ALBANY MEDICAL CENTER

KNOWN FOR OUR EXPERTISE. CHOSEN FOR OUR CARE.

OUR COMMUNITY SERVICE REPORT:

Health Improvement Plan 2014-2017

Submitted: November, 2013

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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 is 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 Med – 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 Community Service Plan also illustrates the collaborative efforts among local hospitals, local health departments, and other health and community organizations.

INTRODUCTION

Health Planning Process:

Supporting community health improvement by fostering multi-stakeholder coalitions

As a result of the community health planning efforts, three priority areas for the Capital District were identified to focus our collective efforts in the coming years: preventing and reducing the burden of diabetes, asthma, and mental health disease/substance abuse. This Community Health Needs Assessment was completed and approved in September 2013.

MISSION STATEMENT

Albany Medical Center is the only academic medical center in Northeastern New York. As such, it is committed to providing care at a level which requires the most complex array of resources, and the most professional staffing and high-end technologies of any hospital within this catchment area.

> *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.

HOW WE DEFINE THE COMMUNITY WE SERVE

Our vast service area

Our tripartite mission and our geographic location in New York State distinguish us from every healthcare provider within approximately 150 miles - which results in how we define our large and vast service area: 25 counties throughout Northeastern New York and Western New England.

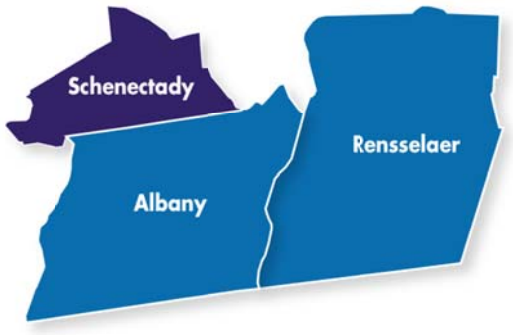
Most facilities in New York State define their health planning service areas by zip code, not county. Because of our role in the region, we define our health planning service area by county. About 2/3 of our patients are from the four counties in our immediate Primary Service Area – Albany, Rensselaer, Saratoga and Schenectady counties. Here, we function to a larger degree as a primary hospital, particularly for Albany, Rensselaer and Schenectady Counties.

Outside the Capital Region we complement existing acute services. Our 24/7 access to specialists unavailable elsewhere in the region continues to drive an increase in patient transfers. In 2012, for example, 8,500 patients were transferred from other hospitals and health facilities throughout the region.

For Community Health Needs Assessment and Improvement Plan

The 830,000 residents of the Capital District depend on Albany Medical Center for a vast range of preventive services and advanced care. Analysis of Saratoga County utilization, however, shows that residents – particularly from the southern region – depend on Albany Med for high-end care. We provide the remainder of the Capital District with a broader range of our services – from community education and primary care, to acute care.

Our partnership with Healthy Capital District Initiative (HCDI) has enabled us to track the public health issues of the residents of Albany, Rensselaer and Schenectady Counties, to meet those needs in a collaborative manner.



HCDI members from Albany and Rensselaer counties, including Albany Med, combined efforts to begin to define a cooperative health improvement plan for residents of those two counties. Simultaneously, the "Schenectady Coalition for a Healthy Community" developed a similar assessment and plan for residents of Schenectady County.

COLLABORATION

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

> *Albany Med and area hospitals, health insurers, county health departments, and many other organizations have partnered to improve the health status of the tri-County region by determining some of the major barriers to health services and developing initiatives to greatly reduce them.*

The current HCDI collaborative expands upon the organization's prior collective efforts. While the health assessment is not completely comprehensive of every health condition or public health issue, it was chosen based upon the availability of reliable, comparable data and the delineated priority health areas of the New York State Department of Health.

Two approaches to assessing the health of our community were embarked upon:

- An in-depth analysis of public health needs based on the most reliable data available
- A community health survey

These data sets provided a broad array of health information that served as the basis for the community health needs assessment.

Finger Lakes Health Systems Agency and the Public Health Information Group provided data and support for the accurate completion of the community health assessment. Additionally, Professors Dwight Williams, M.S.W., Elizabeth Gruber, Dr. PH., and Julia Hastings, Ph.D. from the University at Albany School of Public Health were instrumental in the construction, promotion and analysis of the community survey data. The assessment also benefited from the review and input of the members of the Community Health Needs Assessment Workgroup of the Healthy Capital District Initiative and the Capital Regional Health Prioritization Task Force.

COMMUNITY HEALTH NEEDS ASSESSMENT

For additional detail, please refer to HCDI's "2013 Community Health Needs Assessment: A Compendium of Public Health Data for Albany, Rensselaer and Schenectady Counties", www.hcdiny.org.

The Community Health Needs Assessment (CHNA) is the result of over 12 months of meetings with HCDI member organizations, and community input through a survey of over 3,000 residents of the Capital District.

PROCESS AND METHODS USED TO CONDUCT ASSESSMENT

Selection of Indicators

Selection of health indicators was 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 District, it was decided that building upon the 2008-2012 and 2013-2017 Prevention Agendas 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 of time and continuation of that support is anticipated. This provides us with both reliable and comparable data over time and across the State. These measures include health care utilization and children's health, which, when complemented by Behavioral Risk Factor Surveillance System and Prevention Quality Indicators, provide health indicators that can be potentially improved in the short-term. This is a distinct step forward over mortality data leading public health efforts in the past.

Once the set of indicators was selected, a data request was made to the Finger Lakes Health Systems Agency to provide ZIP code level analyses, emergency room utilization analyses, race and ethnicity for Vital Statistics 2006-2010 and Statewide Planning and Research Cooperative System (SPARCS) data. This period was chosen in order to continue 20 years of trend analyses and to establish more reliable rates when looking at small geographic areas or minority populations.

The databases selected for use include birth, death, hospitalizations and emergency room utilization records, among others. It is important to note that inclusion or exclusion of indicators from this report does not convey any prioritization of health conditions.

Community Engagement

Engaging the community in the health needs assessment process was a priority of HCDI, Albany Med, and other stakeholders. Community engagement began with distribution and participation in a community health survey. The surveys offered multiple choice and open ended questions to learn about residents' health needs, health behaviors and barriers to care. Over-sampling of high need neighborhoods was performed to collect more robust information about areas with disproportionate

health needs. Surveys were distributed in community organizations, churches, by community health workers, in primary care sites and through large employers.

COMMUNITY DEMOGRAPHICS

The following information profiles the demographics and public health data of residents of Albany, Rensselaer and Schenectady Counties. For demographic information specific to the 3,000+ residents of this community who participated in our community health survey, see section "Public Participation" in this report.

For additional detail, please refer to HCDI's "2013 Community Health Needs Assessment: A Compendium of Public Health Data for Albany, Rensselaer and Schenectady Counties", www.hcdiny.org .

Gender

Capital District women present a better preventive health picture than their male counterparts. A greater percentage of females were covered by health insurance, were more likely to have a primary care health provider, were more likely to have received preventive medical services, and were less likely to be obese than men from the Capital District. Heart disease, cancer, Chronic Lower Respiratory Disease (CLRD), and stroke were the leading causes of death in Capital District women. Female residents also had higher ED visit and hospitalization rates for asthma, CLRD, falls in the elderly, and assault than women who reside in Rest of State. However, Capital District women had lower hospitalization rates than Rest of State for coronary heart disease and motor vehicle accidents. Compared to their male counterparts, Capital District females had higher ED visit and hospitalization rates for asthma, CLRD, elderly falls, and self-inflicted injuries. Capital District females also had higher gonorrhea and chlamydia rates than male residents.

Heart disease, cancer, CLRD and stroke were the leading causes of death for male residents of the Capital District. Compared to the Rest of State, Capital District males had higher ED visit and hospitalization rates for asthma, assault, CLRD, and elderly falls. As with females, Capital District males had lower coronary heart disease and motor vehicle accident hospitalizations than male Rest of State residents. Compared to their female counterparts, Capital District males had a higher incidence of lung cancer, coronary heart disease hospitalizations, stroke hospitalizations and colorectal cancer mortality. Males also had a 3 to 4 times the assault hospitalization rate compared to females in the Capital District.

Race/Ethnicity

In general, Black non-Hispanic Capital District residents were at greater health risk than White non-Hispanic residents. Black non-Hispanic residents had 5.4 times the percent of population below poverty compared to White non-Hispanic Capital District residents. Black non-Hispanic residents also had higher age-adjusted total mortality rates than White non-Hispanic residents. Hispanic Capital District residents had the lowest age-adjusted total mortality rates.

When compared to White non-Hispanics, Black non-Hispanic Capital District residents had serious issues with diabetes. They had 2.0 times higher diabetes mortality rates; 3.4 times higher diabetes (primary diagnosis) hospitalization rates; and 3.4 times higher rates of hospitalizations due to short-term complications of diabetes. In addition, Black non-Hispanic Capital District residents also had 4.4

times the asthma hospitalization rates; 4.5 times higher teen pregnancy rates; 50% lower adequate prenatal care rates; and 1.6 times higher drug-related hospitalization rates than their White non-Hispanic counterparts. The difference in assault hospitalizations was especially striking. Black non-Hispanics had 7.9 times the rates than White non-Hispanic residents.

Chronic Lower Respiratory Disease (CLRD), one of the leading causes of death in the Capital District, had unusual disparity data. Black non-Hispanic residents had a 1.5 times higher hospitalization rate for CLRD, while White non-Hispanics had 3.1 times higher CLRD mortality rates than Black non-Hispanic Capital District residents. White non-Hispanic residents also had 2.9 times higher congestive heart failure mortality rates than Black non-Hispanic residents. The rate of hospitalizations of the elderly due to falls also showed that White non-Hispanic Capital District residents had a 2.3 times higher rate than their Black non-Hispanic counterparts.

The relatively small number of Asian non-Hispanic and Hispanic Capital District residents cautions interpretation of indicators for these populations.

MAIN HEALTH CHALLENGES

The health of Capital District residents was generally consistent with other New York counties outside New York City (Rest of State), although 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 that is driven by premature deaths. Chronic diseases were the leading causes of death in the Capital District, with heart disease and cancer 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 District having fewer barriers to care than the Rest of State. Capital District residents, both children and adults, had higher health insurance coverage rates compared to Rest of State. A higher percent of residents also had a regular health care provider. The Capital District's primary care system also seems to be working well compared to Rest of State. When looking at preventable hospitalizations, Capital District residents had much lower rates than residents from Rest of State. However, Emergency Department (ED) utilization was still a Capital District issue. ED visit rates were higher in the Capital District residents compared to Rest of State.

Some data shows improved health trends

- Heart disease, stroke, colorectal cancer, and female breast cancer trends decreased in the past decade
- Decreasing rates in gonorrhea and HIV
- Children 19 mos.-35 mos. of age had higher immunization rates
- Women aged 13-17 years had higher HPV vaccination rates
- Adults 65 years of age and older, had higher influenza immunization rates than the Rest of State
- Untreated tooth decay in third graders not only was lower in the Capital District compared to Rest of State, but all three counties now meet the new Prevention Agenda objective
- Lead screening at 18 and 36 months generally improved in the Capital District

Improved health trends (continued)

- Positive blood lead in children less than 72 months of age decreased in the last decade
- Smoking decreased in the Capital District, with all three counties having lower current smoking rates than the Rest of State
- Particularly in lower income, inner-city neighborhoods, many of the comparative health rates (e.g., mortality, etc.) are 3 to 7 times higher than the county average

Measurements not as positive (continued):

- While the Capital District had good health insurance coverage, still slightly less than 10% of residents were not covered by any form of health insurance
- Obesity and its related diseases were also health issues in the Capital District:
    - Adult residents had seen an increase in obesity since 2003, with rates equal to or greater than Rest of State
    - Obesity in the Capital Region's school children was also alarming, with Rensselaer and Schenectady Counties having childhood obesity rates higher than Rest of State.
- **Diabetes prevalence in adults increased since 2003**
- **Asthma ED visit and hospitalization rates were also higher in the Capital District compared to Rest of State, with hospitalization rates showing an increasing trend in the past decade**
- Positive blood lead in children less than 72 months of age was still higher than residents of Rest of State.
- Similarly, while the trend is decreasing, Albany and Schenectady were still among the counties with the highest gonorrhea rates
- Chlamydia rates were also much higher in the Capital District, with increasing trends in the past decade
- Albany and Rensselaer Counties presented some of the highest Lyme disease case rates in New York State
- **Substance abuse indicators also show there is a growing problem in the Capital District,** including:
    - Drug-related hospitalization and newborn drug-related hospitalization rates were higher than Rest of State, with increasing trends
    - Binge drinking had also increased in the Capital District since 2003

ASSETS AND RESOURCES

Member organizations of the three Community Health Improvement Task Forces supplied an abbreviated list of the assets and resources that they offer the community with regard to the health priorities selected.

Many of Albany Med's assets and resources are listed below, all of which greatly impact the health of our region.

COMMUNITY HEALTH NEEDS ASSESSMENT

The region's only medical college: a valuable asset and resource

Our mission of education inspires us to teach our region's current and future medical professionals.

- Albany Medical College's Patient Safety and Clinical Competency Center houses an incredible collection of simulation and training resources to educate students and other health care workers. It is a critical component of Albany Med's commitment to the highest standards of patient safety – while serving as a resource for the College, the Hospital and the region as a whole, including:
- Our Continuing Medical Education program helps medical professionals maintain competency skills and learn about new and developing areas in their field, all aimed at improved care of the patient (over 450 educational sessions annually).
- Project MEDSCOPE is a unique Albany Medical College program that offers medical students and physicians the opportunity to partner with community organizations and physicians to serve the unmet health care needs of the underserved
- Medical students and residents also participate in numerous advocacy projects, such as anti-smoking education to grade school students.
- Albany Med serves as a clinical rotation site for students from Hudson Valley Community College (HVCC) and Albany College of Pharmacy (ACP) in the fields of nursing, respiratory therapy, ultrasound, cardiovascular, paramedical services, pharmacy and laboratory sciences.
- Additionally, we offer scholarships to students in these HVCC and ACP programs, and has recently included scholarship programs at other local and regional colleges such as College of St. Rose (in the field of clinical laboratory medicine). This initiative has succeeded in increasing enrollment in previously under-enrolled HVCC programs to the point where there are sufficient graduating students to fill vacancies in many other hospitals in this region.

A key community educator in our region: a valuable asset and resource

We are committed to serving as one of the greatest community education resources in the region:

- General Public Education
    - Annual Health Fairs
    - Health Screenings
    - Health seminars and workshops
- Targeted Community Education
    - Disease specific programs
    - Broad range of clinical experts from Albany Med
- Serving as an educational site for local high schools
- Community Support
    - Memberships
    - Partnerships
    - Board service
- Support for awareness programs, programmatic initiatives
    - e.g., Ronald McDonald House, American Cancer Society, American Heart Association
- Support for Economic Development / Workforce Development
    - To attract and retain a trained, educated workforce

A key community educator in our region: a valuable asset and resource (continued)

- Support for Quality of Life programs
    - e.g., Boy Scouts, Jewish Family Services, Capital Region Pride Center, Regional Food Bank

Needed services provided to special populations: a valuable asset and resource

- Major resource for Medicaid and uninsured populations
    - We are the largest single provider of care to the Medicaid and uninsured populations in a 25-county region, making community-based physicians available by accepting public plans that private physician groups often do not
- Hospital that serves other hospitals
    - We provide comprehensive care to the critically ill and injured that is not available at other hospitals – accepting more than 8,000 patients a year
- Diverse population
    - Our caregivers and medical students are from demographically diverse backgrounds, meeting the primary and specialty care needs of a diverse population
- Provider of regional services
    - We coordinate and provide a host of regional services created to improve the health and outcomes of our region's population. Examples of our regional outpatient and hospital-based services are as follows:
        - Regional Perinatal Center
        - Lifestar Regional Trauma Program
        - Regional AIDS Program
        - Regional Trauma Center
        - Regional Resource Center
        - Our Patient Safety and Clinical Competency Center (training for health care professionals in a virtual learning environment)

Collaborating with Regional Health Improvement Task Forces: contributing valuable assets and resources

The following summarizes some of the many resources Albany Med will provide to maximize the health strategies of each Regional Health Improvement Task Force (Asthma, Behavioral Health and Diabetes):

- Multi-specialty physician network
- Acute and tertiary care
- Adult and pediatric health education programs
- Clinical and biomedical research
- Medical education
- Community education programs
- Caregiver education programs
- Various public education forums (health fairs, seminars, workshops, screenings, etc.)
- Continuing Medical Education
- Employee Wellness initiatives

COMMUNITY HEALTH NEEDS ASSESSMENT

Our assets and resources allow us to:

- Host and participate in various education forums open to the community
- Educate caregivers
- Provide high-end , specialty care
- Participate in community-based screenings and health fairs
- Work with other health organizations to develop and distribute relevant patient and caregiver information
- Provide clinical expertise on local, regional and national boards, etc.

An inventory of assets and resources provided each member organization is contributing toward the Regional Health Improvement Task Forces can be found in the appendix of the 2013 Community Health Needs Assessment, *www.hcdiny.org , appendix 'Assets and Resources'*.

PUBLIC PARTICIPATION

For additional detail, please refer to HCDI's "2013 Community Health Needs Assessment: A Compendium of Public Health Data for Albany, Rensselaer and Schenectady Counties", www.hcdiny.org .

> *To better understand the health needs of the Capital District, a Community Health Survey of more than 3,000 residents was conducted from December 2012 to February 2013.*

Community Health Survey

The community health survey gathered data on general health, behavioral health and oral health, as well as chronic conditions, behavioral health factors and access to care issues that are not available elsewhere. The survey was conducted online and on paper, through the HCDI website, in community-based health organizations, and among general service locations within Albany, Rensselaer, and Schenectady counties.

The survey focused on low-income residents by oversampling in ZIP codes identified as being high-need areas (HNAs). The majority of the respondents were white females (70.7%), college graduates (63.3%), and had private insurance (87.5%). Respondents in HNAs were more racially diverse (only 62.9% were white females), less educated (52.2% were college graduates), and more likely to have public health insurance (71.2% had private insurance).

There were 3,059 surveys included in the analysis from residents of Albany, Rensselaer, or Schenectady Counties who were over 18 years old. The majority of survey respondents, 55.2%, were residents of Albany County, while 23.7% of respondents resided in Rensselaer County and 21.2% lived in Schenectady County. Out of all respondents, 821 were identified as living in HNAs. In Rensselaer County, 50.4% of respondents lived in a HNA. This is in contrast to Schenectady County, where 28.4% of respondents lived in a HNA, and Albany County, where 21.2% of respondents were HNA residents.

General Health

Overall, 83.1% of residents reported having private insurance. Of those publicly insured, 5.4% were covered by Medicare, 7.2% enrolled in Medicaid, and 2.3% had no reported coverage. Almost three-quarters of residents reported their health was very good or good. The majority of residents had one or more dentist visits, yet 20.6% had not seen a dentist in the last 12 months. 83% of residents reported they had a physical exam in the last year and the majority of respondents, 60.4%, saw a doctor for a health issue 1 to 3 times in the past year, and 25.8% had an office visit 4 to 9 times in the past year. Only 8.3% had no doctor's visits in the past year. Over 93% of residents in the Capital Region indicated that their primary source of care was the doctor's office, with 5.3% getting primary care at a clinic or health center. Almost all residents, 96.0%, were either satisfied or very satisfied with the primary care they received.

Health Condition Prevalence

The most prevalent health conditions in the overall population that were reported as being diagnosed by a health care professional were high blood pressure (30.7%), arthritis (27.2%), emotional problems

(26.7%), and asthma (19.7%). Additionally, 15.6% of the overall survey sample said they had seen or talked to a mental health professional in the past 12 months.

Physical Activity

Most respondents (38.3%) were sedentary between 2-4 hours a day outside of work. The next most common sedentary period was 1-2 hours a day (26.4%). Slightly more than half of the sample reported exercising three or more times per week, while a third exercised once a week and about 15% of the sample reported never exercising. Most respondents spent 15-30 minutes a day exercising (41.3%), followed by 31-60 minutes a day (29.1%).

High Needs Areas

High needs areas (HNAs) had more residents insured through Medicaid (15.1%), Medicare (6.2%), or with no insurance coverage (3.3%) than non-high need areas (NHNAs). Fifty percent of respondents in HNAs did not have health care coverage due to cost. Health status in HNAs was highly comparable to the health status of residents in NHNAs. In NHNAs, 16.3% of residents were in excellent health, 74.4% in good or very good health, and 0.6% in poor health. In HNA, 13.2% of residents were in excellent health, 73.3% were in good or very good health, and 1.6% were in poor health.

Although 30.5% of HNA respondents had not seen a dentist within the last 12 months, more than half had at least one dentist visit. In HNAs, 89.8% of residents reported their primary source of care was their doctor's office, compared to 94.2% in NHNAs. No time (44.5%) and cost (18.2%) were the most common factors preventing HNA respondents from seeking health care when needed. HNAs had a lower percentage of respondents visiting their doctor more frequently (62.8% had 1 to 3 visits, 22.9% had 4 to 9 visits, 9.5% no visits) than NHNAs (59.7% had 1 to 3 visits, 26.7% had 4 to 9 visits, 8% no visits).

Overall in the HNAs, 20.9% of respondents reported having talked to or seen a mental health professional in the past 12 months. Health conditions reported most frequently in HNAs were high blood pressure (34.4%), **emotional problems** (31.1%), arthritis (28.9%), and **asthma** (23.8%).

ASSESSMENT AND SELECTION OF PUBLIC HEALTH PRIORITIES

For additional detail, please refer to HCDI's "2013 Community Health Needs Assessment: A Compendium of Public Health Data for Albany, Rensselaer and Schenectady Counties", www.hcdiny.org .

> *Selection of the top health priorities for the region was the conclusion of a year-long assessment process building knowledge of current public health conditions, identifying an optimal process for selecting priorities and implementing that process.*

Assessment

The Capital District Public Health Prioritization Task Force was formed to review data analyses prepared by HCDI and to select the top two priorities for the region. The Task Force included community voices through representatives from consumers, community 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. (Participation list will continue to expand as the community health improvement task forces increase the number of partners they engage in their planning and action stages.)

HCDI focused the presentation on:

- health conditions where two of the three counties in the region had higher or significantly higher rates than other Upstate counties; or
- a very high number of people in the region were impacted; or
- the disparity between rates for the general population and a sub-population was high

In a series of three Prioritization Task Force meetings, a total of 19 health indicators that met these criteria were presented. For each selected indicator, data was presented as available on prevalence; then rates for mortality, hospitalizations, emergency department visits and health behaviors; trends over the past 10 years; and equity data for gender, age, race/ethnicity, and neighborhood groupings when available.

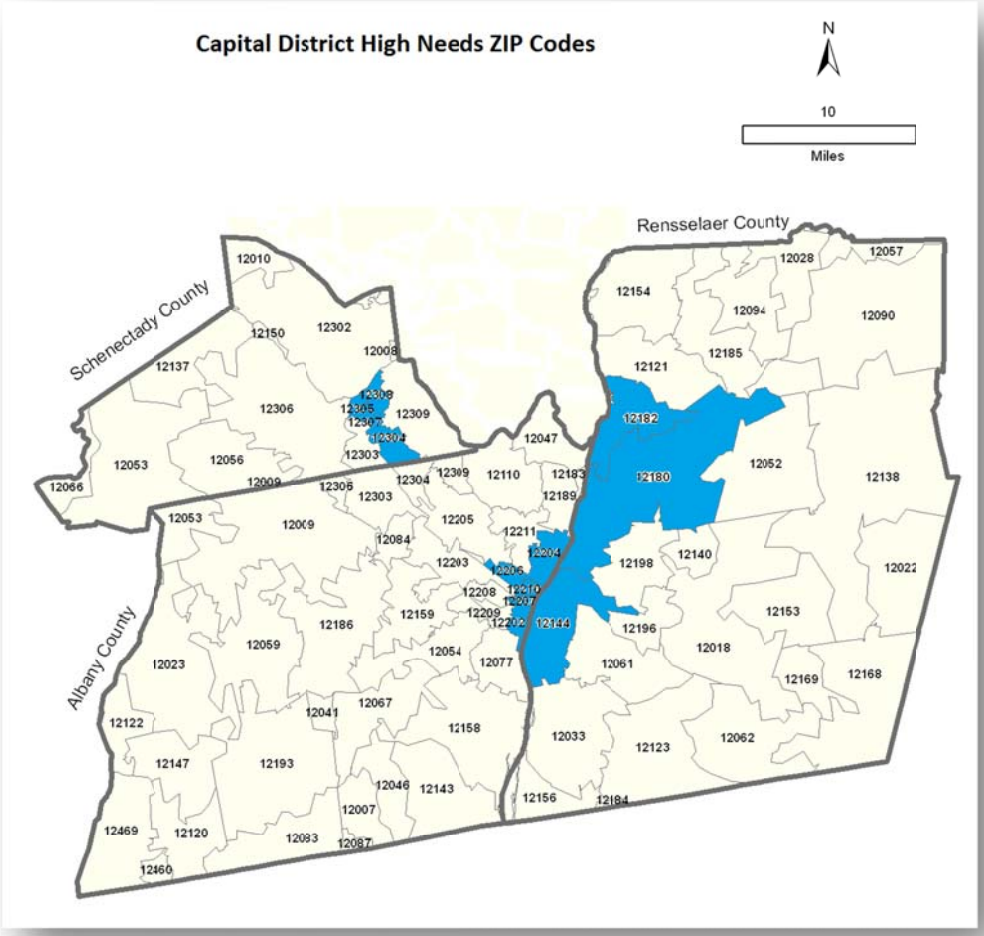
Task force participants shared their views for each indicator on three dimensions:

1. the impact of the condition on quality of life and cost of health care
2. community awareness and concern about the condition
3. the opportunity to prevent or reduce the burden of this health issue on the community.

Task force participants were provided with a Prioritization Tracking Tool to record their own comments about the importance of each indicator as a priority and record their thoughts on the severity, community values, and opportunity to improve.

The ratings of each indicator on the three qualitative dimensions were discussed in groups by Prevention Agenda category. The Task Force members were given an opportunity to make their case for the priority they believed was most meritorious and the group voted on the top two Prevention Agenda categories.

ASSESSMENT AND SELECTION OF PUBLIC HEALTH PRIORITIES



Selection

Behavioral health and **chronic disease** categories received the greatest amount of votes by far because they impact the largest number of people in the most significant ways, both directly and indirectly, through their influence on other health conditions. They were also largely preventable and contributed most significantly to the cost of health care. **Asthma** and **diabetes** were the specific health conditions within the chronic disease that participants thought should be addressed to make the most beneficial impact.

As a result of these efforts, three priority areas for the Capital District were identified to focus collective efforts in the coming years: *preventing and reducing the burdens of:*

- ✓ **Diabetes**
- ✓ **Asthma**
- ✓ **Behavioral health (focus: opiate use and addiction)**

PUBLIC HEALTH PRIORITIES

Subsequent to the results of the prioritization process, Regional Health Improvement Task Forces were formed for the three priority areas:

Diabetes

Asthma

Behavioral health (focus: opiate use and addiction)

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

Albany Med, 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
- A 3-year plan

These priorities are incorporated into the community health assessments and community health improvement plans of all local health departments and hospitals – including Albany Med's - to drive the development of institutional prevention strategies and joint initiatives which address some of the most pressing health needs in the region.

The following sections profile the collaborative efforts among HCDI partners. It should be noted that these sections do not a comprehensive inventory of the services and programs that Albany Med offers to address these public health issues, but rather a range of our programs that enhance and complement those of the coalition.

PUBLIC HEALTH PRIORITY: ASTHMA

In New York State, more than 1.1 million adults live with asthma. If poorly treated, asthma can lead to persistent hospitalization and death. Asthma sufferers can reduce their need for hospitalization through self-management education and adhering to medication protocols.

Research shows that asthma hospitalization rates for the Capital District (Albany, Rensselaer, and Schenectady counties) are significantly higher or higher than New York's Statewide rates.

For childhood asthma Rensselaer County showed an 18% increase in hospitalization rates between 2001-2005 and 2006-2010. Black Non-Hispanics in the region have asthma hospitalization rates 3 to 5 times that of White Non-Hispanics. High risk neighborhoods in Albany and Troy have been identified that have ED visit rates 2.5 to 4 times higher than upstate NY rates. Their hospitalization rates are 4 to 5 times higher than the rest of the state.

Our plan will work to reduce the prevalence of uncontrolled asthma in these neighborhoods. The focus is 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 will promote community environments in enacting tobacco-free policies, and engage the community in smoking cessation programs.

Goal: *Reduce the prevalence of uncontrolled asthma in Albany and Rensselaer Counties with particular attention to ZIP codes with the highest incidence of asthma in the cities of Albany and Troy.*

Objectives & Outcomes:

- **Asthma emergency department visits will decrease by 5% in 2014, 15% in 2015 and 20% in 2016 from 2012 rates.**
- **Asthma hospitalization rates will decrease by 5% in 2014, 7.5% in 2015 and 10% in 2016 from 2012 rates.**

Strategy:

Increase the number of patients engaged in all components of the asthma care loop through strong care transition policies that encourage hospital visit follow-up with primary care, community medical providers, reduction of asthma triggers, and improved self-management.

Tactic:

Develop a care transition program in emergency departments that identifies and refers patients who could benefit from an in-home Asthma Program reducing asthma triggers at discharge. By December 2017, 100% of emergency departments have a care transition program in place.

(Continued on following page)

PUBLIC HEALTH PRIORITY: ASTHMA

Organizational Partners:
Albany Medical Center, St. Peter's Health Partners, Visiting Nurse Association of Albany, Capital District Physician's Health Plan, Asthma Coalition of the Capital Region, Whitney M. Young Health Center, the Eddy of St. Peter's Health Partners

Process Measures:
# of emergency departments who have discussed and clarified their referral policies for referring patients to home-based services.

Outcome Measures:
# of emergency departments adopting a referral program. % increase in the number of patients referred to home-based services

Strategy:

Increase utilization of asthma action plans to affirm knowledge of how to control asthma through the support of community medical providers.

Tactic:
Increase support of the asthma action plan by community medical providers, such as schools, pharmacies, care coordinators, insurers, asthma educators and nurses through education, materials and workflow adjustments. By December 2017, asthma action plan materials delivered to 200 community partners.

Organizational Partners:
Albany Medical Center, Asthma Coalition of the Capital Region, Whitney M. Young Health Center, Next Wave, Albany County Department of Health, City School District of Albany, Visiting Nurse Association of Albany, local pharmacies, St. Peter's Health Partners, The Eddy Of St. Peter's Health Partners, Rensselaer County Department of Health

Process Measures:
Asthma action plan educational materials developed

Outcome Measures:
# of educational materials distributed

(Continued on following page)

PUBLIC HEALTH PRIORITY: ASTHMA

Strategy:

Strengthen collaborative efforts around the self-management and prevention of asthma.

Tactic:

Establish a task force to coordinate implementation of the CHIP and plan future strategies. By December 2017, 80% attendance by coalition members at quarterly meetings.

Organizational Partners:

All members of Asthma Regional Health Improvement Task Force

Process Measures:

Develop coalition participant list and engage additional partners missing to join coalition, hold quarterly meetings

Outcome Measures:

# of providers participating in quarterly meetings

Tactic:

Gather research and data regarding asthma to be considered for future CHIP initiatives.

Organizational Partners:

Albany Medical Center, St. Peter's Health Partners, Next Wave, Healthy Capital District Initiative

Process Measures:

Task force identifies key data sources and measures for adult asthma

Outcome Measures:

Task force prepares a position paper on measurement and strategies to improve adult asthma

PUBLIC HEALTH PRIORITY: BEHAVIORAL HEALTH

Nearly 1 in 5 adults in New York have some form of mental illness. Studies show that 36% of people with mental illness smoke cigarettes. In comparison, only 21% of adults without mental illness smoke cigarettes. These rates among the mentally ill are higher when comparing those who live below the poverty level (48%) to those who live above the poverty level (33%). Also of concern with mental illness sufferers are chemical dependency issues, especially with regards to opiate abuse. Opiates are the reported primary drug of choice for 35.6% of persons seeking admission for non-crisis services.

Drug-related hospitalization rates for the Capital District are higher than the rest of the State, and among Blacks and Hispanics the rates were 1.5 to 2 times higher than for the White population.

New York State has a unique opportunity to reach these individuals through its expansive mental health systems, one of the largest in the United States. Area providers have identified a service gap in this system with regard to tobacco and opiate abuse. This task force has designed strategies to improve provider knowledge regarding: recognizing signs of abuse, discussing treatment options with addicts, and appropriate opiate prescriptions. Concurrently, we will be promoting colocation of services by bringing behavioral health professionals into the primary care setting to assist in this endeavor. Following the lead of the CDC, strategies regarding tobacco cessation will include incorporating cessation programs into overall mental health treatment and encouraging mental health facilities and campuses to enact tobacco-free policies.

Goal: *Reduce opiate abuse, both illicit and prescribed, in Albany and Rensselaer counties.*

Objective:

- **Increase capacity optimization and efficiency of treatment for opiate abuse, as well as knowledge of best practices in prevention and treatment of opiate abuse.**

Outcome Measure:

- **By 2017, reverse the trend of increasing ED visits due to opiate abuse.**

Strategy:

Educate the public about the risks of opiate abuse.

Tactic:

Partners will promote Take Back Drug initiatives in their facilities and community settings, raising awareness of opiate abuse and encouraging people to properly dispose of their old prescription drugs from their medicine cabinets. By December 2017, 75% of partner organizations will promote disposal programs for old prescription drugs.

(Continued on following page)

Organizational Partners:
All Task Force Partners

Process:
# of partners promoting Take Back Drug initiatives

Outcome:
# of partner organizations offering disposal programs for old prescription drugs

Strategy:

Increase PCP knowledge of resources and best practices for opiate use and addiction.

Tactic:
Develop and distribute a decision tree for providers with referral options, resource documents, and patient educational material for use in response to the I-STOP program. By December 2017, 75% of contacted providers report using decision tree.

- This can include written materials, online education, and in-person sessions for CME.
- Develop a brochure of the signs of prescriptive opiate abuse and the location and phone numbers of Suboxone, methadone, and detox providers.
- Use OASAS resources and CME classes.
- Streamline coordination and case management support to PCPs for relapsing patients.

Organizational Partners:
Albany Medical Center, CDPHP, St. Peter's Health Partners, primary care and specialty practices, Catholic Charities, Albany County DMH, Rensselaer County DMH, NYSDOH

Process:
Decision tree developed

Outcome:
# of providers educated about the use of the decision tree

Tactic:
Train over 200 health professionals annually in motivational interviewing and SBIRT techniques. By December 2017, 200 health professionals annually trained in motivational interviewing and SBIRT techniques.

Organizational Partners:
Albany Medical Center, CDPHP, St. Peter's Health Partners, primary care and specialty practices, Catholic Charities, Albany County DMH, Sage College, SUNYA, OASAS, WMYHS

Process:
# of trainings offered in motivational interviewing and SBIRT techniques

(Continued on following page)

Outcome:
# of health professionals attending trainings

Strategy:

Promote cross-system collaboration to optimize utilization and capacity of addiction services.

Tactic:
Form a task force to facilitate knowledge of opiate abuse resources and implementation of the Community Health Improvement Plan. By December 2017, 75% of active partners participating in quarterly meetings.

- Provide educational information to CDPHP and Fidelis regarding available opiate abuse treatment resources.
- Encourage the development of ancillary outpatient withdrawal services through task force identification of the location, lead organization and resources needed.
- Identify high areas of need for doctors with X licenses, develop outreach materials clarifying the benefits of licensure and recruit doctors for licensure.

Organizational Partners:
Albany Medical Center, CDPHP, Catholic Charities, Albany County DMH, Rensselaer County DMH, St. Peter's Health Services, WMYHS, Rensselaer County DMH, ACCA

Process:
Task Force created, # of participants

Outcome:
Quarterly meetings, # of active participants, # of new participants

Tactic:
Increase the number of individuals referred to non-substance abuse treatment services and low-threshold services (such as syringe exchange, treatment readiness, and harm reduction counseling) by primary care and substance abuse treatment providers by 25%. By December 2017, 25% increase in number of individuals or participating in non-substance abuse treatment services and low-threshold services.

Organizational Partners:
Albany Medical Center, Catholic Charities, WMYHS, St. Peter's Health Partners

Process:
# of individuals referred

(Continued on following page)

Outcome:
# of individuals participating in low-threshold services

Tactic:
Tailor a training curriculum to review opiate addiction resources, including an overdose prevention kit to be given to patients at discharge. By December 2017, training curriculum is updated and delivered to 100 people annually.

- Train 100 individuals annually in the NYS Opioid Overdose Prevention Program. By December 2017, 100 individuals annually trained in NYS Opioid Overdose Prevention Program.
- Pursue legislation to make Naloxone/Narcan have standing status so that it is available over the counter to readily treat an opiate overdose event.

Organizational Partners:
Albany Medical Center, AIDS Council, WMYHS, Catholic Charities, St. Peter's Health Partners

Process:
Tailoring of training curriculum, # of training sessions offered

Outcome:
# of individuals trained

PUBLIC HEALTH PRIORITY: DIABETES

Diabetes affects nearly 26 million people currently in the United States. Estimates are that another 79 million people are at risk of diabetes. Treatment plans involve medications and self-management education. Without proper care, people with diabetes will require emergent or hospital care. The total cost of diabetes in the United States was $245 billion in 2012.

The prevalence of adults with diabetes in the Capital District region is increasing and numbers already exceeds Statewide averages.

The hospitalization rate for adults with short term complications from diabetes in the Capital District also exceeds the New York State rate. In particular, the rates for hospitalizations for Black non-Hispanic adults were 2.5-4 times the rates of their White non-Hispanic counterparts. Also, Black non-Hispanic diabetes mortality rates are twice as high as White non-Hispanics. Admissions for short-term diabetes complications in high need neighborhoods were 1.5-5.5 times the admission rate expected, whereas more affluent neighborhoods had 33% to 75% of the expected admissions. This data highlights health disparities that exist in the Capital District.

Our plan will focus on reaching disparate communities to decrease the prevalence of diabetes and assist those currently living with the disease. Strategy tactics will advance a "Health in All Policies" approach. Expanding school and employee wellness programs and opening public areas to the public for safe physical activity will meet individuals where they live, work and play. Lifestyle change and self-management strategies will significantly improve quality of life and reduce treatment costs for those with diabetes. Creating diabetes services resource guides for health care providers and consumers will build and strengthen partnerships that align to improve diabetes care. These strategies will foster an environment that engages individuals in prevention and self-management of diabetes.

Goal: *Reduce the prevalence of Type 2 diabetes in cities of Albany, NY and Troy, NY.*

Objectives & Outcome Measures:

- **Reduce diabetes ED visits by 5%.**
- **Reduce short-term complication hospitalizations by 5%.**

Strategy:

Improve processes that support and increase engagement in prevention and self-management of diabetes and related comorbidities (e.g. hypertension).

Tactic:

Increase engagement in the National Diabetes Prevention Program through increased screening and referrals by PCPs, partnering with hospitals, supermarket chains, and community-based organizations; and implementing initiatives. By December 2017, increase by 25% number of

Tactic (Continued from previous page):
people actively participating in NDPP. By December 2017, increase by 20% number of patients reporting 5% reduction in weight or greater.

Organizational Partners:
Albany Medical Center, YMCA, Center for Excellence in Aging and Community Wellness, Albany Department of Health, Price Chopper, faith-based organizations, food pantries, St. Peter's Health Partners, American Diabetes Association

Process Measures:
# of organizations developing a NDPP referral process, # of referrals to NDPP

Outcome Measures:
# of patients actively participating in NDPP, # of patients reporting 5% reduction in weight or greater

Tactic:
Reduce the amount of sodium in meals offered at venues including senior meal sites, hospitals, and restaurants. By December 2017, 3 organizations reducing the amount of sodium in meals by more than 5%.

Organizational Partners:
Albany Medical Center, Albany Department of Health, Albany County Office for the Aging, St. Peter's Health Partners

Process and Outcome Measures:
Pending

Strategy:
Create, distribute, and provide educational services and resources for patients and providers.

Tactic:
Maintain an ongoing coalition of diabetes service providers to provide guidance and support for strategies that reduce the prevalence and severity of diabetes in the region. By December 2017, 80% of coalition participants participating in quarterly meetings.

Organizational Partners:
All members of Diabetes Regional Health Improvement Task Force

Process Measures:
Develop coalition participant list and engage additional partners missing to join coalition, hold quarterly meetings

Outcome Measures:
# of providers participating in quarterly meetings

(Continued on following page)

Tactic:
Increase utilization of diabetes medical services by increasing community PCP and hospital referrals to CDEs, CSMEs, RDs, Diabetes Educators and diabetes education programs by 10%. By December 2017, increased use of diabetes educators by 25%.

Organizational Partners:
Albany Medical Center, St. Peter's Health Partners, American Diabetes Association, Northeast
New York Diabetes Educators Chapter, National Diabetes Education Program Children's Workgroup, Price Chopper

Process Measures:
# of providers changing protocols to increase patient referrals to diabetes education services

Outcome Measures:
# of referrals

Tactic:
Provide new mothers with information and support on breast feeding and a healthy diet for their babies. By December 2017, 10% increase in women who indicate they will breastfeed.

Organizational Partners:
Albany Medical Center, Burdett Care Center, St. Peter's Health Partners, WIC, Whitney M. Young Health Services, Albany Department of Health

Outcome Measures:
% of women who indicate they will breast feed increased by 10%

Strategy:
Expand school, community and employee wellness programs.

Tactic:
By December 31, 2017, implement and/or expand worksite wellness programs in 20 worksites that increase opportunities for physical activity such as choosing stairs; access to or promotion of healthful foods and beverages; awareness of weight or diabetes management resources. By December 2017, 20 worksite wellness programs implemented and/or expanded. By December 2017, 2,000 employees impacted by initiatives.

- Expand healthy meeting policies sites in order to provide employees and/or clients with healthier food and beverage options.
- Increase point-of-decision prompts on the use of stairs (rather than an elevator or escalator) to provide employees and/or clients with opportunities for physical activity.

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PUBLIC HEALTH PRIORITY: DIABETES

- Initiate worksite walking groups and walking paths in order to provide employees with opportunities for physical activity.
- Provide nutrition education sessions for employees to discuss *MyPlate*, reading food labels, healthy eating on a budget, healthy diet, and available nutrition resources
- Healthy Vending policies.

Organizational Partners:
Albany Medical Center, Albany Department of Health, St. Peter's Health Partners, Price Chopper, American Heart Association, Cornell Cooperative Extension of Rensselaer County

Process Measures:
# of employers expanding diabetes related wellness initiatives, # of new initiatives

Outcome Measures:
# of employees impacted by initiatives

SHARING OUR COMMUNITY SERVICE PLAN WITH THE PUBLIC

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

These include:

- Our website (www.amc.edu)
- "Albany Med Today" newsletter (for staff and for public)
- "Board of Directors" newsletter (for Albany Medical Center's governance)

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 public 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

MAINTAINING ENGAGEMENT WITH LOCAL PARTNERS

The members of each Regional Health Task Force (Asthma, Behavioral Health and Diabetes) strongly agree that successful outcomes are dependent on each partner organization's long-term commitment, accountability and continued endeavors.

Under the leadership and guidance of HCDI, each Task Force was designed with the following:

- Broad-based membership
- Guidelines and structure
- Shared set of values
- Defined goals, strategies, tactics, outcomes, and measures

While the goals of each task force are clearly varied, the strategies employed to accomplish those goals generally fell into four categories:

1. environmental interventions
2. care coordination
3. self-management
4. education

Task Forces will meet regularly to assess progress in meeting delineated goals.

Each Task Force's community health improvement plans include an ongoing quarterly meeting throughout the 2014-2017 Health Improvement planning period:

- subcommittees will work on specified plan activities throughout the year
- HCDI hired staff to support communication, timely scheduling of meetings, the development of tools and resource materials

The resulting efforts should positively impact steps toward eliminating disparities and improving the health of our community – including adding new members, and making any necessary changes to enhance the process and successfully achieve our health improvement goals.