Sullivan County

Community Health Improvement Plan 2022-2024

2023-2024 CHIP Collaborative Partners:

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Executive Summary

Community Health Assessment and Community Health Improvement Plan

A Community Health Assessment (CHA) identifies key needs and issues of a community through the systemic, comprehensive data collection and analysis. Sullivan County Department of Public Health and Garnet Health-Catskills participated in a regional process that included Hudson Valley Local Health Departments and Sienna College to update data and gather community input through community and service providers surveys and focus groups to inform the 2022-2024 Community Health Assessment.

A community Health Improvement Plan (CHIP) is a long-term effort to address public health problems based on a CHA. CHIPs are strategic plans that set priorities and measurable objectives to address the needs of a community. This is a collaborative process between the local health department and key, diverse community stakeholders, including Garnet-Catskills, to coordinate efforts, establish priorities, and combine resources to guide evidence-based health promotion strategies and interventions.

The 2022-2024 Sullivan County CHIP includes a year-long effort to identify two overarching priority areas chosen for Sullivan County, NY. Those identified areas are: 1) Prevention of Chronic Disease and 2) Improve Mental Health and Prevent Substance Use.

Progress continues to be made in Sullivan County to improve health outcomes, particularly in these areas:

- Premature death from cardiovascular disease (ages 35-64) decreased from 159.2/100,000 in 2014-2016 to 124.9/100,000 in 2017-2019.
- Coronary heart disease mortality decreased from 172.1/100,000 in 2014-2016 to 151.9/100,000 in 2017-2019.
- The percentage of premature births (<37 weeks' gestation) improved from 10.6% in 2014-2016 to 9.1% in 2017-2019.
- Teen pregnancy rates (ages 15-19) decreased from 33.4/1,000 females in 2014-2016 to 32.9/1,000 females in 2017-2019. While the rate of teen pregnancies has decreased across all racial/ethnic communities, health disparities continue to be seen in teen pregnancy rates. The rate of teen pregnancy in Hispanic females (9.3/1,000 females) continues to be higher than the pregnancy rate of non-Hispanic White females (4.4/1,000females) and non-Hispanic Black females (5.4/1,000 females) in the same age group.
- Percentage of overweight or obese students in elementary schools has decreased from 35% in 2016-2018 to 32.6% in 2017-2019.
- Percentage of students who dropped out of high school decreased from 12.1% in 2019 to 9.5% in 2020.
- Percentage of students who graduated from high school increased from 79.7% in 2020 to 81.3% in 2020.
- Annual medial income increased from $51,985 in 2018 to $58,851 in 2019

Of note for increased focus are the following concerns:

- Age adjusted suicide mortality rate of 12.2/100,000 continues to be higher than the 8.7/100,000 rate for the Mid-Hudson Region, and the 8.2/100,000 rate for NYS. The rate also continues to be higher than the Prevention Agenda goal of 5.9/100,000. While reported rates are considered unstable, a notable concern is the rise on the suicide mortality rate among those 15-19. This speaks to the need for increased access to mental health and substance use prevention services.
- The percentage of women who had a mammogram between 2017-2019 was 55.3%, lower than the Mid-Hudson Region (65.9%0 and New York State (71%).
- Age adjusted percentage of adults with obesity was 38.9%, higher than the Mid-Hudson Region (25.3%) and New York State (27.9%).
- Overdose death rate from any drug was 42.5/100,000 (crude rate), the highest in New York State.
- Overdose death rate for any opioid death was 39.8/100,000 (crude rate), the highest in New York State.
- Age adjusted non-motor vehicle injury mortality rate increased from 38.8/100,000 in 2014-2016 to 62.2/100,000 in 2017-2019.
- Diabetes mortality rate of 30.6/100,000 in 2017-2019, shows an upward trend from the 2014-2016 rate of 24.4/100,000 population.
- The percentage of the population who experienced food insecurity (did not have access to a reliable source of food during the past year) in 2019 was 11.7%. This rate was highest in the Mid-Hudson Region and was higher than the New York State average of 10.7%. A lack of access to nutritious and affordable food continues to be a significant factor for families and negatively affects health outcomes for residents.

Process for Selection of Priority Areas

To assess the needs of Sullivan County residents and identify Prevention Agenda priorities, there was extensive secondary data review and analysis through the CHA Collaborative between the Hudson Valley Regional Collaborative (a collaboration of local health departments in the Mid-Hudson Region), and Garnet Health System. Data from that review included, but was not limited to: American Community Survey, Behavioral Risk Factors Surveillance System, County Health Rankings and Roadmaps, numerous sources from the New York State Department of Health including the Prevention Agenda Dashboard and Community Health Indicator Reports, New York State Education Department, Comprehensive Housing Affordability Strategy Data, HRSA Data Warehouse, and Vital Statistics of New York State.

The Siena College Research Institute (SCRI), on behalf of the seven local health departments of the Mid-Hudson Region, conducted The Mid-Hudson Regional Community Health Survey. Respondents were contacted via landline telephone, cell phone, an online panel, and online recruitment from Sullivan County at various in –person events and through community partners. The landline sample used randomized digital dialing of both listed and unlisted numbers. The cell phone sample was drawn from a sample of dedicated wireless telephone exchanges within each county. The online panel was conducted through Lucid, an online market research platform that runs an online exchange for survey respondents. Online recruitment for each county was achieved through the distribution of the survey URL to community partners, promotion through social media channels, and providing access to the survey at public events. In 2018, SCRI conducted a similar survey for the Mid-Hudson Region. In both 2018 and 2022, each county estimate was similarly weighted to the most current demographic estimates of the county's population by age, gender, reported race/ethnicity, and income. As such, and despite sampling

design differences, the final weighted estimates by county and the final weighted regional estimates from 2018 and 2022 can be fairly compared to one another.

In addition to the SCRI survey, Sullivan County also held focus groups with human services providers that serve underrepresented populations. Representatives from SALT, the Sullivan County Health Services Advisory Board, Sullivan 180, and other community partners provided focus group input in June-August 2022. The purpose of the focus groups was to collect information on the issues specific to individuals who may be dealing with more complex health issues than the general population. These agencies provide support for persons with low-income, veterans, persons experiencing homelessness, the aging population, and people with a mental health diagnosis or those with substance use issues. An additional focus group was held with SUNY Sullivan students to address their unique perspective and health needs.

In addition, a focus group was held with Garnet Health providers to gather information from the perspective of health care providers. This focus group gathered data on perceived barriers to better health from a health care perspective as well as their perception of what factors contribute the most to the poor health outcomes of the community.

An overall review of the data was provided by the Sullivan County Rural Health Network Board members, Sullivan County Drug Task Force, and the Sullivan County Health Services Advisory Board between September 2022 and October 2022. Approximately 25 partners, including hospitals, health care providers, community-based organizations, community members and academia were in attendance. The groups provided a review of the most current data in all prevention agenda priority areas. The Sullivan County Rural Health Network Board and full membership, and the Health Services Advisory Board (HSAB) participated in an identification process that allowed attendees to vote on the two Prevention Agenda priorities for the 2022-2024 CHIP. This process included a review of the impacts that the social determinants of health have on health outcomes and discussions of both assets and barriers in each of the selected priority areas. These meetings occurred during the months of September and October 2022. Final RHN and HSAB board review of the CHIP document will take place in December.

Identified Priority Areas

All of these processes highlighted a common understanding that there continues to be a need for improved coordination of efforts among the many partner organizations who seek to improve health and quality of life in Sullivan County. Sullivan County, as a mostly rural county, differs from its Mid-Hudson Region partner counties in geography, income, and workforce. A long-term investment in key evidence-based interventions that are focused on two priority areas are necessary in order to realize sustainable improvement in health outcomes. The identified priority areas are:

Prevent Chronic Disease

Improve Mental Health and Prevent Substance Use

More detailed information on the Prevention Agenda: New York State's Health Improvement Plan can be found at: https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

Who is involved and how can the broader community be involved?

Leaders from Sullivan County Public Health, Garnet Health, and community partners will be responsible for recruiting additional partners and/or community members through the 2022-2024 CHIP cycle. Additionally, SCPHS and Garnet Health have strong partnerships with dozens of organizations serving its residents, including two federally qualified health centers, private medical providers, SUNY Sullivan, Touro Medical College and School of Dentistry, NYU Medical College, PRASAD Children's Dental Health Program, Sullivan County BOCES, community-based organizations, and other not-for-profit organizations serving a broad variety of community needs including transportation, housing, faith communities, food pantries, and organizations that provide economic stability to low income residents.

SCPHS has established multiple coalitions, including multiple committees through the Sullivan County Rural Health Network, the Maternal Infant Health Collaborative, and the Sullivan County Visitors' Association. These coalition partners will be mobilized to address the health areas of focus and emerging issues for the 2022-2024 CHA/CHIP cycle. When feasible, community forums and surveys will be conducted to engage the broader community at large. Access to this document, as well as the full Regional Community Health Assessment, will be provided on the Sullivan County Public Health website at: https://sullivanny.us/Departments/Publichealth/healthrelateddataandreports

Within each of the identified priorities, the need for improvements in health outcomes will be addressed through the concentration of efforts in areas of the county with the highest rates of morbidity and mortality, the most pressing economic needs, and in areas where there are significant health disparities.

Prevent Chronic Disease Workplan
Priority Area: Prevent Chronic Diseases
Focus Area 1: Healthy Eating and Food Security
Overarching Goal: Reduce Obesity and the risk of chronic diseases Goal 1.1 Increase access to healthy and affordable foods and beverages Objective #1: By December 31, 2024, decrease the percentage of adults ages 18 and older who are overweight or obese by 5% from 69.9% to 64.9% (Data Source: CHIRS, 2018) Objective #2: By December 31, 2024, decrease the percentage of school age children who are overweight or obese by 5% from 36.8% to 31.8%. (Data Source CHIRS, 2018) **Disparities Addressed: Persons with low socioeconomic status (SES) and targeting communities with high minority populations**

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
Increase the number of institutions with nutrition standards for healthy food and beverage procurement	Utilize the Encouraging Healthy Behaviors Community Challenge to motivate local worksites and government offices to adopt healthy vending standards and implement healthy eating guidelines	SCPHS, Sullivan 180, CCE Sullivan – Healthy Schools, Healthy Communities Contributing Partner: ATI	January 2023-December 2024	Number and type of worksites, municipalities, CBOs, and hospitals who develop and adopt policies to implement nutrition standards including cafeterias, snack bars, vending machines, CSAs and corner stores	By December 2024, 5 large employers or municipalities will adopt nutrition standards at their locations
Work with school districts to implement multi-component school-based obesity prevention interventions	Supporting school buildings in the Empowering a Healthier Generation program to make changes that support their wellness	Sullivan 180, CCE Sullivan (Healthy Schools, Healthy Communities and SNAP-Ed), Single Bite	January 2023-December 2024	Number of schools that improve nutrition policies and practices.	By December 2024, 75% of Sullivan County school buildings will remain in the Empowering a Healthier Generation program, making

	policies. Continue work with districts and supporting partners to submit grant applications that support Farm to Cafeteria initiatives	Contributing Partner: ATI, SCPHS			lasting changes that support the district wellness policy
Increase availability of affordable healthy foods, especially in communities with limited access through sustaining funded farm markets.	Maintain current farm markets in Monticello and Liberty, growing the number of farms who participate. Continue growth of mobile market outreach.	CCE Sullivan, Ulster Community Action	Ongoing seasonal May-November (2023-2024)	Number of participants and farmers	Increased availability of locally produced items and availability in low income areas directed towards those without transportation
	Increase participation of farm markets that take SNAP benefits and WIC checks. Increase the number of SNAP and WIC participants who use their benefits at farm markets, Famer's Market Nutrition Program	SCPHS, Sun River Health, OFA, Veterans, WIC	Ongoing seasonal May-November (2023-2024)	Dollar amount of Fresh Connect Coupons used at markets. EBT transaction dollar amount Dollar amount of senior coupons and veterans coupons used at markets	Increased percentage of low-income and aging adults with access to fresh fruits and vegetables

Prevent Chronic Disease Workplan
Priority Area: Prevent Chronic Diseases
Focus Area 1: Healthy Eating and Food Security
Overarching Goal: Reduce Obesity and the risk of chronic diseases Goal 1.3 Increase Food Security Objective #1 By December 31, 2024, reduce the number of adults with perceived food insecurity by 3% from 11.7% to 8.7% Data Source: 2022 Regional CHA) Objective #2 By December 31, 2024, decrease the percentage of adults who report consuming less than one fruit and less than one vegetable a daily by 2% from 23.5% to 21.5% (Data Source CHIRS, 2018) **Disparities Addressed: Persons with low socioeconomic status (SES) and targeting communities with high minority populations**

Evidence Based Strategy	Activities	Lead Partners	Evaluation Measure	Evaluation Measure	Outcome: Product/Result
Screen for food insecurity, facilitate, and actively support referrals	Develop standardized definition and screening questions for food insecurity	CCE Sullivan, Food Security Network, OFA	January 2023-December 2024	Developed standardized definition and questions to measure food insecurity	Ability to collect hospital and medical provider data in relation to food insecurity
	Creation of internal policies and practices to consistently screen for food insecurity in both pediatric and adult populations	Garnet Health	January 2023-December 2024	Number of health practices that screen for food insecurity and facilitate referrals to supportive services	Increased awareness among healthcare providers about food insecurity and increased number of food insecure residents connected to resources
	Develop and refer potential participants to the FreshRx Nutrition Incentive Program	Garnet Health CCE Sullivan	January 2023-December 2024	Number of participants enrolled in program	
	Regular updating of food pantries listings and other local	SCPHS, Community Assistance Center, Sullivan 180	January 2023-December 2024	Number of food pantry lists available	Community partners with work together to maintain and

	emergency food services. Providing updated food pantry resources and Community Resource Guides to patients upon discharge	Collaborative Partners: ATI, OFA, Independent Living, Veterans Office, Sullivan County Government		to healthcare providers. Number of food pantry resource lists distributed to patients	distribute food pantry lists and community resource guides to at least 10,000 county residents
Maintain the availability of fruit and vegetable incentive programs	Maintain current incentive programs for the purchase of fruits and vegetables at the local farmers markets and mobile markets	CCE Sullivan, SCPHS, Sullivan County Government, Rural Health Network, OFA, Veterans	Seasonal during farm markets (January 2023-December 2024)	Number of coupons distributed by providers Number of coupons redeemed at farm markets	Increased access to healthy fruits and vegetables

Prevent Chronic Disease Workplan
Priority Area: Prevent Chronic Disease
Focus Area 2: Physical Activity
Goal 2.1 Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities. Goal 2.3 Increase access, for people of all ages and abilities, to indoor and/or outdoor places for physical activity Objective #1 Increase the percentage of adults age 18 years and older who participate in leisure time activity (among all adults) by 5% from 66.2% to 71.2% (Data Source, Prevention Agenda Dashboard 2018)

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	Implement a combination of improved pedestrian, bicycle, or transit transportation system components that support safe and accessible activity	CCE Sullivan, Sullivan County Planning Department, Sullivan County DPW, Division of Community Resources, Sullivan 180, SUNY Sullivan	January 2023-December 2024	Number of places that implement new or improve existing community planning and transportation interventions Number of family friendly events held on O&W Rail Trails	Increased number of adults meeting physical activity guidelines. One quarterly event will be held on the rail trails to promote these county resources for increased physical activity

Prevent Chronic Disease Workplan
Priority Area: Prevent Chronic Disease
Focus Area 4: Preventative Care and Management
Goal 4.1.1 Increase cancer screening rates for breast, cervical, and colorectal cancers, especially among disparate populations Objective #1 By December 31, 2024, increase the percentage of adults receiving breast cancer (baseline 66.1%), cervical cancer (baseline 81.7%), and colorectal cancer (baseline 58.8%) screening by 5%. (Data source CHIRS, 2018, PA Dashboard 2018) **Disparities Addressed: Persons with low socioeconomic status (SES) and targeting communities with high minority populations**

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
Remove structural barriers to cancer screening by working with employers to provide employees with paid leave or the option to use flex time for cancer screenings	Sullivan County Worksite Wellness Committee to connect to worksites to establish paid leave policies for screenings	Sullivan County Government, SCPHS	January 2023-December 2024	Number and types of worksites that adopt practices and policies that reduce structural barriers to cancer screening Number of employers with policies for flex time or paid time off for cancer screenings	Increased number of adults able to receive cancer screenings
Remove structural barriers to cancer screening by increasing primary care provider connections	Develop a system to refer patients without primary care when presenting to the emergency department or urgent care setting	Garnet Health	January 2023-December 2024	Number of referrals made to primary care	Supportive community partnerships
Remove economic barriers to cancer screening by	Develop a system to connect insurance patient navigators to	Garnet Health, OFA	January 2023-December 2024	Number of patients signed up for health insurance	Supportive community partnerships

ensuring access to health insurance	patients waiting for care in the emergency department				

Prevent Chronic Disease Workplan
Priority Area: Prevent Chronic Disease
Focus Area 4: Preventative Care and Management
Goal 4.2.1 Increase early detection of cardiovascular disease, diabetes, prediabetes, and obesity Objective #1 By December 31, 2024, increase the percentage of adults 45+ who had a test for high blood sugar within the past three years by 5% from 55.6% to 60.6% Data source: NYS Behavioral Risk Factor Surveillance System, 2018) **Disparities Addressed: Persons with low SES and targeting communities with large minority populations**

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
Remove structural barriers for screenings by increasing primary care provider connections	Develop a system to refer patients without primary care when presenting to the emergency room or urgent care setting	Garnet Health	January 2023-December 2024	Number of referrals to primary care services	Supportive community partnerships
Provide community based preventative program opportunities	Relaunch the Healthy Heart Program to reach local businesses and local community events	Garnet Health	January 2023-December 2024	Number of programs conducted and number of patients screened	Supportive community partnerships
	Provide the Diabetes Prevention Program through multiple media platforms and onsite locations to improve accessibility	Garnet Health, Sullivan 180	January 2023-December 2024	Number of programs conducted and number of patients screened	Supportive community partnerships

Promote Well-Being and Prevent Mental and Substance Use Disorders Workplan
Priority Area: Improve Mental Health and Prevent Substance Use
Focus Area: Promote Well-Being
Goal 1.1 Strengthen opportunities to build well-being and resilience across the lifespan Objective #1 By December 31, 2024, decrease the percentage of disconnected youth by 5% from 17.6% to 12.6%. Data source: Measure of America, 2015-2019 **Disparities Addressed: Persons with low socioeconomic status (SES) and targeting communities with high minority populations**

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
Increase utilization of home visiting programs and community health workers	Utilization of a comprehensive perinatal referral form to connect pregnant women with important services and programs.	SCPHS, Healthy Families, Garnet Health	January 2023-December 2024	Number of referrals received. Number of Healthy Family participants Number of referrals to SCPHS maternal child health nursing	Increase in the number of residents receiving structured visits by trained professionals and paraprofessionals, particularly those at risk, providing parents with the skills and resources to raise children who are physically, socially, and emotionally healthy
Increase offerings in Youth Mental Health First Aid, Teen Mental Health First Aid, and QPR (Question, Persuade, Refer) Suicide Prevention Training	Provide opportunities for more trainings and certifications for both participants and facilitators of evidence-based programs known to positively impact	Sullivan 180, ATI, Sullivan County Youth Bureau	January 2023-December 2024	Number of training participants/graduates	Train 50 Sullivan County 10th grade teachers in Youth Mental Health First Aid. Train 20% of Sullivan County Fire Departments in QPR Suicide Prevention training

	mental health and reduce stigma.				
Increase trauma informed practices and knowledge of Adverse Childhood Experiences (ACEs)	Screen the film "Resilience" and lead community café conversations about the impact of ACEs on health. Explore programs known to reduce ACEs and build social-emotional wellness such as Miss Kendra's, the TTY curriculum, and the Boston Basics	Sullivan 180, ATI	January 2023-December 2024	Number of film screenings and viewers. Number of schools/community settings that adopt social emotional wellness programs to reduce ACEs and instill resilience in children and families.	Support two Sullivan County school buildings and at least two community settings to utilize trauma informed, evidence-based programming / curricula.
Increase activities and improve access to activities for youth that promote greater socialization, skill development and, and positive youth development.	Continue the promotion of low and no cost youth activities. Utilize mapping of existing activities in order to identify gaps and develop solutions to access issues	Sullivan County Youth Bureau, Center for Workforce Development, CCE Sullivan, Sullivan County Human Rights Commission, ATI	January 2023-December 2024	Number of youth participating in county activities Completed comprehensive map of youth services and activities	Increase in youth engagement The map is a foundation for a comprehensive network of youth activities and will inform the solutions for access

Promote Well-Being and Prevent Mental and Substance Use Disorders Workplan
Priority Area: Mental Health and Substance Use Disorder Prevention
Focus Area: Mental Health and Substance Use Disorder Prevention
Goal 2.2 Prevent opioid and other substances misuse and deaths Objective #1 By December 31, 2024, reduce the age-adjusted overdose death rate involving any opioid by 5% from 41 to 38.9 per 100,000 population. **Disparities Addressed: Persons with low socioeconomic status (SES) and targeting communities with high minority populations**

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
Implement school-based prevention: Implement and/or expand programs including Life Skills and Too Good For Drugs	Implementation of Too Good for Drugs. Expansion of Life Skills in Sullivan County schools	SALT, CCE Sullivan, SCPHS, Youth Bureau, ATI, Sullivan 180	January 2023-December 2024	Number of schools who implemented Like Skills or Too Good For Drugs	Increase the number of integrated support and education programs to help teens reduce and eliminate substance use.
Increase availability of/access and linkages to MOUD (MAT) including Buprenorphine	Develop policies/procedures for the initiation of MOUD (MAT) in emergency departments	Garnet Health	January 2023-December 2024	Number of patients receiving MOUD (MAT) in the ED	Supportive community partnerships
Increase the availability of access to MOUD (MAT) including Buprenorphine	Organize and fund MOUD (MAT) implementation trainings for health care providers prescribing Buprenorphine	Garnet Health, HCS, Sullivan County Jail	January 2023-December 2024	Number of patients receiving MOUD (MAT) in the ED	Supportive Community Partnerships

Promote and support the expansion of Peer RX application for referrals at the emergency department		Garnet Health	January 2023-December 2024	Number of peer referrals made	Supportive community partnerships

Promote Well-Being and Prevent Mental and Substance Use Disorders Workplan
Priority Area: Improve Mental Health and Prevent Substance Use
Focus Area 2 Mental Health and Substance Use Disorders Prevention
Goal 2.2 Prevent opioid and other substance misuse and deaths Objective #1 By December 31, 2024, increase the number of trained overdose responders (Naloxone) by 20% from 800-960. Objective #2 By December 31, 2024, increase the number of installed public access Naloxboxes from 0 to 3. **Disparities Addressed: Persons with low socioeconomic status (SES) and targeting communities with high minority populations**

Evidence Based Strategy	Activities	Lead Partners	Timeframe	Evaluation Measure	Outcome: Product/Result
Increase availability of/ access to overdose reversal (Naloxone) trainers to prescribers, pharmacists, first responders, and consumers	Expand the number of opioid overdose prevention (Naloxone) trainings to the general community through virtual and onsite trainings.	SCPHS, SALT, Catholic Charities, Independent Living, Sullivan 180, ATI	January 2023-December 2024	Number of overdose responders trained in the use of opioid reversal medication (Naloxone)	Increased access to overdose reversal medication (Naloxone)

	Install public access Naloxboxes in community business partners and in areas needing improved access to opioid reversal medication (Naloxone)	HCS, Drug Task Force, SCOOP, Independent Living	January 2023-December 2024	Number of Public Access Naloxboxes installed in the community	Increased access to overdose reversal medication (Naloxone).

COVID-19

Sullivan County Public Health and all of our community partners faced many challenges during the 2019-2021 CHIP cycle. There were several public health concerns, including measles and COVID-19 that strained resources and challenged the health of our communities.

The COVID-19 pandemic created many challenges and obstacles for community organizations, heath care providers, and the residents of Sullivan County. Since 2020, Sullivan County has faced a decline in both physical and mental health care providers. This decrease in providers, combined with transportation concerns, made it much more difficult for some residents to make appointments for routine and preventative office visits. In addition, COVID-19 restrictions made some unwilling or unable to visit their health care providers. Telehealth visits were offered, but internet access and computer skills and knowledge vary greatly throughout the county, restricting access to this service for some residents. In addition to access, the lack of personal interaction with providers during telehealth visits also effects the patient doctor relationship necessary to provide complete health care. Many mental health and substance use services were either closed or dramatically decreased during the pandemic. This shuttering of service, combined with social isolation, is contributing to the numbers of mental health issues, overdoses and overdose deaths that we continue to see in the county.

While the intense focus on COVID-19 activities resulted in some improved relationships and increased knowledge of the public health system, it also created an erosion in collaborative activities at the local community health level. Progress that had been made to implement and promote activities to improve the health of residents was slowed or stopped due to businesses shutting down and public events no longer occurring. The work to re-engage with these activities and partners continues through the current CHIP cycle.

Despite the challenges, much good work was still accomplished. Our schools are active participants in Empowering A Healthier Generation and developed wellness policies. The Farmer's Markets and mobile market saw an increase in the number of participants through incentive programs such as Food is Medicine, SNAP, veterans and seniors' programs. A community Resource Guide was developed and distributed to connect residents to the available services throughout the county.

The continued dedication and commitment to health from all the community partners will continue through this new CHIP cycle and the health of our residents will benefit from it.

Sullivan County CHIP Participating Partners

2022 Health Services Advisory Board / Sullivan County Public Health Services:	
	Affiliation
Bruce E. Ellsweig, MD, Chairperson	Family Practice, Primary Care - Crystal Run Healthcare
Sam Avrett, MPH	Consultant, The Fremont Center
M. Cecilia Escarra, MD	Executive Director, PRASAD Children's Dental Health Program
Joan Patterson, RN, MSN	Director of Operations – Sullivan County, Crystal Run Healthcare
Laryssa Dyrska, MD	Retired pediatrician
Gerald Skoda	Community representative, business/healthcare sector
Carol Ryan, RN, MPH	President and Director, Health Promotion Strategies
Gene Burns, DPh	Riverside Remedies Pharmacy
Deborah Worden	Executive Director, Action Toward Independence
Karen Holden	Interim Public Health Director, Sullivan County Department of Public Health

2022 Sullivan County Rural Health Network Board Members	
	Affiliation
Colleen Monaghan, MPA Chairperson	Executive Director, Cornell Cooperative Extension of Sullivan County
Carol Ryan, RN, MPH	President and Director, Health Promotion Strategies
Robert Dufour, Ed. D.	Sullivan County BOCES Superintendent
Lise-Ann Deoul	Director, Office for the Aging
Cecilia Escarra, DDS	Executive Director, PRASAD Children's Dental Health Program
Dan Grady	Executive Director, Hospice of Orange & Sullivan Counties
Giovanna Rogow	Executive Director, Maternal Infant Services Network (MISN)
Laura Quigley	Commissioner, Division of Community Resources
Jay Quaintance	President, SUNY Sullivan
Amanda Langseder	Executive Director, Sullivan 180
Moira Mencher	Physician Liaison, Garnet Health
Donna Willi	Sullivan County Childcare Council
Rachel Steingart/Aileen Gunther	Assemblywoman Aileen Gunther's Office
Ann Nolan	Sun River Health Care
Jill Hubert-Simon	Community Health Coordinator, Sullivan County Department of Public Health
Karen Holden (non-voting)	Interim Public Health Director, Sullivan County

Sullivan County CHIP Participating Partners

2022 Sullivan County Rural Health Network Committee Members:		RHN Committees			
Committee members:	Title/Affiliation	Drug Prevention Task Force* * See footnote	Oral Health Committee	Perinatal Drug Task Force	Health Equity / Common Ground Committee
Karen Holden	Interim Public Health Director, Sullivan County	X	X	X	X
Wendy Brown, RN, MS	Coordinator, Drug Prevention Task Force, Deputy Commissioner DHHS	X	X	X	X
Jill Hubert-Simon, MS	Community Health Coordinator, SCPHS	X	X	X	X
Lise-Anne Deoul	Director, Sullivan County Office for the Aging	X			X
John Liddle	Commissioner, Division of Health & Family Services	X			
Melissa Stickle, MSW, CASAC	Director, Community Services	X		X	
Carol Ryan, RN, MPH	Health Promotion Strategies	X	X	X	X
Karen Holden, RN, BSN	Interim Director, Sullivan County Public Health Services	X		X	
Amy Kolakowski, LMSW	Chief Clinical Officer, Catholic Charities Community Services of Orange and Sullivan	X		X	
Cecilia Escarra, DDS	PRASAD CHDP		X		X
Martin Colavito	S.A.L.T.	X			X
Heidi Reimer	Community Services	X			
Julie Pisall	Kingfisher Project/WJFF	X			

*** In 2021-22, the Drug Prevention Task Force subcommittee of the Rural Health Network was moved out of Public Health Services and became a Countywide broader task force. Members of the RHN and Public Health continue to be very active on the various Pillars of the Sullivan County Drug Task Force in 2022 and key initiatives are shared with the Rural Health Network, as Substance Use and Mental Health continues to be a top priority area for Sullivan County.

2022 Sullivan County Rural Health Network Committee Members:		RHN Committees			
Committee members:	Title/Affiliation	Drug Prevention Task Force	Oral Health Committee	Perinatal Drug Task Force	Health Equity / Common Ground Committee
Amanda Langseder	Executive Director, Sullivan 180	X	X	X	X
Moreen Lerner	Healthy Bethel Committee		X		X
Alex Rau	EMS Coordinator, Sullivan County	X			
Robert Dufour, Ed.D.	Superintendent, BOCES	X	X		X
July Balaban	SC Professional Advisory Committee (PAC)	X	X		X

Contact Information for this report: Jill Hubert-Simon
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PDF Downloadable and available publicly at: http://sullivanny.us/Departments/Publichealth

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