



Albany Medical Center Hospital

Community Service Plan
Community Health Needs Assessment
Implementation Strategy 2016-2018

Table of Contents

Introduction	Pages 3-4
Mission Statement	Page 5
Summary of Previous Community Health Needs Assessment	Pages 6-10
2016-2018 Community Health Needs Assessment (CHNA)	Pages 11-14
Description of CHNA process	Pages 15-16
Collaborative Partners	Pages 17-22
Community Input	Pages 23-24
Significant Community Health Needs	Pages 25-28
AMCH's Implementation Strategy/Community Service Plan	Pages 29-41
Regional needs not addressed in AMCH's Implementation Strategy	Pages 42-43
Evaluation of Preceding CHNA	Page 44
Approvals	Page 45
Publicizing AMCH's Community Service Plan/CHNA	Page 46
HCDI's 2016 Community Health Needs Assessment	Attachment

Introduction

Albany Medical Center's unique tri-partite mission of medical education, biomedical research, and patient care is also our defining role as a community health provider, ensuring access to medical and technological innovations that are traditionally found in academic medical centers - for residents of our region and beyond.

Because of our unwavering commitment, assessing the health care needs of our community is an ongoing process. We are engaged in myriad affiliations and collaborations throughout our service area, with one common goal: improving our region's health.

- Community service and community partnerships are an integral part of our institutional strategic planning.
- We actively promote public health, health education and conducting various health screenings, often in collaboration and partnership with organizations throughout our service area.
- Physicians, nurses, medical students and residents, and many of the staff of Albany Medical Center volunteer their time and talents to the Capital Region community – through their involvement in community organizations, community action groups, and healthcare organizations.
- Our missions of medical education and biomedical research improve our community's health through:
 - education, training, recruitment and retention of physicians and health professionals for our community
 - advancement of new discoveries through medical science
- As the only academic medical center within nearly 150 miles, we provide a host of unique and/or highly specialized services to our community and to hospitals in our region – including a Level I Trauma Center and largest Emergency Department, a Level IV NICU, the only Children's Hospital in the region, the major resource for the Medicaid population, and a provider of high-end surgical services and medical care for the acutely ill.

The following plan is not a comprehensive report of the many aforementioned programs and services offered to our community at a free or reduced-fee basis, often in partnership with other organizations.

Rather, the process and resulting efforts described in this Community Service Plan are focused on several pressing health issues of our local community, and identify how Albany Medical Center Hospital – with partner organizations – is working to:

- Execute a community health improvement plan
- Reduce duplication of services and costs
- Assist each other for improved efficiency and efficacy
- Collaborate to maximize available resources and assets

The information in the attached copy of the Healthy Capital District Initiative's 2016 Community Health Needs Assessment is integral to this document and is hereby incorporated by reference.

See Attachment 1 (also: URL:

http://www.hcdiny.org/content/sites/hcdi/2016_chna/2016_HCDI_community_health_needs_assessment.pdf).

The Healthy Capital District Initiative is an independent, non-profit organization leading the coordination of our region's health needs assessment, selection of significant health priorities, and the development of regional health improvement plans. Through this Initiative, area hospitals, health insurers, county health departments, Catholic Charities and other community-based organizations work together determine some of the major barriers to health services and develop initiatives to greatly reduce them.

The Community Service Plan illustrates the collaborative efforts among HCDI member hospitals, local health departments, and other health and community organizations.

Health Planning Process:

Supporting community health improvement by fostering multi-stakeholder coalitions



It should be noted that Albany Medical Center Hospital and its South Clinical Campus operate under a single state license, and serve the same populations. This community health needs assessment includes both campuses.

Mission Statement

As an academic health sciences center, Albany Medical Center has a mission of excellence in medical education, biomedical research, and patient care.

Albany Medical Center has a responsibility to:

- Educate medical students, physicians, biomedical students, and other health care professionals from demographically diverse backgrounds in order to meet the future primary and specialty health care needs of the region and nation;
- Foster biomedical research that leads to scientific advances and the improvement of the health of the public; and
- Provide a broad range of patient services to the people of eastern New York and western New England, including illness-prevention programs, comprehensive care, and the highly complex care associated with academic medical centers.

This mission will be achieved through commitment to the values of Quality, Excellence, Service, Collaboration, Compassion, Integrity, and Fiscal Responsibility.

Summary of previous CHNA

Key findings of the 2013-2014 CHNA included issues pertaining to behavioral health and chronic disease in Albany and Rensselaer Counties.

Behavioral health, particularly opiate abuse – was selected as a significant health priority in our region. Accordingly, asthma and diabetes were significant conditions within chronic disease that were selected to be addressed.

Coordinated and led by the Healthy Capital District Initiative (HCDI), three regional task forces were developed: the Regional Behavioral Health Task Force, and the Regional Diabetes Task Force, and the Regional Asthma Task Force. Members included representatives from all hospitals and local health departments in the region, as well as community-based organizations which represent the needs of the populations being addressed.

Below is a summary of initiatives undertaken by the collaborative, and by Albany Medical Center Hospital:

Behavioral Health:

Drug-related hospitalization rates for the Capital District were higher than the rest of the state. Also of concern with mental illness sufferers were chemical dependency issues, especially with regard to opiate abuse. Opiates were the reported primary drug of choice for 35.6% of persons seeking hospital admission for non-crisis services.

Area providers identified a service gap in the system with regard to tobacco and opiate abuse. The Regional Behavioral Health Task Force designed strategies to improve provider knowledge regarding: recognizing signs of abuse, discussing treatment options with addicts, and appropriate opiate prescriptions. Following the lead of the Centers for Disease Control, strategies regarding tobacco cessation included incorporating cessation programs into overall mental health treatment and encouraging mental health facilities and campuses to enact tobacco-free policies.

Collectively, the Regional Behavioral Health Task Force executed the following tactics:

- Over 2,200 individuals were trained in delivery of Naloxone/Narcan to prevent heroin overdosing and sudden death by Albany Medical Center professionals and other partner organizations
- I-STOP brochure was made available electronically to medical staff were printed and distributed to opioid prescribers (also available electronically)
- Dozens of locations participated in regularly scheduled drug "take back" days to remove opioids from consumer's homes
- A series of legislative measures, supported by OASAS and other Task Force members, were enacted in 2014 including improved measures to support addiction treatment.

Measures We joined forces with partners to help strengthen infrastructure across systems and track accomplishments using such measures as the number of community members trained in the New York State Opioid Overdose Prevention Program. The task force also created an "ISTOP" brochure for providers; tracking its distribution was one of the measurements.

Disparities The rate of drug-related hospitalizations among Blacks and Hispanics were 1.5 to 2 times higher than for Whites. This is a population of particular concern and focus for the task force.

Engagement Albany Medical Center Hospital and our partners have stayed highly engaged in the coordination intervention by conducting educational activities, and assisting with advocacy.

Successes The task force advocates trained thousands of community members in the New York State Opioid Overdose Prevention Program. In addition, ISTOP brochures were distributed to partnering providers throughout the Capital Region, and it is posted on the provider section of Albany Medical Center's website as well.

Challenges Challenges faced during the implementation of the intervention include disseminating results broadly through a variety of methods, particularly the ISTOP brochure.

Albany Medical Center Hospital's Related Initiatives

Educator and community health resource

- We serve as a trainer in the SBIRT program (Screening, Brief Intervention, Referral to Treatment) and the NYS Opioid Overdose Prevention Program
 - Training psychiatry residents, staff, and medical students through a grant extension
- Albany Medical Center Hospital continues its work as a community health resource
- One of our lead emergency medicine physicians has been instrumental in a program that makes Narcan available to law enforcement officers and emergency medical professionals in Albany and Rensselaer Counties and beyond

Diabetes:

The prevalence of adults with diabetes in the Capital District region has been increasing as numbers already exceed statewide averages. Albany Medical Center Hospital and a broad group of local partners have been working together to reduce the prevalence of Type II diabetes among the residents of Albany and Rensselaer Counties.

The plan focused on reaching disparate communities to decrease the prevalence of diabetes and assist those currently living with the disease. Strategy tactics advanced a "Health in All Policies" approach. We worked to expand school and employee wellness programs and open public areas to the public for safe physical activity in order to meet individuals where they live, work and play. Lifestyle change and self-management strategies were promoted to significantly improve quality of life and reduce treatment costs for those with diabetes. Creating a diabetes services resource guide (in both English and Spanish) for health care providers and consumers helped to build and strengthen partnerships that align to improve diabetes care. These strategies helped to foster an environment that engages individuals in prevention and self-management of diabetes.

Collectively, the task force executed the following tactics:

- 5000+ Diabetes Resource guides were printed and distributed to providers and consumers (also available electronically)
- NDPP participation increased in Albany and Rensselaer Counties
- Local hospitals participating in the Sodium Reduction in Communities program (Albany Medical Center Hospital included) reduced sodium content in many popular food options, such as soups,

stir fries, omelets, deli meats. These changes impact thousands of staff, patients and visitors of hospitals in Albany and Rensselaer Counties.

- Regional hospitals and health departments provided numerous diabetes prevention and management education sessions for providers, patients and caregivers.

Measures With our partners, we established a strategy to increase engagement in prevention and self-management of diabetes and related co-morbidities for residents of Albany and Rensselaer Counties. We reached hundreds of patients through programs such as the National Diabetes Prevention Program, Chronic Disease Self-Management and the Diabetes Self-Management Program, and through our individually-tailored diabetes education for our patients.

Disparities We focused on addressing populations of income and socioeconomic status disparity by targeting efforts particularly in the cities of Albany and Troy, where prevalence is higher.

Engagement With our HCDCI partners, we remained engaged in the coordination of diabetes education and self-management by contributing staff time, allowing for clear progress on the initiative and offering intervention activities to identified target populations.

Successes Successes experienced during the implementation of diabetes interventions: Clear identification of the problem; defining the target population; identifying process and outcome measures to monitor progress toward reaching our goals; developing data collection methods and reviewing and monitoring progress with our partners.

Challenges During the implementation phase, challenges included community education and engaging community leaders to address the problem.

Albany Medical Center Hospital's Related initiatives

Diabetes Education

We believe education is key to preventing and managing Type II diabetes. We host a series of education sessions annually for patients with diabetes, their families, and for caregivers. In addition, our certified diabetes educators provide education for nutrition, exercise and other related topic designed for each individual patient. We also post a diabetes education on our website.

"Sodium Reduction in Communities" grant

As administered by the Albany County Department of Health (DOH), the grant has supported various efforts in our cafeteria linked to sodium reduction and improved nutrition signage and food placement. Albany Medical Center Hospital and St. Peter's Health Partners, working in partnership with Albany County DOH both experienced successes. We reduced sodium in soup available at our cafeteria by over 50%, improved nutrition signage, and placed more healthy snacks at checkouts, impacting the more than 3,000 visitors per day.

The "Healthy Lunches to Go" provide staff and other visitors healthy lunch options with reduced sodium, sugar and fat.

Hypertension Initiative

Working across specialties and in collaboration with community physicians, Albany Medical Center physicians closely monitor and manage the blood pressure of every one of the hundreds of thousands of

patients cared for each year, regardless of whether the primary condition they are being treated for relates to hypertension.

Since adopting protocols in 2012 to closely monitor, report and treat a patient's hypertension in collaboration with their primary care physician. As a result, the percentage of patients diagnosed with hypertension who lowered their blood pressure through treatment rose to 90 percent in 2014 from 66 percent in 2012. According to the American Heart Association, in 2013 only 52 percent of Americans with hypertension nationwide had it under control.

Expansion of worksite wellness programs

Our very active workplace health planning group continues to grow in size and scope including its sponsored challenges, wellness fairs, and sharing nutrition and wellness data through our Intranet, promoting fitness classes and walking routes, and serving as a wellness resource for our 9,000+ employees.

- Our annual Employee Wellness Fair offered screenings, vendors, interaction with clinical staff. Between 700-1,000 employees attend annually
- The "Healthy for Life" initiative in conjunction with our food service, promotes the role of good nutrition in a healthy lifestyle.
- Beginning April 2014, selected meals offered in our cafeteria were launched to sync with the "My Fitness Pal" app.

Asthma:

Asthma hospitalization rates in the Capital District are significantly higher than New York statewide rates, particularly in the cities of Albany and Troy, where incidence was highest.

In the past three years, the task force worked to reduce the prevalence of uncontrolled asthma in high prevalence neighborhoods. The focus was on increasing the number of patients engaged in an asthma continuum of care and increasing the utilization of asthma action plans and controller medication. Strategies promoted community environments in enacting tobacco-free policies and engaging the community in smoking cessation programs.

Collectively:

- Albany Medical Center increased its number of certified asthma educators.
- Our work with community agencies resulted in numerous communities implementing tobacco free parks and two housing authorities representing nearly 4,500 units becoming tobacco free. Albany County passed a 21 year old minimum purchase age of tobacco products.
- Albany County Department of Mental Health, Rensselaer County Department of Health, Unity House, and Rehabilitation Support Services facilities became tobacco free.
- The Albany Medical Center Hospital DSRIP (Delivery System Reform Incentive Payment) performing provider system (PPS) and the St. Peter's Health Partners/Ellis Medicine PPS projects have undertaken asthma projects to address the high rates of asthma among Medicaid beneficiaries.

Measures Led by the Asthma Coalition of the Capital Region, collaborative efforts have been targeted towards increasing patient self-management and promoting a community environment that helps prevent and manage asthma. Benchmarks include tracking the distribution of Action Plans, increasing the number of certified asthma educators, working to promote the asthma care transition program in ERs, and promoting healthy environments.

Disparities As with diabetes, efforts have been aimed at vulnerable populations within the cities of Albany and Troy, which have significantly higher asthma hospitalization rates.

Engagement With the guidance of the Asthma Coalition of the Capital Region, HCDI partners promoted various strategies through staff support, community education and screenings and coordinated task force endeavors.

Successes Self-management efforts were advanced through the distribution of thousands of Asthma Action Plans to nurses throughout the Albany City School District. Albany Medical Center Hospital continues to promote the asthma care transition program in our Emergency Room. We also trained 18 additional staff as certified asthma educators. Additionally, the Albany Common Council voted to make its parks 100% tobacco free; a decision fully supported by the Capital District Tobacco Free Coalition and other HCDI members.

Challenges Challenges include current lack of ability for the inclusion of an Asthma Action Plan in a patient's electronic health record, difficulty promoting the care transition program among all ED staff, and engaging community champions in community education and smoking cessation.

Albany Medical Center Hospital's Related Initiatives

Asthma educator and community health resource

- "Asthma Awareness Day" hosted by our Asthma Awareness Education Committee for community, patients, caregivers
- Annual Asthma, Allergy and Immunology conference for healthcare workers
- We have trained 20+ additional staff as Asthma Educators

The 2013-2014 regional Community Health Needs Assessment has been a broadly-publicized and well-known document throughout our community. However, Albany Medical Center Hospital has not received any written comments on the 2014 CHNA or its related implementation strategies.

2016-2018 Community Health Needs Assessment

Community Served

A description of the community served, and how it was determined

The service area defined was chosen by the Health Capital District Initiative, an independent, non-profit organization intended to improve health care in the Capital Region through collaborative means.

As adopted by members of the Healthy Capital District Initiative, the communities being assessed in this report are the 6 counties of Albany, Rensselaer, Schenectady, Saratoga, Columbia and Greene. They form the common service area covered by the local health departments in Albany, Rensselaer, Schenectady, Saratoga, Columbia and Greene Counties and the primary patient population served by Albany Medical Center Hospital, Ellis Hospital, St Peter’s Health Partners, Saratoga Hospital and Columbia Memorial Hospital, which are located within the six counties.

This 6-county region is also referred to as the Capital Region:



Demographic information on the population analyzed was based on 2009-2013 U.S. Census’ American Community Survey (ACS). The combined population in the Capital Region is roughly 952,500 individuals. About 24.2% were 0-19 years of age, while 14.5% were 65 years of age or older. Approximately 11.3% were living in poverty. The race/ethnicity distribution was 85.1% White, 7.7% Black, 3.2% Asian/Pacific Islander, and 4.0% other races; 4.4% were Hispanic/Latino (any race).

Data Summary – Capital Region

In addition to the data analyses contained in the county-specific Prevention Agenda Prioritization PowerPoint presentations given at the Public Health Priority Workgroup meetings (<http://hcdiny.org/>, “2016 Capital Region Health Prioritization Presentations”), the 2016 Community Health Profile analyzed

the health needs of the Region. In 2014, the most recent demographic profile available, the Capital Region was home to approximately 952,500 residents, equally distributed between males and females, with counties ranging from urban (Schenectady-758 pop. /sq. mile) to rural (Greene-75 pop. / sq. mile). The Region's mean age of 40.2 years was higher than that of New York State (NYS). About 17% of the population was 14 years of age or younger, while 16% was 65 years of age and older. Approximately 15% of the Capital Region's population was non-White and 4.4% Hispanic. The Region's median household income of \$60,722 was higher than NYS. Its poverty rate of 11.3% was lower than NYS. Almost 16% of the Region's children less than 18 years of age were below poverty. About 8.8% of the Capital Region's population 25 years of age or older had less than a high school education.

The health of Capital Region residents was generally consistent with other New York counties outside New York City (Rest of State), although Capital Region residents had a higher overall age-adjusted mortality rate as well as a higher rate of Years of Potential Life Lost (YPLL) than Rest of State. The YPLL is an indicator driven by premature deaths. Chronic diseases were the leading causes of death in the Capital Region, with heart disease, cancer, chronic lower respiratory disease (CLRD), and stroke being the major causes. Injuries were the major cause of death in the child, adolescent, and young adult populations.

Health care access indicators show the Capital Region having fewer barriers to care than the Rest of State. Capital Region residents, both children and adults, had higher health insurance coverage rates compared to Rest of State. A higher percent of Capital Region residents also had a regular health care provider. The Capital Region's primary care system also seemed to be working well compared to Rest of State. When looking at preventable hospitalizations, Capital Region residents had much lower rates than residents from Rest of State did. Total Emergency Department visit rates, as well as total hospitalization rates were also lower in the Capital Region compared to Rest of State.

There were many positive trends in the Capital Region. Coronary heart disease, stroke, asthma, colorectal cancer, and female breast cancer trends decreased in the past decade. There were also decreasing rates in gonorrhea and HIV. Children 19-35 months of age had higher immunization rates, and women aged 13-17 years had higher HPV vaccination rates than the Rest of State. The Capital Region had also seen a positive change in certain health behaviors. While adult obesity rates have increased slightly in the Capital Region, they have not increased as much as the Rest of State. A greater percentage of residents participated in some leisure time physical activity than the Rest of State. They also consumed less sugary drinks, and ate at "fast food" establishments less than their Rest of State counterparts.

However, many measurements were not as positive, particularly in lower income, inner-city neighborhoods where many rates were 3 to 7 times higher than the county average.

- Obesity and its related diseases continue to be health issues in the Capital Region. Almost 28% of adult residents were considered obese, or approximately 196,000 adult residents. Obesity in the Capital Region's school children was also alarming, with over 17% of children being considered obese.
- Diabetes mortality and short-term complication hospitalizations were higher in the Capital Region than Rest of State.
- Adult smoking rates, lung cancer incidence and mortality, and chronic lower respiratory disease mortality rates were all higher in the Capital Region compared to Rest of State.
- Adult asthma prevalence, as well as asthma ED visit and hospitalization rates were also higher in the Capital Region.

- The incidence of positive blood lead in children less than 72 months of age, as well as childhood lead screening, continued to be a Capital Region issue, with rates much higher than residents of Rest of State.
- Capital Region women had higher rates of infant mortality, low birthweight, and late or no prenatal care than Rest of State women. Capital Region teens had much higher pregnancy rates compared to their Rest of State counterparts.
- Mammography screening rates for the general population, as well as the Medicaid population, were lower in the Capital Region, while late stage female breast incidence and mortality rates were higher, compared to Rest of State.
- Chlamydia rates were also much higher in the Capital Region, with increasing trends over the past decade.
- Capital Region counties presented some of the highest Lyme disease case rates in New York State.
- Mental Health indicators such as “poor mental health days”, suicide mortality, and self-inflicted injury hospitalization rates were higher in the Capital Region compared to Rest of State.
- Substance abuse indicators also show there is a growing problem in the Capital Region. Substance abuse (any diagnosis) ED visit and hospitalization rates were higher than Rest of State, with increasing trends. Opioid-related ED visit rates have been increasing in all Capital Region counties. New York State Office of Alcoholism and Substance Abuse Services (OASAS) certified treatment programs in the Capital Region have seen a 90% increase in clients receiving heroin dependency treatment between 2011 and 2014.
- Binge drinking and cirrhosis mortality were also higher in the Capital Region compared to Rest of State.

Community Health Survey data

The Siena Community Health Survey collected responses from a representative sample of Capital Region adults (18+ years). A set of questions asked for feedback on perceived community obstacles. Even with the increased percentage of Capital Region residents covered by some form of health insurance, 40% identified the cost of getting medical care as a very significant obstacle; slightly less of the residents (27%) identified the cost of mental health services as a very significant obstacle. However, 31% identified their reluctance to seek help with a mental health issue as a very significant obstacle. About 31% of Capital Region residents felt the cost of food, and 14% identified access to grocery stores with nutritious options, as very significant obstacles. About 18% of the residents felt access to a safe place to exercise, and 21% the costs associated with being physically active, as very significant community obstacles. Capital Region residents were asked to identify what were the most important health-related issues to address in their community. About 31% of the residents identified “reducing obesity in both teens and adults”, 27% identified “improving both substance abuse treatment and awareness programs”, and 23% identified “improving both preventive care and management for chronic diseases like diabetes, asthma and heart disease” as the most important issues.

Service Areas/Regional Workgroups

HCDI partners formed regional work groups to target and address health priorities specific to particular regions in the defined community. For example, four health priority work groups were established: Albany-Rensselaer, Columbia-Greene, Saratoga, and Schenectady.

Albany Medical Center Hospital participated in the Albany-Rensselaer Work Group. Representatives, including Albany Medical Center Hospital, combined efforts to continue work on a cooperative health improvement plan for residents of these two counties.

Albany Medical Center Hospital did not define the community it serves to exclude areas from which it draws patients or that otherwise should be included based on the method it used to define its community.

Albany Medical Center Hospital's service area was not defined to exclude medically underserved, low-income or minority populations.

Albany Medical Center Hospital provides care to all patients, regardless of their ability to pay, how much they or their insurers pay, or whether they are eligible for assistance under our Hospital's financial assistance policy.

Description of process and methods used to conduct CHNA

The 2016 Community Health Needs Assessment and its full report follow the 2013 Community Health Profile as the fifth data analysis of health needs in the region.

In addition to the original three Capital District counties of Albany, Schenectady and Rensselaer, the 2016 Report includes the additional Population Health Improvement Project (PHIP) counties of Saratoga, Columbia and Greene, into the 6 county Capital Region.

The Health Profile expands upon the predominant mortality and years of life lost focus of early editions to include hospitalization and emergency department analyses, prevention quality indicators, and health behaviors. These additional levels of analysis will enable us to track the need and impact of collective efforts to improve health far before the results are terminal.

The structure of this report is based upon the 2013-2018 Prevention Agenda of New York State. Utilizing the Prevention Agenda framework for examining public health data, aligns our analysis with that of the New York State Department of Health, creating opportunities to compare the Capital Region to other Upstate counties and New York State goals.

The health indicators selected for this analysis were based on a review of available public health data and New York State priorities promulgated through the *Prevention Agenda for a Healthier New York*. Upon examination of these key resources, identification of additional indicators of importance with data available, and discussion with public health as well as health care professionals in the Capital Region, it was decided that building upon the 2013-2018 Prevention Agenda would provide the most comprehensive analysis of available public health needs and behaviors for the Region. The collection and management of this data has been supported by the state for an extended period and are very likely to continue to be supported. This provides reliable and comparable data over time and across the state. These measures, when complemented by the recent Expanded Behavioral Risk Factor Surveillance System and Prevention Quality Indicators, provide health indicators that can be potentially impacted in the short-term. This is a distinct step forward from mortality data leading public health efforts in the past.

Additional data was examined from a wide variety of sources:

- Prevention Agenda 2013-18 indicators
- Community Health Indicator Reports (2011-2013)
- County Health Assessment Indicators (2011-2013)
- County Health Indicators by Race/Ethnicity (2011-2013)
- County Perinatal Profiles (2011-2013)
- Behavioral Risk Factor Surveillance System (BRFSS) and Expanded BRFSS (2013-14)
- Cancer Registry, New York State (2010-2012)
- Prevention Quality Indicators (2011-2013)
- Communicable Disease Annual Reports (2011-2013)
- The Pediatric Nutrition Surveillance System (PedNSS) (2010-2012)
- Student Weight Status Category Reporting System (2010-2014)
- New York State Office of Alcoholism and Substance Abuse Services Data Warehouse (2007-2014)

- New York State Conference of Local Mental Hygiene Directors Behavioral Health Information Portal (2013)
- Hospital-Acquired Infection Reporting System (2010-2013)
- NYS Child Health Lead Poisoning Prevention Program (2010 birth cohort; 2011-2013)
- NYS Kids' Well-being Indicator Clearinghouse (KWIC) (2011, 2014)
- County Health Rankings (2016)
- American Fact Finder (factfinder2.census.gov) (2009-2013)
- Bureau of Census, American Community Survey (2009-2013)

These data sources were supplemented by a Siena College Research Institute Community Health Survey. The 2016 Community Health Survey was conducted from February to March 2016 by the Siena College Research Institute. The survey was a random digit dial telephone survey of adult (18+ years) residents for each of the six counties (n=400 per county; 2,400 for Capital Region). Cell phones and landlines were utilized for the survey. This consumer survey was conducted to learn about the health needs and concerns of residents in the Capital Region. The Community Health Needs Assessment appendix (2016 Capital Region Community Health Survey) contains a detailed summary of the findings, as well as the questionnaire used.

Local data were compiled from these data sources and draft reports were prepared by health condition for inclusion in this community health needs assessment. Drafts were reviewed for accuracy and thoroughness by two staff with specialized health knowledge:

- Kevin Jobin-Davis, Ph.D. who has over 15 years of public health data analysis experience in the Capital Region
- Michael Medvesky, M.P.H. who has over 35 years of experience working with public health data in the New York State Department of Health in many roles including Director of the Public Health Information Group.

Drafts of the sections were sent to local subject matter experts for review in the health departments of Albany, Rensselaer, Schenectady, Saratoga, Columbia and Greene Counties and in St. Peter's Health Partners, Albany Medical Center Hospital, Ellis Hospital, Saratoga Hospital and Columbia Memorial. Comments were addressed and changes were incorporated into the final document.

The Community Health Needs Assessment is not completely comprehensive of every health condition or public health issue. In addition, individuals working on a particular health issue, or experiencing it first hand, undoubtedly have other local data and valuable knowledge to contribute beyond the data reported. The analysis completed was chosen based upon the availability of reliable, comparable data and the delineated priority health areas of the New York State Department of Health. The results should provide a clear description of the prevalence and concentration of each health indicator included. This document would not be possible without the labor, input and support of our sponsors and members of the community. It is the result of over 8 months of meetings with member organizations and community input through our survey of over 2,400 residents of the Capital Region. Their collaboration was invaluable. As a result of these efforts, priority areas for the Capital Region were identified to focus our collective efforts in the coming years: preventing and reducing the burden of obesity and diabetes, mental health, and substance abuse.

This Community Health Needs Assessment was conducted throughout early 2016, and completed by June 2016.

Collaborative Partners

Albany Medical Center Hospital's partnership with Healthy Capital District Initiative (HCDI) has enabled us to track the public health issues of the residents of Albany and Rensselaer Counties, and to meet those needs in a collaborative manner. Other HCDI member organizations have been tracking and working together to address significant health priorities in the remaining Capital Region counties.

The CHNA document benefited from the review and input of the members of the Prevention Agenda Workgroup of the Healthy Capital District Initiative. These individuals are subject matter experts from area county public health departments and each of the Capital Region hospitals. They were joined by representatives from community based organizations, businesses, consumers, schools, academics, and disease groups for a total of approximately 150 different organizations participating in the four Capital Region Public Health Prioritization, and CHIP Work Groups.

The process took into account input from 5 local health departments, scores of organizations across the Capital Region representing the interests and needs of the medically underserved, low-income and minority populations in the community. They assisted with:

- Identifying and prioritizing significant health needs
- Identifying resources potentially available to address those health needs

Other participants in the process comprised community voices through representatives of consumers; advocacy groups; employers; providers, hospitals; and health insurers.

Albany Medical Center Hospital (and partner HCDI members) received input from all required sources from which it requested feedback and insight. Participants were encouraged to share data of their own and to advocate for the needs of their constituents.

These representatives were actively engaged, and many participated in all the prioritization meetings. They provided comments, data, and helped identify critical health resources within the Capital Region.

These sources included:

820 River Street Treatment Facility
Albany County Department of Health
Albany County Department of Mental Health
Albany County Department of Social Services
Albany Medical Center
Albany Medical Center Hospital
Albany Medical Center Physicians Assistant Program
Albany Medical Center: DSRIP
Albany Rensselaer Cancer Program
Alcohol & Substance Abuse Prevention Council
Alliance For Better Health Care
Alzheimer's Association

Alzheimer's Association, Faith Outreach
Apogee Center
Belvedere Health Services, LLC
Berkshire Farm Center & Youth Services
Boys and Girls Club
Capital Consulting Group, LLC
Capital District Childcare Coordinating Council
Capital District Physicians' Health Plan (CDPHP)
Capital District Psychiatric Center
Capital District Tobacco Free Coalition
Capital District Transportation Committee
Capital District YMCA
Capital Roots
Capital Region BOCES
Captain Youth and Family Services
Care Central
Care Coordination Services
Catholic Charities
Catholic Charities: Community Maternity Services
Center for Disability Services
City of Albany Police Department
City of Saratoga Springs
COARC
Colonie Senior Services Centers
Columbia County Community Healthcare Consortium
Columbia County Community Healthcare Consortium (Tobacco-Free Action)
Columbia County Department of Health
Columbia County Emergency Medical Service
Columbia Greene Community College
Columbia Memorial Hospital, Community Health Services
Columbia Memorial Hospital, Mobile Dental Health Services
Columbia-Greene Mental Health Center
Commission for Economic Opportunity
Community Action of Greene County
Community Care Behavioral Health Organization
Conifer Park
Consumer Directed Choices
Cornell Cooperative Extension
Council for Prevention and DSRIP
DePaul Housing Management
Division of Community Services (Greene County)
Domestic Violence Advocacy/ Family Res Programs
Eddy visiting Nurse Association

Ellis Asthma Care
Ellis Family Health Center
Ellis Hospital Urgent Care, Clifton Park
Ellis Medicine
Ellis Primary Care
Fidelis Care Network
Four Winds
Franklin Community Center, Inc.
Greene County Department of Social Services
Greene County Family Planning
Greene County Human Services
Greene County Legislature
Greene County Mental Health
Greene County Public Health
Healthy Capital District Initiative (HCDI)
Hometown Health Centers
Hospitality House
Hudson City School District
Independent Living Center of the Hudson Valley
Interfaith Partnership
Jewish Family Services of Northeastern NY
Kingsway Community
LaSalle Counseling
LaSalle School
Mental Health ~ Saratoga Hospital
Mental Health Empowerment Project
Mobilizing for Action Through Planning and Partnership (MAPP)
MVP Health Care
National Association of Social Workers
National Grid
New Choices Recovery Center
Next Wave
Northern Rivers Family of Services
NYS Court System
Office of Mental Health
Parsons @ Malta
Planned Parenthood
Recovery Advocacy In Saratoga
Recovery Support Services
Rehabilitation Support Services
Rensselaer County Department of Health
Rensselaer County Department of Mental Health
Rensselaer Park Elementary school

Rural Health Network
Samaritan Radiation Oncology
Saratoga Center for the Family
Saratoga City Court Judge
Saratoga Community Health Center
Saratoga County Alcohol and Sub Abuse Services
Saratoga County Dept. of Disability and Social Services
Saratoga County Emergency Medical Services
Saratoga County Mental Health Ctr.
Saratoga County Public Health
Saratoga County Sheriff
Saratoga Emergency Physicians
Saratoga Hospital
Saratoga Hospital Emergency Department
Saratoga Springs Police Department
Saratoga Springs, Mayor's Office
Schenectady Community Action Program
Schenectady County Community College
Schenectady County Human Rights
Schenectady County Public Library
Schenectady County The ARC
Schenectady Inner City Ministry
Schenectady Public Health Services
Schenectady County Office of Community Service
Schuylerville High School
Senator Neil Breslin
Senior Hope
Senior Services of Albany and Cohoes Multi-Service Senior Citizen Center, Inc.
Shelters of Saratoga
Shenendehowa School District
St Luke's Recovery Residence Center
St Peter's Addiction Recovery Services Saratoga
St. Catherine's Center for Children
St. Mary's Hospital
St. Peter's Health Partners
St. Peter's Health Partners (Health Program and Promotion)
St. Peter's Health Partners (Tobacco-Free Health System)
Substance Abuse Prevention Coalition
Sunnyview Hospital
The Community Hospice
The Food Pantries for the Capital District
The Sage Colleges
Tobacco Free Coalition

Transitional Services Association, Inc.
Twin County Recovery Services
United Way of the Greater Capital Region
Unity House
University at Albany
University at Albany School of Public Health
Upper Hudson Planned Parenthood
Van Rensselaer Manor
Veteran Mental Health Council @ VA
Village of Colonie Outreach
Visiting Nurses Association of Albany
Wellspring
Xerox State Healthcare
YMCA

Coordinated through the Healthy Capital District Initiative (HCDI), the counties of Albany and Rensselaer implemented a joint project to engage health providers and community members in a regional health assessment and prioritization process.

Organizations participating in the Albany-Rensselaer Public Health Priority Workgroup include:

- Albany County Department of Health
- Albany County Department of Mental Health
- Albany County Department of Social Services
- Albany Medical Center
- Albany Medical Center Hospital
- Albany Medical Center Physicians Assistant Program
- Albany Medical Center: DSRIP
- Albany Rensselaer Cancer Program
- Alzheimer's Association
- Belvedere Health Services, LLC
- Berkshire Farm Center & Youth Services
- Capital District Childcare Coordinating Council
- Capital District Physicians' Health Plan (CDPHP)
- Capital District Psychiatric Center- Office of Mental Health
- Capital District Tobacco-Free Coalition
- Capital District Transportation Committee
- Capital District YMCA
- Capitol Region BOCES
- Care Coordination Services
- Catholic Charities
- Catholic Charities: Community Maternity Services
- Center for Disability Services
- City of Albany Police Department
- Colonie Senior Services Centers

- Commission for Economic Opportunity
- Community Care Behavioral Health Organization
- Conifer Park
- Fidelis Care Network
- Food Pantries of the Capital District
- Hometown Health Centers
- Hospitality House
- Independent Living Center of the Hudson Valley
- Interfaith Partnership
- Jewish Family Services of Northeastern NY
- LaSalle School
- Mental Health Empowerment Project
- National Association of Social Workers
- National Grid
- Next Wave
- Rehabilitation Support Services
- Rensselaer County Department of Health
- Rensselaer County Department of Mental Health
- Rensselaer Park Elementary school
- Samaritan Radiation Oncology
- Senator Neil Breslin
- Senior Hope
- Senior Services of Albany and Cohoes Multi-Service Senior Citizen Center, Inc.
- St. Catherine's Center for Children
- St. Mary's Hospital
- St. Peter's Health Partners
- The Community Hospice
- The Food Pantries for the Capital District
- The Sage Colleges
- United Way of the Greater Capital Region
- Unity House
- University at Albany School of Public Health
- Upper Hudson Planned Parenthood
- Van Rensselaer Manor
- Village of Colonie Outreach
- Visiting Nurses Association of Albany
- Xerox State Healthcare

A copy of the full Community Needs Health Assessment is attached to this report and available on HCDI's website:

http://www.hcdiny.org/content/sites/hcdi/2016_chna/2016_HCDI_community_health_needs_assessment.pdf .

Community Input

Engaging the community in the health needs assessment process was a priority of Albany Medical Center Hospital, HCDI and all involved stakeholders. Broad community engagement began with participation in the community health survey. The surveys offered multiple choice and open-ended questions to learn about residents' health needs, health behaviors and barriers to care. Demographic information collected by the survey allowed review of information by age, gender, race/ethnicity and income.

The communities assessed in the CHNA report are residents of the counties of Albany, Rensselaer, Schenectady, Saratoga, Columbia and Greene. They form the common service area covered by the local health departments in Albany, Rensselaer, Schenectady, Saratoga, Columbia and Greene Counties and the primary patient population served by Albany Medical Center Hospital, Ellis Hospital, St Peter's Health Partners, Saratoga Hospital and Columbia Memorial Hospital, which are located within the six counties.

In conjunction with the time, input and support of organizations throughout the Capital Region, participation by the community through a survey of more than 2,400 residents of the Region was key in helping identify and confirm priority areas.

The Siena College Research Institute is a recognized and respected market research center that operates under Siena College in Loudonville, NY. They conduct regional, statewide and national surveys on business, economic, political, health care, voter, social, academic and historical issues.

HCDI contracted with Siena College Research Institute to conduct a community health survey as part of the community health needs assessment process.

The Community Health Survey collected responses from a representative sample of Capital Region adults (18+ years).

The 2016 Community Health Survey was conducted from February to March 2016 by the Siena College Research Institute. The survey was a random digit dial telephone survey of adult (18+ years) residents for each of the six counties (n=400 per county; 2,400 for Capital Region). Cell phones and landlines were utilized for the survey. This consumer survey was conducted to learn about the health needs and concerns of residents in the Capital Region. The Appendix found in the attached CHNA (pages 298-325, 2016 Capital Region Community Health Survey, contains a detailed summary of the findings, as well as the questionnaire used. (<http://hcdiny.org/>)

The survey results were incorporated into the examination of health needs by the members of the 4 Capital Region Public Health Prioritization Workgroups (Albany-Rensselaer, Columbia-Greene, Saratoga and Schenectady).

The Workgroups included community voices through representatives from consumers, community based organizations that serve low-income residents, the homeless, those with HIV/AIDS, advocacy groups, employers, public health departments, providers and health insurers. Participants were encouraged to share data of their own and to advocate for the needs of their constituents. While all health institutions serve high need individuals, the two federally qualified health centers, Food Pantries

of the Capital District, United Way of the Capital Region, Interfaith Partnership for the Homeless, and our consumer community representatives have unique access to medically underserved residents.

Significant Community Health Needs

Selection of the top health priorities for the Capital Region was based on a multi-year process, building on existing knowledge from present Community Health Improvement Plan/Community Service Plan implementation efforts, as well as the 2015 Medicaid Delivery System Reform Incentive Payment (DSRIP) Needs Assessment. A Capital Region Prevention Agenda Steering Committee was formed to guide the 2016 Public Health Prioritization process and Plan development. Meetings were held during Fall/Winter 2015-2016 with participation from the five local health departments of Albany, Columbia, Greene, Rensselaer, Saratoga and Schenectady counties, St. Peter's Health Partners, Ellis Medicine, Albany Medical Center Hospital, Saratoga Hospital, Columbia Memorial Hospital and HCDI to ensure that health needs analysis, prioritization and community health plans were timely and of high quality.

Members of these organizations worked to identify individuals to participate in the Capital Region Public Health Prioritization Workgroups.

The Capital Region Public Health Prioritization Workgroups were formed to review data analyses prepared by HCDI and to select the top priorities with one health disparity to be addressed. Data presentations were given at the meetings to provide summarized available data on the leading problems in each of the Workgroup's service areas. Health indicators were included in the Prioritization data presentations if:

- At least one of the county rates were significantly higher than the New York State, excluding New York City data; or
- At least one of the county rates are in the highest risk quartile in the state; or
- Rates for the health condition worsened over the past decade for one of the counties; or
- The health condition was a leading cause of death in one of the counties; or
- Disparity between rates was clearly evident in sub-populations; or
- There were a high absolute number of cases in the counties.

Health indicators that met the criteria were included in the data presentations for each of the five Prevention Agenda Priority Areas: Prevent Chronic Diseases, Promote a Healthy and Safe Environment, Promote Healthy Women, Infants, and Children, Promote Mental Health and Prevent Substance Abuse, and Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections.

Ninety (90) health indicators across the five Prevention Agenda Priority Areas were presented. Available data on prevalence, emergency department visits, hospitalizations, mortality and trends were included for each indicator. Equity data for gender, age, race/ethnicity, and neighborhood groupings were presented as available. After the presentation, these data were made available to Capital Region partners on the HCDI website (<http://hcdiny.org/>). They are also included as attachments.

After the presentation of each set of health indicators, a discussion was held to answer any questions, or for individuals to share their experiences with the health condition in the population. Participants did a preliminary vote on the importance of the condition in the community based on three qualitative dimensions: the impact of the condition on quality of life and cost of health care; if there was community awareness and concern about the condition; and the opportunity to prevent or reduce the burden of this health issue on the community. Participants were provided with a Prioritization Tracking Tool to record their own comments and measure their thoughts on the severity, community values, and opportunity regarding each health indicator.

Upon completion of the data summaries, Capital Region Public Health Prioritization Workgroup members were given an opportunity to advocate for the priority they believed was most meritorious and the group voted on the top two Prevention Agenda categories. Behavioral health and chronic disease categories received the greatest amount of votes by far, because they impacted the largest number of people in the most significant ways, both directly and indirectly, through their influence on other health conditions. They also contributed most significantly to the cost of health care.

Significant Health Priorities

A summary of each Capital Region Public Health Priority Workgroup is as follows:

Columbia-Greene Public Health Priority Workgroup

The Columbia-Greene Public Health Priority Workgroup was led by Greene County Public Health, Columbia County Department of Health, and Columbia Memorial Hospital. Columbia and Greene counties share similar demographic characteristics and health metrics. For this reason the counties elected to align efforts around mutually-selected priority areas. The Prioritization Workgroup was the product of the collaborative decision. Three meetings were held during the prioritization process on: February 12th, March 2nd, and March 16th. During these meetings, HCDI presented health indicators related to the five Prevention Agenda Priority Areas and then facilitated discussions. The PowerPoint data presentations used during these meetings were made available to the Workgroup members, and the general public on the HCDI website (<http://www.hcdiny.org/>). The workgroup chose the priority areas they would focus on during the last workgroup meeting.

More detail about the Columbia-Greene Counties health priority process is described in the CHNA (<http://www.hcdiny.org/>).

In summary, the prioritized, significant health needs selected were:

- Substance Abuse
- Mental Health
- Diabetes/Obesity
- Lyme Disease
- Respiratory (smoking/asthma)
- Heart Disease
- Access to specialists
- Alcohol abuse

Saratoga Public Health Priority Workgroup

The Saratoga Public Health Priority Workgroup was spearheaded by the Saratoga County Health Department and Saratoga Hospital. Three meetings were held on February 10, February 24, and March 18, 2016. During these meetings, HCDI presented health indicators for each of the 5 Prevention agenda Priority Areas, and facilitated Workgroup discussions. The PowerPoint data presentations used during these meetings were made available to the Workgroup members and the general public on the HCDI Website (<http://www.hcdiny.org/>). The Workgroup chose their priorities at the last Workgroup meeting.

More detail about the Saratoga County health priority process is described in the CHNA (<http://www.hcdiny.org/>).

In summary, the prioritized, significant health needs selected were:

- Substance Abuse
- Mental Health
- Alcohol abuse
- Diabetes/Obesity
- Smoking
- Cardiovascular disease
- Lyme Disease

Schenectady County Public Health Priority Workgroup

The Schenectady Public Health Priority Workgroup was spearheaded by Schenectady County Public Health Services, Ellis Medicine and Sunnyview Rehabilitation Hospital. However, they have been working with other Schenectady Partners through the Schenectady Coalition for Healthy Communities (SCHC). The SCHC has been implementing, monitoring and evaluating Schenectady County Prevention Agenda activities since 2013. Three meetings were held on February 4, February 19, and March 31, 2016. During these meetings, HCDI presented health indicators for each of the 5 Prevention agenda Priority Areas, and facilitated Workgroup discussions. The Power Point data presentations used during these meetings were made available to the Workgroup members and the general public on the HCDI Website (<http://www.hcdiny.org/>). The Workgroup choose their priorities at the last Workgroup meeting.

More detail about the Schenectady County health priority process is described in the CHNA (<http://www.hcdiny.org/>).

In summary, the prioritized, significant health needs selected were:

- Mental Health and Substance Abuse (combined)
- Obesity
- Food scarcity
- Smoking related illnesses
- Teen pregnancy
- Asthma
- Diabetes
- Falls
- Childhood lead

Because Albany Medical Center Hospital's service area includes Albany and Rensselaer Counties, the following information is specific to those 2 counties.

Albany-Rensselaer Public Health Priority Workgroup

The Albany Rensselaer Public Health Priority Workgroup was spearheaded by the Albany County Department of Health, the Rensselaer County Department of Health, Albany Medical Center Hospital, and St. Peters Health Partners. Because the hospitals catchment areas covered both counties, it was felt a joint-county Albany-Rensselaer Public Health Priority Workgroup was appropriate. Three meetings were held on February 10, February 24, and March 18, 2016. During these meetings, HCDI presented health indicators for each of the 5 Prevention agenda Priority Areas, and facilitated Albany-Rensselaer Public Health Priority Workgroup discussions. The Power Point data presentations used during these meetings were made available to the Albany-Rensselaer Public Health Priority Workgroup members and

the public on the HCDI Website (<http://www.hcdiny.org/>). The Albany-Rensselaer Public Health Priority Workgroup chose their priorities at the last Workgroup meeting. Organizations participating in the Albany-Rensselaer Public Health Priority Workgroup are listed on pages 20-21.

Albany and Rensselaer Counties completed the Community Health Prioritization Meetings together between February and March 2016. Attendance during these meetings ranged between 40-60 participants representing many health care, community based and public service providers. Participants were engaged in the data presentations, raised many questions, and provided what services look like day to day. During the Asthma Data presentation there was much reflection on how Care Coordination Services truly help patients understand how to reduce asthma emergencies and also how to react in the midst of a crisis that helps reduce emergency room visits. Action plans were viewed as positive for patients especially when patients make them visible on refrigerators, in the school, etc.

During the Diabetes discussion participants raised many questions around the availability of data on other health related matters that maybe risks of diabetes such as vision issues and obesity. Medication therapy for diabetes may require dose adjustments or may be contraindicated in patients with chronic kidney disease. When reviewing obesity data participants began to draw a correlation to neighborhoods that maybe more of risk due to lack of access to healthy foods, and recreation. Participants were able to provide insight to students in school and their inability to pass many of the physical assessments conducted in Physical Education classes. During the Mental Health and Substance Abuse presentation participants from both counties reflected how much of a crisis the opioid epidemic is here in the Capital Region. Data presented supported the need for more Mental Health and Substance Abuse professionals.

In summary, the prioritized, significant health needs selected were:

- Mental Health
- Substance Abuse
- Obesity
- Diabetes
- Respiratory (smoking/asthma)
- Adverse birth outcome
- STD/HIV
- Lyme disease
- Female breast cancer
- Falls

A description of resources potentially available to address these needs is contained in the HCDI 2016 CHNA (attached and at <http://www.hcdiny.org/>).

Albany Medical Center Hospital's Implementation Strategy

Selected Health Priorities: Albany-Rensselaer Counties

Behavioral health and **chronic disease** categories received the greatest amount of votes due to their impact on a large number of people in the most significant ways, both directly and indirectly, and through their influence on other health conditions. They are also largely preventable and contribute most significantly to the cost of health care.

The group's priorities also reflect the participating entities' abilities to effectively align resources to make the most positive impact on the Albany-Rensselaer County community.

Albany and Rensselaer Counties selected the following significant, prioritized health needs:

I. CHRONIC DISEASE

- a. **Reduce Obesity in Children and Adults** (inclusive of risk factors and promotion of evidenced-based intervention programs)
- b. **Asthma / tobacco cessation** (to be addressed through Delivery System Reform Incentive Payment activity)

II. BEHAVIORAL HEALTH

- a. **Prevent Substance Abuse** (e.g. opioid abuse)
- b. **Strengthen Mental Health Infrastructure across Systems** (to be addressed through Delivery System Reform Incentive Payment activity)

Why were these health needs selected?

CHRONIC DISEASE

Diabetes/Obesity

- Both counties are significantly higher in comparison to NYS, excluding NYC for short term complication (18+yrs) hospitalizations
- Rensselaer County fell into the 4th risk quartile
- The diabetes short term complication hospitalization trend has been increasing since 2008
 - Albany showed a 35% increase in adult obesity between 2003 and 2014
 - Rensselaer County showed a 13% increase
- the prevalence of obesity increases with age in both counties
- Albany County and Rensselaer County showed lower or similar rates of adults "not engaged" in some type of leisure time physical activity than ROS.

Asthma

- Prevalence is higher than rest of Upstate NY
- ED visits significantly higher for both young children and adults
- Both Albany and Rensselaer Counties' adult asthma prevalence, asthma ED visits and hospitalization rates were higher or significantly higher than the rest of Upstate NY

- High risk neighborhoods are 2 to 6 times higher than Upstate NY rates for both ED visits and hospitalizations

BEHAVIORAL HEALTH

Substance Abuse

- Substance abuse mortality trends for both counties increased from 2009-11 through 2011-13
- Albany had higher opiate ED visits and similar opiate hospitalization rates than rest of state (ROS)
- Rensselaer had slightly lower ED and hospitalization rates than ROS
- Both counties showed a major increase in opiate ED rates between 2013 and 2014, but decreases in the opiate hospitalization rates
- Males had 2.3 to 3.5 times higher substance abuse mortality, 1.0 to 1.3 times higher substance abuse ED and hospitalization rates, and 1.5 to 1.9 times the opiate ED and hospitalization rates than females
- Black non-Hispanics had about 1.5 times the drug-related hospitalization rates compared to their white non-Hispanic counterparts
- High risk neighborhoods had 1.1 to 1.4 times higher substance abuse mortality, 2 to 4.5 times the substance abuse ED visit and hospitalization rates, and 1.7 to 4.7 times the opiate ED and hospitalization than ROS
- There was an over 90% increase in clients receiving Heroin Dependency Treatment at Capital Region OASAS certified treatment programs between 2011 to 2014

Mental Health

- Both counties had a higher % of adults with poor mental health compared to ROS
- Rensselaer fell into the 4th risk quartile and Albany the 3rd risk quartile
- The % of adults with poor mental health days increased in both counties between 2008-09 and 2013-14
- An estimated 19% of both county's adult population had a mental illness; 4% had a serious mental illness

How are we addressing these needs?

Each Regional Health Improvement Task Force has identified best known practices for intervention, and resources available in the community to address these concerns.

Albany Medical Center Hospital, a member of each Task Force, is engaged in many of the activities outlined by the Task Forces, which aim to collaboratively improve efforts related to disease prevention and management through a process that includes:

- An over-arching goal
- Measurable objectives
- Specific strategies
- Tactics and partnerships to support strategies

Through the Health Capital District Initiative (HCDI), two task forces were formed to respond to the priority health needs identified in the 2013 Community Health Needs assessment.

The existing Diabetes/Obesity Task Force will continue efforts to prevent type 2 diabetes, and help patients learn how to self-manage and live a healthy lifestyle. As learned during the 2016 Prioritization Meetings, obesity rates continue to increase. Given the connection between both diabetes and obesity this task force has added goals related to the reduction in obesity rates in Albany and Rensselaer Counties.

Albany Medical Center Hospital will provide the staff, facilities and budget necessary to carry out our initiatives as outlined on the following pages.

Chronic Disease: Albany-Rensselaer Counties

Goal: Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.

Target Population: Adults

Objective: By December 31, 2018, increase the percentage of adults 18+ who had a test for high blood sugar or diabetes within the past three years by 5%, from 58.8% (2011) to 61.7%. [Data Source: Behavioral Risk Factor Surveillance System]

Strategy	Partner Roles and Resources	Process Measures
<p>Promote prediabetes through the use of evidence-based screening tools and marketing</p>	<p>Albany Medical Center Hospital: Provide professional diabetes education summit; provide assistance in development of educational materials; educate our primary care physicians St. Peter’s Hospital: provide funding for professionals to be trained in NDPP and expand existing NDPP programs in Rensselaer County; provide access to St. Peter’s professionals to become trained on prediabetes screening and resources available within Rensselaer County community Rensselaer County: educate and provide technical assistance to primary care offices; outreach within the community; produce marketing materials Diabetes/Obesity Task Force: assist in development of marketing materials; provide support for outreach programming</p>	<ul style="list-style-type: none"> • # of healthcare professionals educated on evidence-based screening tool • # community members educated on prediabetes through outreach activities • # marketing materials distributed and locations

Chronic Disease: Albany-Rensselaer Counties

Goal: Create Community environments that promote and support healthy food and beverage choices and physical activity.

Target Population: Adults and children

Objective: By December 31, 2018, reduce the percentage of obese youth and adults.

Strategy	Partner Roles and Resources	Process Measures
Implement nutrition and beverage standards in public institutions, worksites, school districts and childcare centers	<p>Albany Medical Center Hospital: Promote healthy living and wellness through our “Wellness: Healthy Choices, Healthy You” program, a 4-pronged wellness approach which includes healthy nutrition education; participation in “<i>Sodium Reduction in Communities</i>” grant</p> <p>St. Peter’s Hospital: encourage healthy living through St. Peter’s Wellness Committee; provide technical assistance in developing and implementing strategies for school district health and wellness policies</p> <p>Albany County DOH: provide technical assistance in designing and implementing nutrition and beverage standards</p> <p>Rensselaer County DOH: Provide technical assistance to area worksites implementing healthy workplace strategies</p> <p>Diabetes/Obesity Task Force: Promote worksite wellness, and health and wellness policies, and evidence-based practices</p>	<ul style="list-style-type: none"> • # of organizations that adopt and implement nutrition and beverage standards • # of schools that adopt and implement comprehensive and strong Local School Wellness Policies
Promote physical activity in childcare centers, school districts, and community venues	<p>Albany Medical Center Hospital: Promote healthy living as part of Albany Med’s Wellness Program’s “Move, Learn, Heal and Eat” initiatives – Fitness Center, Fitness Classes, Fitness App, walking groups, etc.; exercise prescriptions given to patient populations</p> <p>St. Peter’s Hospital: Encourage</p>	<ul style="list-style-type: none"> • # of plans adopted or opportunities available promoting physical activity • # school districts that implement comprehensive school physical activity programs • # children participating in community soccer program

	<p>healthy living through Wellness Committee. Community Soccer Program. <i>Creating Healthy Schools and Communities</i> Grant.</p> <p><u>Albany County DOH</u>: provide technical assistance in designing and implementing nutrition and beverage standards</p> <p><u>Childcare Coordinating Council</u>: Provides technical assistance to childcare centers and family-based centers re Eat Well Play Hard standards; provides support training to Champion Centers once completed 3 EWPH trainings.</p> <p><u>Capital Roots</u>: Provides technical assistance in designing and implementing Complete Streets</p> <p><u>Rensselaer County DOH</u>: promote physical activity and wellness through community outreach</p> <p><u>Diabetes/Obesity Task Force</u>: Promote & provide support to outreach activities throughout both counties</p>	
--	---	--

Chronic Disease: Albany-Rensselaer Counties

Goal: Promote culturally relevant chronic disease self-management education.

Target Population: Adults

Objective: By December 31, 2018, increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition.

Strategy	Partner Roles and Resources	Process Measures
Participation of adults in self-management programs	<p>Albany Medical Center Hospital: Promote lifestyle changes and prediabetes education; diabetes prevention and education sessions and brochures; increase # of Certified Diabetes Educators</p> <p>St. Peter’s Hospital: offer NDPP to employees, encourage patients to participate in NDPP</p> <p>Albany County DOH: Promote NDPP, strengthen NDPP referral systems, and other evidence-based programs</p> <p>Rensselaer County DOH: promote and provide NDPP training, strengthen NDPP referral systems</p> <p>Diabetes/Obesity Task Force: Promote NDPP, review and update Diabetes Resource Guide, review Alternative Lifestyle Change programs</p>	<ul style="list-style-type: none"> • # participants in NDPP and YDPP programs • # participants in other (non-NDPP) evidence-based intervention programs that support Lifestyle Change

The existing Behavioral Health Task Force will focus on Substance Abuse and Opioid Prevention. Mental Health and Tobacco will receive direction from *DSRIP (Delivery System Reform Incentive Payment Program)* activities. DSRIP has initiatives for Mental Health facilities going Tobacco Free, and implementing Tobacco Cessation into treatment planning for those receiving Mental Health Treatment. The Integration of Mental Health and Primary Care is also a focal point of DSRIP. Activities conducted through these DSRIP projects will be documented through this priority area.

Substance Abuse: Albany-Rensselaer Counties

Goal: Reduce non-medical use of prescription pain medication.

Target Population: Adults

Objective: Increase education and practice strategies to reduce opioid overdose and non-medical use of opiates.

Strategy	Partner Roles and Resources	Process Measures
Provider education <ul style="list-style-type: none"> • Prescribing guidelines • Community resources • Patient education 	Albany Medical Center Hospital: Educate physicians regarding prescribing guidelines; participate in prescription drug monitoring program; host provider addiction/pain medicine conference <u>St. Peter’s Hospital:</u> provide hospital pharmacies with marketing materials on 3-point message; provide physicians with prescribing guidelines, patient contracts, etc. <u>Albany County DOH:</u> provide provider education; promote use of standing order naloxone in local pharmacies <u>Behavioral Health Task Force:</u> design patient education materials (risk factors of opiate addiction)	<ul style="list-style-type: none"> • # primary care and pharmacy sites that have implemented ISTOP provider education • # or % of providers participating in prescription drug monitoring program
Increase education on, and mechanisms for proper disposal of unused prescribed medication <ul style="list-style-type: none"> • Proper storage • Drug take backs 	Albany Medical Center Hospital: Will provide public a mechanism for proper disposal of unused medications; promote proper storage <u>St. Peter’s Hospital:</u> publicize drug take backs and proper storage materials <u>Albany County DOH:</u> initiate Project Orange	<ul style="list-style-type: none"> • # of safe prescription opiate disposal programs, take-back events, drop boxes, safe storage education efforts • # public awareness, outreach, and educational efforts to change attitudes, beliefs, and norms toward underage and excessive adult alcohol use, and

	<p><u>Rensselaer County</u>: promote drug take backs and proper storage</p> <p><u>Behavioral Health Task Force</u>: promote drug take backs and proper storage</p>	prescription opiates
Increase number of patients receiving outpatient services	<u>DSRIP</u> : St. Peter's Addiction Recover Center (SPARC)	<ul style="list-style-type: none"> • # of patients receiving treatment annually
New York State Opioid Overdose Prevention Training	<p>Albany Medical Center Hospital: Educate and train law enforcement and emergency medical professionals on Narcan distribution</p> <p><u>St. Peter's Hospital</u>: host and publicize community Narcan trainings</p> <p><u>Albany County DOH</u>: host and publicize Narcan trainings</p> <p><u>Rensselaer County DOH</u>: host and publicize Narcan trainings</p> <p><u>Catholic Charities</u>: provide Narcan training in both counties</p> <p><u>Behavioral Health Task Force</u>: design patient education materials (risk factors of opiate addiction)</p>	<ul style="list-style-type: none"> • # of persons participating in Naloxone training

Other health needs

While not addressed through HCDI's Regional Health Task Forces, below are examples of Albany Medical Center Hospitals' programs and initiatives to address other health needs for residents of the Albany-Rensselaer County region.

Asthma: Albany County's adult current asthma prevalence, asthma emergency department visit rate, and asthma hospitalization rate were higher or significantly higher than Rest of State; the West Hills/South End and West End neighborhoods of Albany County, zip codes with a high population of Medicaid beneficiaries, had 5 times the asthma ED rates and 4 times the asthma hospitalization rates than Rest of State.

The Asthma Management project of Albany Medical Center's DSRIP program (Delivery System Reform Incentive Payment) is driving key tasks to:

- Implement evidence based asthma management guidelines between primary care practitioners, specialists, and community based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population-based approach to asthma management.
- Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.
- Deliver educational activities addressing asthma management to participating primary care providers.
- Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.
- Use EHRs or other technical platforms to track all patients engaged in this project.

Adverse Birth Outcome: Albany and Rensselaer Counties have slightly higher to significantly higher percentages of preterm and low birth weight births. Albany and Rensselaer Counties are in the 4th Risk quartile for preterm births compared to all NYS counties; Albany is also the 4th risk quartile while Rensselaer is in the 3rd quartile for low birth weight births. Albany and Rensselaer Counties have a slightly increasing trend for both % of preterm births and % of low birth weight births; by race/ethnicity, infant mortality rates in Albany and Rensselaer Counties were higher than rest of Upstate NY, except among Black non-Hispanic infants in Rensselaer County.

- Albany Medical Center Hospital has the region's only:
 - Children's Hospital
 - New York State Level IV Neonatal Intensive Care Unit – approximately 800 preterm infants are cared for each year; a significant number of these babies are from low-income families
 - New York State designated Level IV Regional Perinatal Care Center
 - High-risk Maternal-Child Coordinated Care Program operated by perinatologists and pediatrician teams
 - Management of Diabetic Pregnancy
 - Management of High-Risk Pregnancy
 - Oral Health and Pregnancy
 - Perinatal HIV and Infectious Diseases
- Women, Infants and Children (WIC) Program –

- We operate 3 convenient locations throughout Albany County, in areas such as inner-city Albany, Ravena, and the hill towns of Berne-Knox-Westerlo. The WIC office also makes evening appointments available.
- Our WIC programs serve more than 3,000 each month.
- Breastfeeding classes, support groups are offered on a regular basis
- Albany Medical Center Hospital's Birth Place promotes education to help women during their pregnancy. Through its many classes, mothers and their families make well-informed choices about pregnancy, birth, infant care and parenting. Approximately 2,000 women give birth at Albany Medical Center Hospital annually; most attend at least one of the education sessions.

STDs/HIV: Albany County has significantly higher rates of gonorrhea compared to the ROS and fell into the 4th risk quartile; Albany County had significantly higher male and female chlamydia rate compared to the ROS and fell into the 4th risk quartile; Rensselaer County had significantly higher female rates, chlamydia has been an increasing trend for both counties since 2004.

Albany County had the highest new HIV case rate, AIDS case rate and AIDS mortality rate in the Capital Region. While Rensselaer County HIV case rates have been consistently below the Upstate average, their case rate spiked in 2013 (year for which the most recent data is available).

It is well documented that people who contract an STD often also have HIV or are more likely to become HIV-infected.

- We are the region's only designated AIDS Treatment Center, which allows for increased services, coordinated care, and a wider range of programs for patients.
 - We provide a wide range of services on a 24-hour basis for people with HIV infection and AIDS and our case managers will help patients identify resources available to help pay bills if needed. We strive to provide the most comprehensive services, including medical, social, nutritional, psychological, educational and clinical research services to both hospitalized patients and outpatients regardless of their location or ability to pay.
 - Our goal is to offer accessible, quality health care to those residents of our service area who become HIV-infected. We help coordinate support services for patients seeking care by working with community organizations. Our expert staff, health care providers, and community members receive continued education about HIV infection and provide compassionate and appropriate care to patients.
- The Specialized Care Center for Adolescents and Young Adults at the Bernard & Millie Duker Children's Hospital at Albany Medical Center Hospital developed a marketing plan to reach as many at-risk young people as possible with information on PrEP, or pre-exposure prophylaxis. 1,500 rack cards list the services we make available to at-risk youth. 4,000 PrEP brochures have been distributed at various community locations such as the Pride Center, Albany Public Library branches, and others. Our PrEP services have been advertised on the Capital District Transit Authority bus shelters.
- We also worked with Trinity Alliance and the University at Albany to hold lectures with nationally-recognized speaker Damon Jacobs about PrEP.
- We had a presence at a "Stay Well" community event offering education on HIV awareness. The event was a collaboration with partners Trinity Alliance and the Alpha Phi Alpha fraternity.

Lyme disease: Annually, Albany and Rensselaer Counties have 823 cases of Lyme disease. Rensselaer County has 3 times the amount of cases seen in Albany County. Both Albany and Rensselaer counties fall into the 4th risk quartile. Rensselaer County has the 3rd highest Lyme disease case rate of all NYS counties.

- Our division of infectious disease works closely with each patient to provide infection surveillance, exposure and outbreak investigations, education and if applicable, infection control consultation.
- Our pediatric infectious disease division provides outpatient and inpatient care for the evaluation and management of children and adolescents with conditions including Lyme disease, Albany Med's subspecialty board certified pediatric infectious disease specialists are the only pediatric infectious disease specialists in the 22 counties of northeastern New York.
- Albany Medical College's Microbial and Immunology Research Program brings together a diverse group of scientists and investigators. The research and training effort concentrates on exploring, in an integrated fashion, host-pathogen interactions during infections with various microbes, including HIV-1, Lyme disease, MRSA, and pneumococcal infections.

Female breast cancer: The mammogram screening rate for women 40+ for Albany and Rensselaer Counties were lower than the Upstate NY average. Albany County's rates for female breast cancer incidence, including late stage, were higher or significantly higher than the rest of Upstate NY. In addition, female breast cancer mortality in Albany County was higher than the rest of Upstate NY. And while Rensselaer County had a high breast cancer screening rate for women 50+, Albany County had one of the lowest rates in the region as well as below the Upstate NY rate.

- Our Breast Care Center offers a full range of preventative, routine, and advanced services in breast health and provides thousands of patients each year access to specialty services unavailable anywhere else in the Capital Region.
- The Breast Care Center offers expertise in breast imaging, medical management and surgery.
- Our breast center employs a full-time liaison to the New York Cancer Services Program. This individual is the interface between the uninsured/underinsured and the Cancer Services Program, and has assisted many women since being introduced.
- Annually, we conduct 11,000 mammography screenings, serving women (and men) from a wide catchment area.

Falls: Emergency Department visit rates from falls for Albany and Rensselaer County residents are below both Prevention Agenda objectives and Upstate NY average. However, for the hospitalization rate for falls per 10,000 of residents 65+ years, Rensselaer County exceeded the Prevention Agenda goal.

Overall, among the 85+ population, the Capital Region's fall hospitalization rate was nearly 8 times higher than the rate of the 65-74 age cohort.

Falls are the leading cause of fatal and non-fatal injuries for older Americans, resulting in more than 2.5 million injuries treated in emergency departments annually, including over 734,000 hospitalizations and more than 21,700 deaths.

- Through practical lifestyle adjustments, fall prevention programs, and clinical-community partnerships, the number of falls among seniors can be substantially reduced.
- Albany Medical Center Hospital's Outpatient Physical Therapy practice:
 - screens the vast majority of patients 65+ (90% to 94%) who they care for. Patients are screened for their propensity to fall, based on a measured test entitled "Timed Up and Go" to assess a person's mobility and balance
 - administers the CDC's "STEADI" (Stopping Elderly Accidents, Deaths and Injuries) fall risk checklist to determine a patient's risk of falls
 - educates patients at risk for a fall and why based on fall checklist answers

- educates patients and caregivers about reducing the risk of falling

Regional health needs identified in the 2016 CHNA that **will not be** addressed in Albany Medical Center Hospital's Implementation Strategy

During the prioritization process, many health needs were selected by the Prioritization Workgroups as important to address. While there was commonality among many of the pressing health needs, there were also some regional differences.

These health priorities of Columbia, Greene, Saratoga, and Schenectady Counties are being addressed largely by hospitals, local health departments, and other organizations in their communities.

Columbia-Greene Counties

- Substance Abuse
- Mental Health
- Diabetes/Obesity
- Lyme Disease
- Respiratory (smoking/asthma)
- Heart Disease
- Access to specialists
- Alcohol abuse

Partner Columbia Memorial Hospital, with Greene County Public Health and Columbia County Department of Health is taking the lead on aligning efforts around these mutually-selected priority areas.

When feasible, Albany Medical Center Hospital will assist with the implementation of the Workgroup's initiatives.

Saratoga County

- Substance Abuse
- Mental Health
- Alcohol abuse
- Diabetes/Obesity
- Smoking
- Cardiovascular disease
- Lyme Disease

Partner Saratoga Hospital, with Saratoga County Department of Health is taking the lead on aligning efforts around these mutually-selected priority areas.

When feasible, Albany Medical Center Hospital will assist with the implementation of the Workgroup's initiatives.

Schenectady County

- Mental Health and Substance Abuse (combined)

- Obesity
- Food scarcity
- Smoking related illnesses
- Teen pregnancy
- Asthma
- Diabetes
- Falls
- Childhood lead

Schenectady County Public Health Services, Ellis Medicine and Sunnyview Rehabilitation Hospital are taking the lead to address the priority areas selected for this region. They have also been working closely with other Schenectady Partners through the Schenectady Coalition for Healthy Communities (SCHC).

When feasible, Albany Medical Center Hospital will assist with the implementation of the Workgroup's initiatives.

Evaluation of impact of any actions taken since the preceding CHNA

Throughout 2014-2017, the time period of the previous CHNA and related community service plans, quarterly task force meetings, coordinated by the Health Capital District Initiative (HCDI) assessed the progress of strategies and tactics for the selected behavioral health and chronic disease goals.

The Population Health Improvement Plan Committee of the Healthy Capital District Initiative, in which Albany Medical Center Hospital participates, also served as an oversight group to determine successes and challenges related to the implementation of the community health strategies.

It was determined that while many tactics were successful, others were difficult to execute due to resources, funding, etc. Other goals were determined to be too broad or too vague to implement.

The impact was evaluated by which tactics were executed, and if the deliverables were met.

In addition, other than County Health Rankings (2016 data), public health data is currently not available to allow for a full evaluation of the tactics of the task forces. Most of the public health data is available through 2013, the year preceding the 2014 CHNA.

The task forces, using the results of the 2016 CHNA to confirm pressing health priorities, agreed that the 2014-2017 task force plans should be continued, but should be streamlined to ensure effective outcomes.

Approvals

Adoption of Community Health Needs Assessment and Community Service Plan

On October 25, 2016 the Hospital Affairs Committee approved and recommended to the Albany Medical Center Hospital Board the approval of Albany Medical Center Hospital's Community Health Needs Assessment ("CHNA"), Implementation Strategy and Community Service Plan ("CSP"). On November 2, 2016 the Board approved the CHNA and CSP.

Making CSP widely available to the public

As in past years, Albany Medical Center Hospital's Community Service Plan will be publicized through various outlets.

These include:

- Our website (www.amc.edu)
 - Our CHNA will remain posted on our site for 2 subsequent CHNA cycles
- "Albany Med Today" newsletter (for staff and for public)
- "Board of Directors" newsletter (for Albany Medical Center's governance)
- Printed copies will also be made available upon request.

Additionally:

- Active engagement in a broad range of community organizations provides a platform for sharing information about our Community Service Plan and our health promotion priorities
- Information about all of our community health initiatives is made widely available through targeted brochures, select advertisements (such as announcement of free screenings and seminars), and maximum use of free media to promote these services

Attachment: “HCDI 2016 Community Health Needs Assessment”

Please refer to the attachment entitled “CSP Attachment_HCDI CHNA_2016” for more detail about the community health needs assessment process:

- Summarizes the public health needs of communities in the Capital Region with the most reliable data available
- Provides a broad array of health information that may be useful in determining and monitoring health promotion priorities for the community
- Provides an overview of the processes used to select indicators and priorities, and details about individuals and organizations who participated in these processes
- Provides information about the selection of significant health priorities, and plans to address them

