community Health Needs Assessment 2016-2018

Bon Secours Community Hospital, Port Jervis, NY

Executive Summary

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

For nearly a century, Bon Secours Community Hospital in Port Jervis, New York, has served the residents of Western Orange County, New York, Pike County, Pennsylvania, and Northern Sussex County, New Jersey, as the area's premier healthcare provider. The hospital serves its community with 122 beds for acute care and medical-surgical services, a 24-hour emergency department, long-term care and rehabilitation, a dedicated bariatric surgery unit, behavioral health, and outpatient services.

Westchester Medical Center Health Network

The Westchester Medical Center Health Network (WMCHealth) 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. WMCHealth 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 WMCHealth is the pre-eminent provider of integrated healthcare in the Hudson Valley.

WMC is the anchor institution for a DSRIP (Delivery System Reform Incentive Payment Plan) Performing Provider System (PPS) in the Hudson Valley region of New York State that spans eight counties. As part of its DSRIP planning efforts, WMC led a comprehensive, collaborative Community Needs Assessment (CNA), recognizing the integral role that a CNA plays in supporting the delivery of patient-centered, population-based health care. This eight county CNA was undertaken in collaboration with Westchester Medical Center, Montefiore Medical Center, Refuah Health Center, and Health Alliance of the Hudson Valley.

In addition to performing a CNA, all hospitals in New York State (NYS) are required to submit a three year Community Service Plan to the NYS Department of Health by December 31, 2016. NYS mandates that each Community Service Plan is based on the NYS Prevention Agenda 2013-18. This Prevention Agenda is the blueprint for state and local action to improve the health of New Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disability, socioeconomic and other groups who experience them.

Based on data from the above mentioned CNA and the NYS Prevention Agenda priorities, the most significant health needs of our service area are as follows:

- Prevent Chronic Diseases
- Promote Healthy and Safe Environments
- Promote Healthy Women, Infants and Children
- Promote Mental Health and Prevent Substance Abuse
- Prevent HIV/STDs, Vaccine-Preventable Disease and Healthcare Associated Infections

The Prevention Agenda priorities and goals outlined in this CNA form the framework through which we will address the health needs of our community. If you would like additional information on this CNA please contact Bon Secours Community Hospital at 845-858-7000.

FACILITY DESCRIPTION AND VISION

Bon Secours Community Hospital 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.

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.

Inspired by the Healing Ministry of Jesus and the Charisms of Bon Secours and the Sisters of Charity of Saint Elizabeth, the Bon Secours Charity Health System by the year 2018, will be distinguished as the leading provider of quality, compassionate and regional community health care services in the Hudson-Delaware Valley.

SECTION I: FACILITY SERVICE AREA AND DESCRIPTION OF COMMUNITY

Bon Secours Community Hospital is located in the city of Port Jervis, NY and is in the westernmost part of Orange County, bordering the states of Pennsylvania and New Jersey. Orange County comprises approximately 816 square miles. Orange County continues to experience steady population growth, with the 2010 Census indicating that Orange County grew 9.2% from 2000 to 2010, and now includes 372,813 residents.

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, largely due to the impact of the village of Kiryas Joel, where the poverty rate is more than 4 times the county average.

SECTION II: METHODOLOGY

In July 2014 the CNA leadership of the PPS in the Hudson Valley Region partnered to undertake an extensive regional assessment of community needs. We recognized the integral role that a community needs assessment plays in supporting the delivery of patient-centered, population-based health care. We were guided by the CDC's Community Health Assessment and Group Evaluation (CHANGE) toolkit. The needs and opinions of community stakeholders across sectors were gathered in a systematic way that included compilations of data into workbooks, chart books, and map books; surveys; focus groups, key informant interviews; and a public comment period. Rigorous analysis of extant health, socio-demographics, and built environment data enhanced our ability to identify DSRIP projects that focus interventions on individuals and communities most in need.

Our CNA utilized the power of geospatial data analysis to inform project selection and planning. The needs assessment was designed within a geographic information science (GISc) framework. GISc and spatial analyses were used to identify particular population-based health issues. For example, access to care at clinics or hospitals, socio-economic data and patterns of disease burden by population and region have all been assessed utilizing this framework. Detailed-level SPARCS (Statewide Planning and Research Cooperative System) data provided by our academic colleagues at Iona College, along with Medicaid claims data accessed through Health.NY.Gov dashboard, combined with Census information, were mapped to identify community needs by prevalence indicators for major diagnostic categories. Using SPARCS data we identified patients' ER visits, hospitalizations and readmissions and analyzed trends over the past three years to identify negative quality indicators.

We worked with the other three PPS partners in our region and county health department teams to coordinate local surveys about capabilities (e.g., health IT, Community Resources, Healthcare Resources, consumer survey, focus groups) to supplement what was available on secondary websites. Conforming to our goal of improving population health, we isolated "hot and cold spots" (statistical clusters of zip codes with values higher or lower than would be expected). This approach was expanded to include variables from a range of other sources (e.g., American Community Survey, Vital Statistics, DSRIP dashboards) related to outcomes and sociodemographic determinants (e.g., poverty, English-speaking ability, race/ethnicity, employment, physical activity). Select narrative and community profiles were developed for hot spot zip codes so that community "stories" could more easily be shared with stakeholders. To ensure broad representation across all community sectors, we met with and sought input from local teams established by each county DOH. All data analyses and chart, map and work books were shared as they were developed with providers and stakeholders across the region through public meetings with county health commissioners and project team meetings conducted by the PPS in the region.

As part of the CNA, the PPS conducted a survey of Hudson Valley consumers to gather information and feedback about demographics and community health needs. The survey was drafted at a sixth grade reading level and reviewed and approved by health literacy experts. It is available online and in paper form in five languages prevalent in the Hudson Valley: English, Spanish, Portuguese, French Creole, and Yiddish. The survey received almost 5,000 responses from respondents living in 303 ZIP codes across the eight counties and respondent demographics are representative of the overall region.

CNA Survey Timeline:

Prior to Mid-September 2014

- Prepared, translated and finalized survey instruments; created public facing websites as platforms for data collection and communication
- Distributed survey through email and postal mail to DOH and PPS partners; carried out public awareness campaigns
- Commenced data collection

Mid-September- December 2014

- Continued with data collection and entry
- Conducted quality assurances and data cleaning
- Performed preliminary data analysis for PPS's DSRIP applications

January 2015- March 2015

- Completed data collection and entry
- Completed data cleaning and quality assurances
- Conducted data analyses and disseminated research findings

CNA Survey Key Findings for Orange County:

Top ranked health issues in the community y respondents (out of 17):

- Diabetes*¥
- Obesity
- Mental Health
- Cancer*
- Heart Disease*

**Top 3 leading causes of death in NYS, according to the NYS DOH Vital Statistics*

¥One of the leading causes of death among minority populations

Orange County - Health Services Access & Utilization Take Away Points:

Among the 8% of respondents that did not have a routine physical check-up and 30% of respondents that did not have a routine dental check-up, cost, time, fear, and the quality of care were some of the barriers for participants to access good primary and preventive care.

Respondents from Orange County also reported the highest rate (30%) of Emergency Department utilization in the past year, compared to the region. Diabetes, obesity, mental health, and cancer were identified among the top community health issues, yet 9% - 23% of respondents did not know where to get basic preventive care for these conditions.

The complete One Region, One CNA Orange County document can be found at the end of this report.

SECTION III: IDENTIFIED HEALTH NEEDS

The Prevention Agenda 2013-2018 is New York State's health improvement plan for 2013 through 2018, developed by the New York State Public Health and Health Planning Council (PHHPC) at the request of the Department of Health, in partnership with more than 140 organizations across the state. This plan involves a unique mix of organizations including local health departments, health care providers, health plans, community based organizations, advocacy groups, academia, employers as well as state agencies, schools, and businesses whose activities can influence the health of individuals and communities and address health disparities.

The Prevention Agenda will serve as a guide to local health departments as they work with their community to develop mandated Community Health Assessments and to hospitals as they develop mandated Community Service Plans and Community Health Needs Assessments required by the Affordable Care Act.

All hospitals in New York State (NYS) are required to submit a three year Community Service Plan to the NYS Department of Health by December 31, 2016. NYS mandates that each Community Service Plan is based on the NYS Prevention Agenda 2013-18. The Prevention Agenda establishes goals for each priority area and defines indicators to measure progress toward achieving these goals, including reductions in health disparities among racial, ethnic, and socioeconomic groups and persons with disabilities.

Prevent Chronic Diseases

Chronic diseases such as cancer, heart disease, stroke and asthma are among the leading cause of death and disability for New Yorkers, accounting for approximately 70 percent of all deaths. In addition, chronic diseases affect the daily living of one out of every ten New Yorkers. Key focus areas include reducing obesity in adults and children; reducing death, disability and illness related to tobacco use and secondhand smoke exposure; and increasing access to high-quality chronic disease preventive care and management in clinical and community settings.

Promote Healthy and Safe Environments

Enhancing the quality of our physical environment – air, water, and the "built" environment – can have a major impact on public health and safety. The Prevention Agenda establishes four focus areas to achieve this objective: improving outdoor air quality; increasing the percentage of New Yorkers who receive fluoridated water and reducing health risks associated with drinking water and recreational waters; enhancing the design of communities to promote healthy physical activity and reducing exposure to lead, mold and toxic chemicals; and decreasing injuries, violence and occupational health risks.

Promote Healthy Women, Infants and Children

Recognizing that key population indicators related to maternal and child health have remained stagnant, or in some cases worsened in the past decade, the Prevention Agenda has established focus areas for maternal and infant health; child health; and reproductive, pre-conception and inter-conception (between pregnancies) health. Goals include reducing pre-term births and maternal mortality; promoting breastfeeding; increasing the use of comprehensive well-child care; preventing dental cavities in children; preventing adolescent and unintended pregnancies; and promoting greater utilization of health care services for women of reproductive age.

Promote Mental Health and Prevent Substance Abuse

At any given time, almost one in five young people in the U.S. is affected by mental, emotional or behavioral disorders such as conduct disorders, depression or substance abuse. The Prevention Agenda recognizes that the best opportunities to improve mental health are to initiate interventions before a disorder manifests itself. The Prevention Agenda calls for greater utilization of counseling and education; clinical and long-lasting protective interventions to promote mental, emotional and behavioral well-being in communities; preventing substance abuse; and strengthening the infrastructure across various systems to promote prevention and better health.

Prevent HIV/STDs, Vaccine-Preventable Disease and Healthcare Associated Infections

The Prevention Agenda strategy will promote community-driven prevention efforts to promote healthy behaviors, increase HIV testing, and reduce the incidence of diseases. The Prevention Agenda focuses on promoting early diagnosis and treatment of HIV and sexually transmitted diseases (STDs); improving rates of childhood immunizations, especially children aged 19-35 months; and encouraging greater utilization of sanitary procedures in hospitals and other health care facilities to reduce the potential for healthcare-associated infections.

SECTION IV: PRIORITY NEEDS AND 3-YEAR IMPLEMENTATION PLAN

An internal steering committee reviewed CNA data and prioritized interventions. Steering committee members included Jason Rashford, Director Building Healthy Communities, Barbara Demundo, RN, Director Community Outreach, Dr. Deborah Viola, MBA, PhD, and Thao Doan, MPH, Dr.PH. The steering committee identified two priority areas as the main objectives of our community health improvement strategies over the next three years. We determined these priority areas in partnership with the Bon Secours Charity Population Health department, and Jackie Lawler, MPH, Epidemiologist, Orange County Dept. of Health.

Bon Secours Community Hospital has established a Three-Year Implementation Plan to address these Priority Needs in conjunction with other resources in our community. The planned interventions are a means to achieving the NYS 2013-2018 Prevention Agenda objectives, and WMC Health DSRIP Project Milestones and Deliverables. The following two focus areas are the main objectives for our community health improvement strategies over the next three years:

1) Prevent Chronic Diseases

2) Promote Mental Health and Prevent Substance Abuse

Focus Area 1: Prevent Chronic Diseases

Evidence-Based Intervention for Focus Area 1: Increase Access to High-Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings

Action Plan: Create a Medical Village

The following interventions are included in the WMC Health PPS Implementation Plan Provider Engagement Actively Engaged Patients:

Milestone 1: Convert outdated or unneeded hospital capacity into an outpatient services center, stand-alone emergency department/urgent care center or other healthcare related purpose. Targeted completion date: 3/31/19

Milestone 2: Provide a detailed timeline documenting the specifics of bed reduction and rationale. Specified bed reduction proposed in the project must include active or “staffed” beds. Targeted completion date: 3/31/17

Milestone 3: Ensure that all participating PCP’s meet NCQA 2014 Level3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3. Targeted completion date: 3/31/18

Milestone 4: Ensure that all safety net providers participating in Medical Villages are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts, and patient record look up. Targeted completion date: 3/31/18

Milestone 5: Use EHRs and other technical platforms to track all patients engaged in the project. Targeted completion date: 3/31/17

Milestone 6: Ensure that EHR systems used in Medical Villages meet Meaningful Use Stage 2. Targeted completion date: 3/31/18

Milestone 7: Ensure that services which migrate to a different setting or location (clinic, hospitals, etc.) are supported by the comprehensive community needs assessment. Targeted completion date: 3/31/17

Focus Area 2: Promote Mental Health and Substance Abuse

Evidence-Based Intervention for Focus Area 2: Promote Mental, Emotional and Behavioral Well-Being in Communities

Action Plan: Integration of Primary Care and Behavioral Health Services

The following interventions are included in the WMC Health PPS Implementation Plan Provider Engagement Actively Engaged Patients:

Milestone 1: Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DSRIP Year 3. Targeted completion date: 3/31/18

Milestone 2: Develop collaborative evidence-based standards of care including medication management and care engagement process. Targeted completion date: 3/31/17

Milestone 3: Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs. Targeted completion date: 3/31/18

Milestone 4: Use EHRs or other technical platforms to track all patients engaged in this project. Targeted completion date: 3/31/18

SECTION V: DESCRIPTION OF EXISTING HEALTH CARE FACILITIES AND COMMUNITY RESOURCES AVAILABLE TO MEET IDENTIFIED COMMUNITY NEEDS

Several partner organizations that have additional expertise to assist in addressing the NYS Prevention Agenda Priority Areas are identified below.

Prevent Chronic Diseases:

In addition to Bon Secours Community Hospital's planned interventions the following hospitals and healthcare organizations have the expertise and resources available to address chronic diseases:

- St. Anthony Community Hospital
- St. Luke's Cornwall Hospital
- Orange Regional Medical Center
- Hudson River Healthcare
- Cornerstone Family Health Center
- Middletown Community Health Center
- Ezras Choilim Health Center

Promote Healthy and Safe Environments:

Healthy and Safe Environments encompasses air and water quality issues, access to healthy foods, assault-related hospitalizations, and hospitalizations/ED visits related to falls. We are partnered with the Orange County Department of Health along with their public health outreach initiative *Healthy Orange* to help address these concerns.

Healthy Orange is an initiative through the Orange County Department of Health that addresses vital issues of improved nutrition, increased physical activity and movement, and a tobacco-free lifestyle to improve the overall health of Orange County residents. It addresses issues surrounding obesity and chronic disease, utilizing best practices to make policy, systems and environmental changes relative to exercise, nutrition, and tobacco control. Healthy Orange has become the umbrella for many programs that address these core goals.

Promote Healthy Women, Infants and Children:

Bon Secours works closely with the Middletown Family Health Center, located in Port Jervis, and the Maternal Infant Services Network who have expertise and resources available to address these concerns. Both agencies are dedicated to family and community health and wellness. Who they serve:

- Pregnant women and women of childbearing age
- Parents of infants and young children
- Schools concerned with pregnant and parenting teens
- Health and Human Service providers

Promote Mental Health and Prevent Substance Abuse

Bon Secours Community Hospital provides psychiatric, psychological, medical and neurological care in a supportive environment. The New Directions Program utilizes a multidisciplinary treatment team consisting of psychiatrists, nurses, case managers, social workers, and CASAC counselors. The Adult Inpatient Program at Bon Secours Community Hospital is designed to provide a patient-centered and comprehensive treatment program for adults ages 18 and older who are struggling with an acute phase of mental illness.

The Orange County Department of Mental Health exists to ensure that quality Mental Health, Developmental Disabilities and Chemical Dependency services are accessible to all the people of Orange County, that such services are delivered in a cost effective, timely, and culturally sensitive manner under the jurisdiction of the Mental Hygiene Law of New York State and provided within the rules, regulations, policies and procedures of the licensing authority of appropriate State Offices. Additional mental health and substance abuse resources are available at Orange Regional Medical Center.

Prevent HIV/STDs, Vaccine-Preventable Disease and Healthcare Associated Infections:

Along with Bon Secours Community Hospital's efforts to prevent communicable diseases, the following public health and healthcare organizations also have the expertise to address communicable diseases:

- St. Anthony Community Hospital
- Orange Regional Medical Center
- Hudson River Healthcare
- Cornerstone Family Health Center
- Middletown Community Health Center
- Orange County Department of Health
- New York State Department of Health

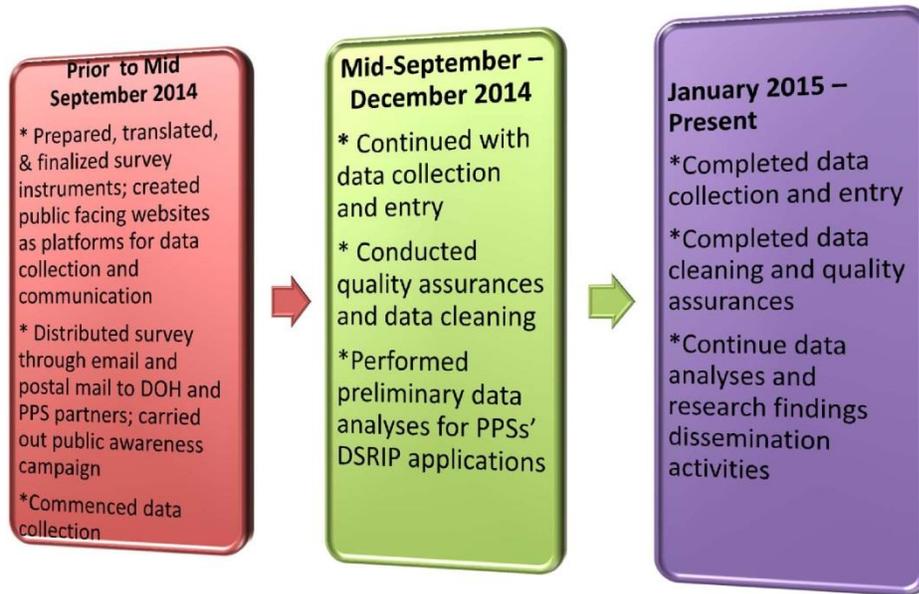
ONE REGION, ONE CNA

Orange County

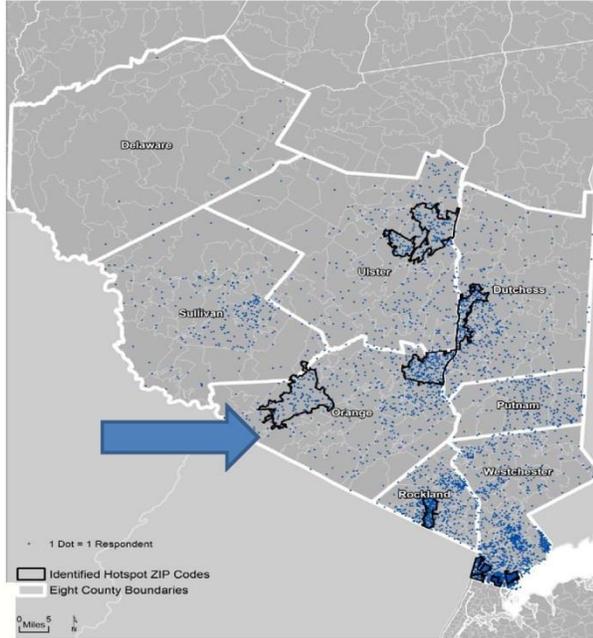
A REGIONAL COMMUNITY NEEDS ASSESSMENT (CNA) UNDERTAKEN IN
COLLABORATION WITH: WESTCHESTER MEDICAL CENTER, MONTEFIORE
MEDICAL CENTER, REFUAH HEALTH CENTER AND HEALTH ALLIANCE OF
THE HUDSON VALLEY



CNA PROCESS and TIMELINE



Distribution of Respondents (N=4,952) Respondents from Orange County (n=741)

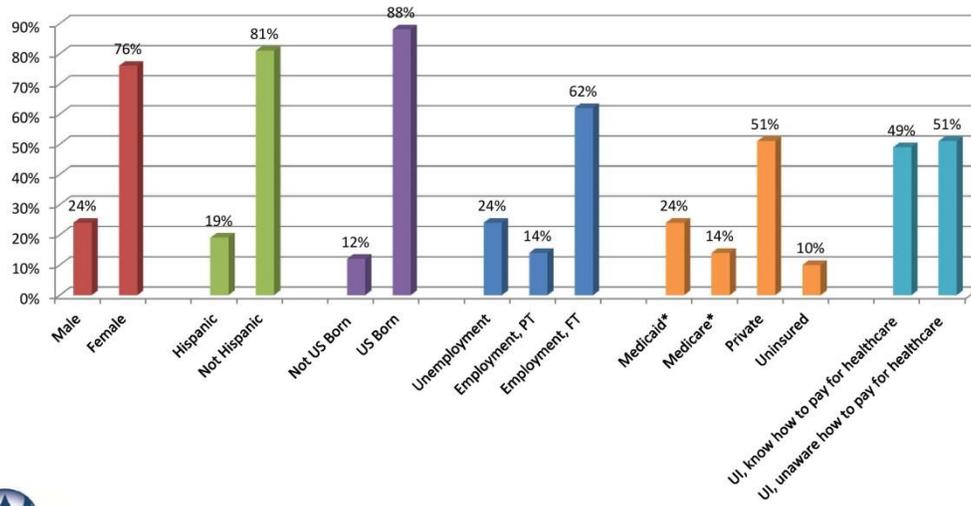


From a total sample of 4,952 survey respondents, 741 are from Orange County. This subpopulation (n=741), however, are demographically different from the overall Orange County population. Findings presented here, therefore, are only reflective of those who participated in the survey and not representative of the County.



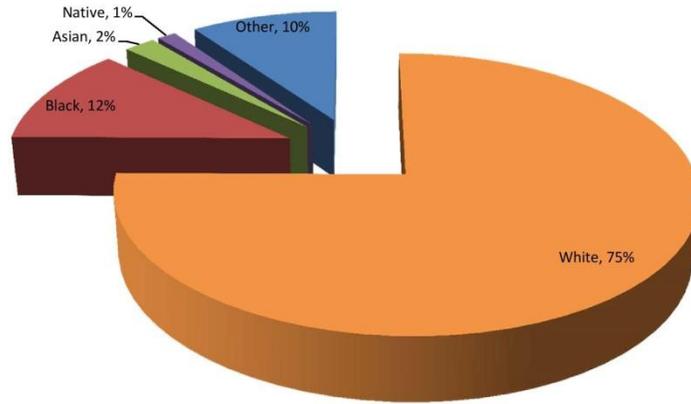


Orange County (n= 741) – Respondents Demographics





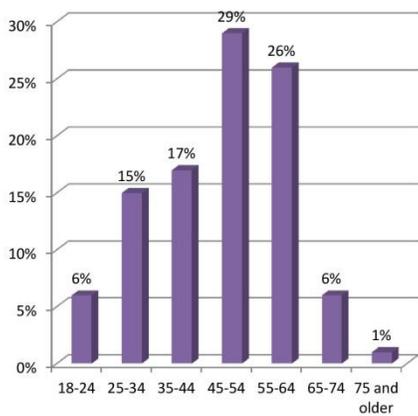
Orange County (n=741) – Respondents Race



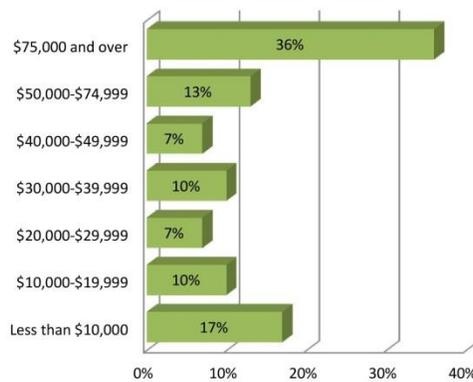
Orange County (n=741)



Respondents Age



Respondents Annual Household Income



CNA Demographics Take Away Points



Compare to the 2013 Census data, our survey sample from Orange County was not representative of the overall demographics for the county. We oversampled Black/African American, Native American, and those with low social economic status. Our Orange County's sample also has more women and most were younger than 65 years of age.



Among the uninsured from Orange County, 51% of respondents were not aware of how to get their healthcare paid for.



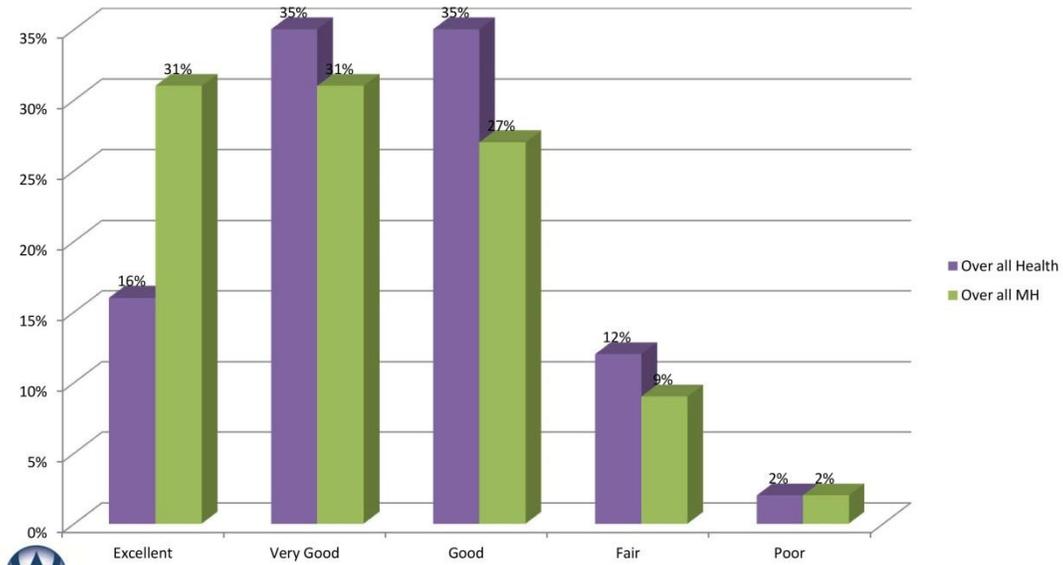
24% of the respondents from Orange County reported that they were unemployed, compared to 6.3% for the whole county (NYS Dept of Labor for March 2014).



Orange County (n=741)



Respondents' Ranking of Their Overall Health and Mental Health



Orange County – Community Health Issues



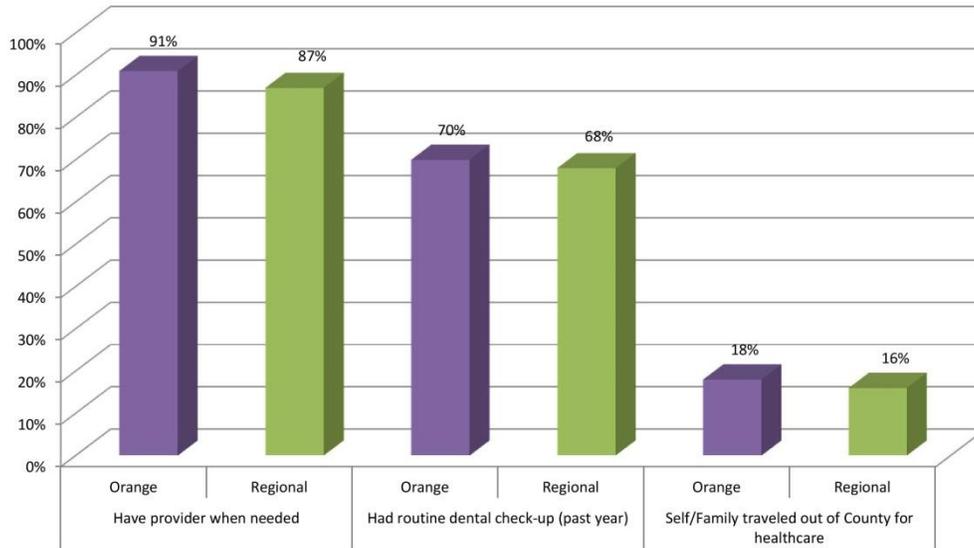
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- Diabetes*¥
- Obesity
- Mental Health
- Cancer*
- Heart Disease*

- **Top 3 leading causes of death in NYS, according to the NYS DOH Vital Statistics*
- *¥One of the leading causes of death among minority populations*



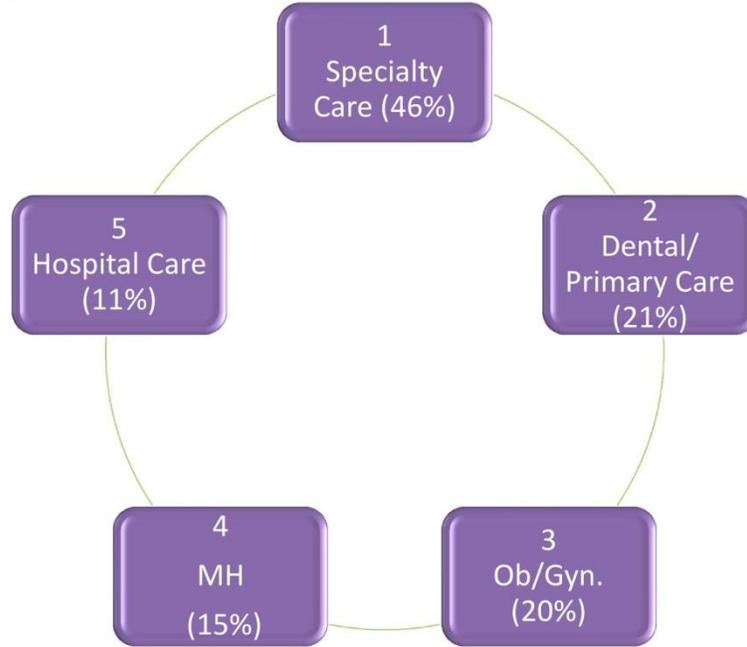
Health Services Access & Utilization by Respondents Orange County (n=741)/Regional (N = 4,952)



Orange County – Health Services Access & Utilization by Respondents (cont.)



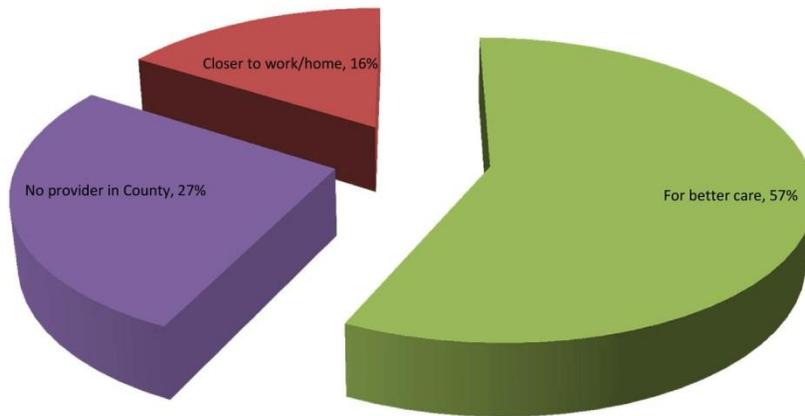
Top Health Services to Leave County for Care (out of 9 services, n=123)



Orange County - Health Services Access & Utilization by Respondents (cont.)



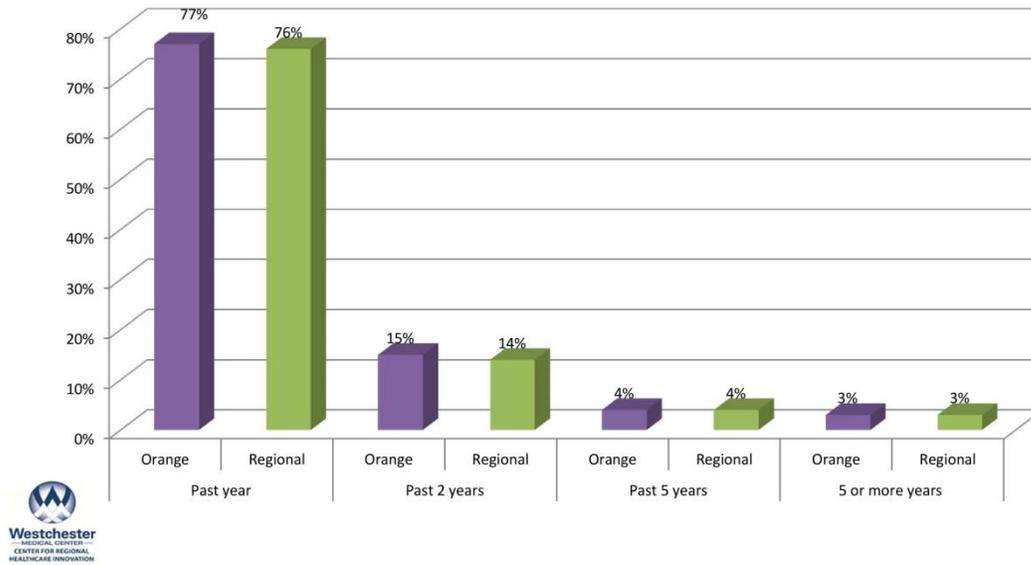
Main reasons for traveling outside of county for health services (n=123)



Health Services Access & Utilization by Respondents (cont.) Orange County (n=741)/Regional (n = 4,952)



Last Routine Physical Check-Up



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Orange County – Health Services Access & Utilization
by Respondents (cont.)



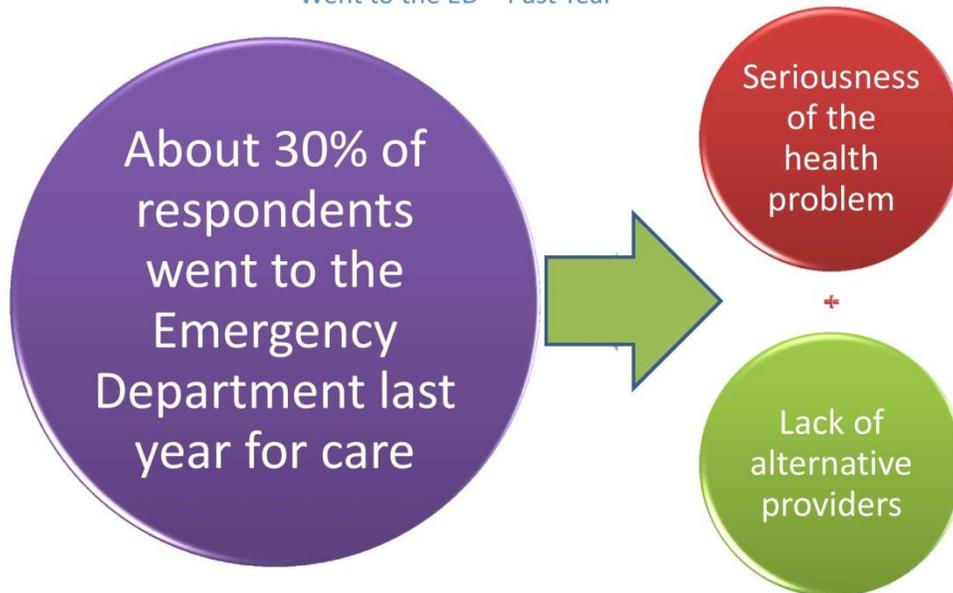
TOP REASONS FOR LACK OF
ROUTINE CHECK-UPS



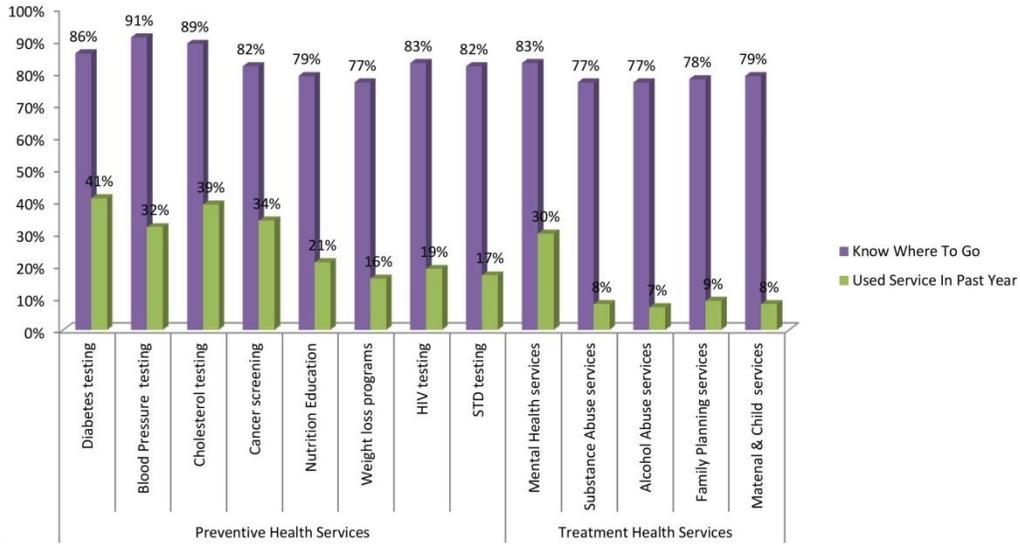
Orange County – Health Services Access & Utilization
by Respondents (cont.)



Went to the ED – Past Year



CNA – Health Services Access & Utilization by Respondents (cont.)



Orange County - Health Services Access & Utilization Take Away Points



Among the 8% of respondents that did not have a routine physical check-up and 30% of respondents that did not have a routine dental check-up, cost, time, fear, and the quality of care were some of the barriers for participants to access good primary and preventive care.



Respondents from Orange county also reported the highest rate (30%) of Emergency Department utilization in the past year, compared to the region.



Diabetes, obesity, mental health, and cancer were identified among the top community health issues, yet 9% - 23% of respondents did not know where to get basic preventive care for these conditions .

ACKNOWLEDGEMENT

This survey was made possible through the help and support of many individuals and organizations, including the staff of Orange County Department of Health and the three Performing Provider Systems (PPSs) in the Hudson Valley Region (Westchester Medical Center, Montefiore Medical Center, and Refuah Health Center). We sincerely acknowledge the interest shown in our survey by our network partners and all respondents who were willing to share their opinions on health care delivery in our region. Their insights are invaluable.



Contact Information



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