

Samaritan Hospital

COMMUNITY SERVICE PLAN

2013



Samaritan Hospital

ST PETER'S HEALTH PARTNERS

northeasthealth.com | sphp.com

This document represents the 2013 Community Service Plan for Samaritan Hospital, a community hospital, located in Troy, New York (Rensselaer County). Following a merger with St. Peter's Health Care Services and Seton Health in October 2011, Samaritan Hospital is now part of St. Peter's Health Partners (SPHP). With nearly 12,500 employees in more than 165 locations, it is the largest and most comprehensive not-for-profit network of high-quality, advanced medical care, primary care, rehabilitation, and senior services in the region. SPHP is a member of Catholic Health East/Trinity Health, one of the largest health care systems in the country.

Samaritan Hospital opened its doors in 1898, at a time when major clinical and technological discoveries, such as x-rays, the electrocardiogram and new methods of diagnosis and treatment, were dramatically changing the way healthcare could be delivered. First located on Eighth Street in Troy, in the former Troy Orphan's Asylum, the hospital moved to its present location at the corner of Burdett and Peoples Avenues in the early 20th century.

SECTION 1: MISSION STATEMENT

Founded in community-based legacies of compassionate healing, we provide the highest quality comprehensive continuum of integrated health care, supportive housing and community services, especially for the needy and vulnerable.

Values

- **Respect:** We treat each person – mind, body and spirit – with dignity, understanding and compassion.
- **Excellence:** We achieve the highest quality through a vibrant culture dedicated to shared learning and continuous improvement.
- **Stewardship:** We thoughtfully steward our valuable but finite human, financial and physical resources to strengthen our service to the community.
- **Community:** We improve community health and well-being as a caring community member and catalyst.
- **Integrity:** We inspire trust through personal leadership.
- **Creativity:** We pursue courageous innovation.

SECTION 2: DEFINITION AND BRIEF DESCRIPTION OF COMMUNITY SERVED

For the purposes of the Community Service Plan, Seton Health/St. Mary’s Hospital used Albany and Rensselaer Counties which represent the home zip codes of 74.2% of its patients. A summary of the demographics of these counties follows:

Selected Demographics	Albany	Rensselaer
Population	304,204	159,429
% White	76.0%	85.7%
% African-American	12.0%	6.0%
% Hispanic	4.9%	3.8%
% High School Graduates	91.1%	89.4%
% Employed	65.8%	67.7%
Median Household Income	\$ 57,715	\$ 56,271
% Living Below Poverty Level	7.6%	9.2%

More information about the community demographics is contained in Attachment A, the 2013 Community Health Needs Assessment prepared by the Healthy Capital District Initiative of which Samaritan Hospital is a member.

SECTION 3: PUBLIC PARTICIPATION

The Community Health Needs Assessment and subsequent Community Health Improvement Plans were the result of a collaborative process led by the Healthy Capital District Initiative (HCDI). HCDI is a 501(c) 3 sponsored by the capital region hospitals, the Albany, Rensselaer and Schenectady County health departments, local insurers, Catholic Charities and community members. It started with a small group of public health leaders discussing how the capital region could be more effective in identifying and addressing public health problems. Thirteen years later, it has become a focus of regional health planning and has helped over 35,000 needy children and adults in the Capital Region get health services that they might not have accessed otherwise.

Representatives of the HCDI sponsors determined the process for completing the needs assessment, reviewed the collected data, and participated in the prioritization process and the development of the improvement plans.

The health indicators selected for this report 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 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 are very likely to continue to be supported. 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 complimented by 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 over mortality data leading public health efforts in the past.

The Finger Lakes Health Systems Agency provided county and ZIP code level analyses of mortality, hospitalizations, and emergency room utilization, for all residents, by gender, race and ethnicity. The source of these reports was 2006-2010 Vital Statistics and Statewide Planning and Research Cooperative System (SPARCS) data. This period was chosen to continue 20 years of trend analyses and to establish more reliable rates when looking at small geographic areas or minority populations. It is important to note that inclusion or exclusion of indicators from this report does not convey any a priori prioritization of health conditions.

Additional data was examined from a wide variety of sources:

- Prevention Agenda 2013-17 indicators
- Prevention Agenda 2008-12 indicators
- Community Health Indicator Reports
- County Health Indicators by Race/Ethnicity
- Behavioral Risk Factor Surveillance System (BRFSS) and Expanded BRFSS
- Cancer Registry, New York State
- Prevention Quality Indicators
- Communicable Disease Annual Reports
- The Pediatric Nutrition Surveillance System (PedNSS)
- Student Weight Status Category Reporting System
- New York State School Survey and New York State Adult Household Survey
- New York State Office of Alcoholism and Substance Abuse Services Data Warehouse
- Hospital-Acquired Infection Reporting System
- NYS Child Health Lead Poisoning Prevention Program
- NYS Kids' Well-being Indicator Clearinghouse (KWIC)
- Youth Risk Behavior Survey
- HCDI Facilitated Enrollment data
- American Fact Finder (factfinder2.census.gov)
- Access to state, county and city information collected by the census or American Community Survey

- Consumer Survey of Capital District Residents (convenience survey re access to, and satisfaction with health care in the Capital District)
- Homeless data from local homeless service providers

These data sources were supplemented by a community health survey. Engaging the community in the health needs assessment process was a priority of HCDI and its stakeholders. Broad community engagement began with distribution and participation in the community health survey. The Community Health Survey was conducted from December 2012 to February 2013. It gathered data on general health, mental 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. Surveys were distributed in community organizations, churches, by community health workers, in primary care sites and through large employers.

The survey relied on a convenience sample, which is not as reliably representative as a fully stratified random sample. It 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. Respondents’ summary characteristics are in the table below:

Survey Respondents			
<i>n=3,059</i>	Albany	Rensselaer	Schenectady
Percent from each County	55.2%	23.7%	21.2%
Percent in HNA	21.2%	50.4%	28.4%

Full survey results are available in Attachment A, 2013 Community Health Needs Assessment of the Capital Region.

SECTION 4: ASSESSMENT & SELECTION PUBLIC HEALTH PRIORITIES

The Capital District Public Health Prioritization Task Force was convened to review the Community Health Needs Assessment and the community survey results to select the priorities for collaborative action. Along with HCDI sponsor representatives, 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. A full list of Capital District Public Health Prioritization Task Force members is contained in Attachment A. While all of the health institutions serve high need individuals, the two federally qualified health centers, Capital District Coalition on Aids, Interfaith Partnership for the Homeless, Capital District Community Gardens and our consumer/faith community representatives have unique access to medically underserved residents.

Selection of the top health priorities for the region was the culmination of a year-long process of building our knowledge of current public health conditions, identifying an optimal process for selecting priorities and implementing that process. Meetings were held biweekly throughout the first half of 2013 with participation from local health departments in Albany, Schenectady, and Rensselaer counties, St. Peter's Health Partners (St. Peter's Hospital, Albany Memorial Hospital, Samaritan Hospital, Seton Health/St. Mary's Hospital, and Sunnyview Rehabilitation Hospital), Ellis Medicine, Albany Medical Center, Burdett Care Center and HCDI staff 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 District Public Health Prioritization Task Force.

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. Presentations were given at the meetings to summarize available data on the leading problems in the capital district. Health indicators from the 2013 Community Health Needs Assessment were included in the presentation if:

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

Health indicators that met the criteria were included from all five of the Prevention Agenda areas:

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

A total of 19 health indicators were selected to be 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 each health indicator was presented, 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 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. They 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.

Task force participants shared their views for each indicator on three qualitative dimensions: the impact of the condition on quality of life and cost of health care, community awareness and concern about the condition, and the opportunity to prevent or reduce the burden of this health issue on the community. A basic representation of the group's view on each dimension was recorded.

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

- The impact of the condition on quality of life and cost of health care
- Community awareness and concern about the condition
- The opportunity to prevent or reduce the burden of this health issue on the community

Upon completion of the data summaries, the Task Force 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 number 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 chronic disease that participants thought should be addressed to make the most beneficial impact. The results for asthma show significant disparities among sub-populations.

New Regional Health Improvement Task Forces were formed for asthma, diabetes, and mental health, comprised of members in the community who have expertise in, or work for an organization in, one of those health areas. These task forces were charged with proposing regional community health improvement plans to drive the development of institutional prevention strategies and joint initiatives to address pressing health needs in the region.

SECTION 5: THREE YEAR PLAN OF ACTION

As previously noted, community health improvement planning task forces were formed with a diverse group of individuals having specialized knowledge of the needs and services in this region for each condition (asthma, diabetes and behavioral health). Participating organizations were surveyed to identify organizational activities and resources for each health condition. Task force participants were given a detailed summary of these organizational assets and resources during the first meeting. A summary of these resources is contained in the attached Community Health Needs Assessment. Each task force was provided a detailed review of the data pertaining to their health need accompanied by reports on organizational assets, evidence-based practices identified by the Centers for Disease Control and other respected national sources, and evidence-based practices undertaken by counties during the 2008-2012 Prevention Agenda.

Task force members built upon these reference sources by identifying other local best practices and important factors contributing to poor health outcomes. Proposals were solicited for strategies that would reduce the prevalence of their health condition. These proposals were organized according to the Wisconsin model promulgated by the National Association of County and City Health Officials. They were further refined and discussed to clarify what would have the greatest impact, which evidence-based practices could be expanded upon and where there was support for cross-institutional collaboration. Drafts were reviewed by the host organizations of task force representatives and refinements were made to the tactics, time-framed targets, process and outcome measures. The meeting content and participants for the

task forces can be found in Attachment A. Each of the community health improvement plans were voted on and passed unanimously.

Task forces developed community health improvement plans that include an ongoing quarterly meeting with subcommittees working on specified plan activities throughout the year. Staff was hired to support communication, timely scheduling of meetings, and the development of tools and resource materials. While the goals of each task force clearly varied, the strategies employed to accomplish those goals generally fell into four categories – environmental interventions, care coordination, self-management and education.

Samaritan Hospital will play an integral role in each of the three Community Health Improvement Plans (CHIP). The specific activities of our organization are identified in the red boxes. As an affiliate of St. Peter's Health Partners, these activities are integrated with the work of the other SPHP acute care hospitals (Seton Health/St. Mary's, St. Peter's and Albany Memorial) as well as our physician network (St. Peter's Health Partners Medical Associates (SPHPMA)) and our continuing care arm, the Eddy. SPHPMA, a physician-governed, multi-specialty group, is one of the largest multi-specialty physician group practices in the region with more than 32 specialties and sub-specialties represented, over 270 physicians and 80 advanced practitioners, and more than 40 office locations in a five county region. The Eddy offers a comprehensive continuum of services, all designed to help seniors remain independent in their own homes for as long as possible and as comfortable as their conditions allow. Eddy services also help avoid premature institutionalization for older adults.

Asthma Community Health Improvement Plan

In New York State, there are more than 1.1 million adults living with asthma. At times, these individuals experience an asthma attack: a distressing and potentially life-threatening experience where the airways constrict, causing difficulty breathing. 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 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:

1. Asthma emergency department visits for children under 18 will decrease by 5% in 2014, 15% in 2015 and 20% in 2016 from 2012 rates.
2. Asthma hospitalization rates for children under 18 will decrease by 5% in 2014, 7.5% in 2015 and 10% in 2016 from 2012 rates.

Strategy 1: 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.

Tactics:

1. Expand pulmonary management program care transition program to provide asthma education, support medication retention and primary care transition to all asthma patients across the St. Peter's Health Partners network. By December 2017, 100% of patients at St. Peter's Health Partners have access to Pulmonary Management Program.

Samaritan Hospital will implement a lung center in 2013 to provide pulmonary management.

2. Develop a primary care provider referral initiative in Troy to encourage physicians to refer their asthma patients to local asthma education and self-management programs. By December 2017, 75% of contacted physicians referring patients.

Samaritan Hospital, along with Seton Health/St. Mary's Hospital, is currently developing this initiative.

3. 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.

An affiliate of St. Peter's Health Partners, the Eddy VNA is exploring the development of this program for all SPHP hospitals.

4. Work with stakeholders to create improved information links between providers; hospital emergency departments and PCP; PCP and specialist; schools and PCP to support planned interactions with patients and evidence-based care. By December 2017, 20% increase in providers and 50% increase in patients signed up for push notifications with HIXNY.

SPHP is committed to ensuring that all members of the SPHP Medical Associates are enrolled and active with HIXNY or other health exchange.

5. appointments, follow-up after routine and urgent care visits. By December 2017, 50% of emergency department asthma patients follow up with their primary care provider or asthma educator.

The Samaritan Hospital Lung Center is responsible for this referral and will track compliance.

Organizational Partners:

1. St. Peter's Health Partners, Capital District Physician's Health Plan
2. St. Peter's Health Partners, Whitney M. Young Health Center, Asthma Coalition of the Capital Region, Capital District Physician's Health Plan, Visiting Nurse Association of Albany
3. 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
4. Asthma Coalition of the Capital Region, Whitney M. Young Health Center
5. Asthma Coalition of the Capital Region, Whitney M. Young Health Center, Visiting Nurse Association of Albany, St. Peter's Health Partners

Strategy 2: Increase utilization of asthma action plans to affirm knowledge of how to control asthma through the support of community medical providers.

Tactics:

1. Encourage policies in city schools to require students with asthma to submit an asthma action plan. By December 2017, 100% of schools have implemented an asthma action plan initiative.
2. Reinforce the effective use of asthma action plans by offering at least 10 community based asthma self-management classes serving 100 people per year. By December 2017, 300 people attended community based asthma self-management classes.

St. Peter's Health Partners will develop asthma self-management classes to offer to patients and community members.

3. 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.

St. Peter's Health Partners Medical Associates will be educated regarding the use of Asthma Action Plans.

St. Peter's Health Partners hospitals (St. Peter's, Albany Memorial, Samaritan and St. Mary's) are covering the cost of printing 2,000 asthma action plans to distribute to community providers.

Organizational Partners:

1. Next Wave, City School District of Albany, Asthma Coalition of the Capital Region, Whitney M. Young Health Center
2. St. Peter's Health Partners, Asthma Coalition of the Capital Region, Whitney M. Young Health Center
3. 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, Albany Medical Center, the Eddy Of St. Peter's Health Partners, Rensselaer County Department of Health

Strategy 3: Increase access to and utilization of asthma controller medications.

Tactics:

1. Home care patients will be educated about affordable prescription options and receive resources and support for fulfilling their prescriptions. By December 2017, 100% of home care providers will have educational material about affordable prescription options to share.

The Eddy VNA will distribute information to appropriate patients regarding affordable prescription options.

2. School nurses in the Albany, Troy, and Lansingburgh School Districts will be trained to support asthmatic students, and will be provided with the necessary educational resources. By December 2017, 90% of school nurses in Albany, Troy and Lansingburgh will be provided educational resources on asthma.
3. Improve the asthma management and outcomes of underserved patients (Medicaid, Medicaid managed, and uninsured) age 0-40 years with "not well controlled" or "poorly controlled" asthma through a community pharmacist intervention program that assesses and counsels patients on 1) knowledge and use of controller and rescue medications, and 2) self-management skills. By December 2017, 5 community pharmacist intervention programs established.

Organizational Partners:

1. Health Capital District Initiative, Visiting Nurse Association of Albany, St. Peter's Health Partners-select Hospital operated primary care sites, the Eddy of St. Peter's Health Partners
2. City School Districts of Albany, Troy City School District, Lansingburgh Central School District, Asthma Coalition of the Capital Region, Whitney M. Young, Jr. Health Center, Visiting Nurse Association of Albany, Albany County Department of Health, Rensselaer County Department of Health
3. Asthma Coalition of the Capital Region, Whitney M. Young, Jr. Health Center, Capital District Physician's Health Plan, Albany College of Pharmacy and Health Sciences, community pharmacies, community partners

Strategy 4: Promote a community environment that helps prevent and manage asthma.

Tactics:

1. Provide education, pulmonary screenings, and interventions to the community through faith community nurses and already-established community events. By December 2017, community asthma education reach over 200 people annually.

SPHP Staff (including hospital based respiratory therapists, community educators and sponsored faith community nurses) will provide education and screening

2. Reduce exposure to secondhand smoke in public and affordable housing facilities through assisting housing managers implement no-smoking policies. By December 2017, 25% of contacted housing managers implementing no-smoking policies.

The Tobacco Free Coalition, based at Seton Health/St. Mary's Hospital, will work with housing managers to affect policy change.

3. Engage community champions in asthma education and smoking cessation. By December 2017, 10 community champions participate in asthma reduction events.
4. Train all asthma educators on how to make a proactive referral to *The Butt Stops Here* or other smoking cessation program. By December 2017, 100% of all asthma educators we be consistently proactively referring all willing patients ready to make a quit attempt to a cessation program.

The Center for Smoking Cessation at Seton Health will work with asthma educators to ensure that they are versed in the availability of smoking cessation programs available to their patients.

The Center for Smoking Cessation at Seton Health will work with hospitals to implement the “Opt to Quit” program in which all patients who smoke are proactively offered referral to the NYS Smokers’ Quitline which provides continual smoking cessation support post discharge. By December 2017 the four St. Peters Health Partners affiliated acute care hospitals, as well as Burdett Care Center, will be consistently referring to the NYS Smokers’ Quitline patients who smoke who opt in for the cessation service.

The NYS Smokers Quitline, “Opt to Quit” program, a system-wide solution for ensuring that cessation support is offered and accessible to patients once they leave the health care setting will be implemented at Samaritan Hospital by 2014.

5. Provide perinatal information to prospective parents about environmental issues related to asthma and asthma triggers. By December 2017, 100% of prospective parents provided asthma information.
6. Identify and refer appropriate expecting and new mothers to the Center for Smoking Cessation. By December 2017, 100% of appropriate expecting and new mothers referred to Center for Smoking Cessation.

Organizational Partners:

1. St. Peter’s Health Partners, Capital District Physician’s Health Plan
2. St. Peter’s Health Partners, Albany County Department of Health, Asthma Coalition of the Capital Region, Whitney M. Young Health Center, Capital District Tobacco Free Coalition
3. St. Peter’s Health Partners, Whitney M. Young Health Center, Albany County Department of Health, Rensselaer County Department of Health, Next Wave, Capital District Tobacco Free Coalition
4. Center for Smoking Cessation at Seton Health
5. Center for Smoking Cessation, St. Peter’s Health Partners, Burdett Care Center
6. St. Peter’s Health Partners, Burdett Care Center, SPHPMA obstetrical providers
7. St. Peter’s Hospital, Burdett Care Center, SPHPMA obstetrical providers

Strategy 5: Strengthen collaborative efforts around the self-management and prevention of asthma.

Tactics:

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

Staff representing the SPHP hospitals (including Samaritan) will participate in these meetings.

2. Gather research and data regarding asthma to be considered for future CHIP inclusion in the CHIP.

SPHP staff will assist in research and data collection.

Organizational Partners:

1. Existing regional health improvement task force
2. St. Peter's Health Partners, Albany Medical Center, Next Wave, Healthy Capital District Initiative

Diabetes Community Health Improvement Plan

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 Albany and Troy.

Objectives:

Reduce diabetes ED visits by 5%.

Reduce short-term complication hospitalizations by 5%.

Strategy 1: Improve processes that support and increase engagement in prevention and self-management of diabetes and related comorbidities (e.g. hypertension).

Tactics:

1. 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 people actively participating in NDPP. By December 2017, increase by 20% number of patients reporting 5% reduction in weight or greater.

Affiliated and employed physicians will be educated about the need to screen and refer appropriate patients. Diabetes Resource Nurse training will be offered to inpatient RNs at all SPHP affiliated hospitals in order to enhance the care of hospitalized diabetes patients. On an outpatient basis, Samaritan Hospital Diabetes Educators are certified in the NDPP program and will provide direct services. Financial assistance is available to those without resources.

By December 31, 2017 increase the number of health centers that are prescribing fruit and vegetable vouchers with VeggieRx Program. By December 2017, 100% increase in number of providers issuing scripts. By December 2017, 50% increase in number of people redeeming scripts.

Funding is being sought to support this activity in targeted SPHP Medical Associates offices.

2. Provide nutritional education to 100 food pantry or food bank staff and encourage implementation of healthy eating policies in food pantries. By December 2017, 50% of food pantry patrons receiving foods within MyPlate guidelines.
Create and implement educational strategies for food donors to increase the nutritional value of donated foods.
3. Educate and train local health educators about the nutritional value tools in supermarket chains. By December 2017, train over 100 health educators about nutritional value tools.
4. 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:

1. 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, Albany Medical Center, American Diabetes Association
2. Capital District Community Gardens, Whitney M. Young Health Centers, SUNY School of Public Health, Koinonia Primary Care, St. Peter's Health Partners
3. Sage College, Price Chopper, Albany Department of Health, Rensselaer Department of Health, Capital Region Healthy Communities Coalition, United Way, SUNY Albany
4. Price Chopper, Hannaford, Albany Department of Health, Rensselaer Department of Health

5. Albany Department of Health, Albany County Office for the Aging, Albany Medical Center, St. Peter's Health Partners, Albany Memorial Hospital and St. Peter's Hospital.

Strategy 2: Create, distribute, and provide educational services and resources for patients and providers.

Tactics:

1. 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.

SPHP Diabetes Educators (representing all SPHP hospitals) will actively participate in this coalition.

2. Create, distribute and maintain a diabetes resource guide for 1) primary care physicians and school nurses about available and covered services; and 2) consumers. By December 2017, 100 guides distributed to providers and nurses. By December 2017, 300 guides provided to consumers.

SPHP Diabetes Educators (representing all SPHP hospitals) will participate in the development of this resource guide.

3. 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%.
4. 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.
5. Provide diabetes education and/or nutrition education to expectant mothers with gestational diabetes or other risk factors. By December 2017, 25% increase in number of mothers receiving nutrition education. By December 2017, 25% increase in number of expectant mothers with gestational diabetes receiving diabetes education.

Organizational Partners:

1. All Task Force Partners
2. Healthy Capital District Initiative, Price Chopper, Albany Department of Health, Rensselaer Department of Health, American Diabetes Association

3. 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
4. Burdett Care Center, St. Peter's Health Partners, WIC, Albany Medical Center, Whitney M. Young Health Services, Albany Department of Health
5. Burdett Center, St. Peter's Health Partners, Albany Department of Health, Rensselaer Department of Health, WIC

Strategy 3: Expand school, community and employee wellness programs.

Tactics:

1. 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.
 - 1.1 Expand healthy meeting policies sites in order to provide employees and/or clients with healthier food and beverage options.
 - 1.2 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.
 - 1.3 Initiate worksite walking groups and walking paths in order to provide employees with opportunities for physical activity.
 - 1.4 Provide nutrition education sessions for employees to discuss MyPlate, reading food labels, healthy eating on a budget, healthy diet, and available nutrition resources
 - 1.5 Healthy Vending policies.

St. Peter's Health Partners will develop policies and programs related to the wellness of all of its affiliate employees.

2. By December 31, 2017, expand the number of eligible schools that implement and/or expand universal breakfast program(s) by 5.

Organizational Partners:

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

2. Albany Department of Health, Rensselaer Department of Health, City School District of Albany, Troy City School District

Strategy 4: Expand opportunities for safe physical activity in the community.

Tactics:

1. By December 31, 2017, establish joint use agreement per year to open additional public areas and facilities for safe physical activity, such as walking programs. By December 2017, 3 new joint use agreements established.
 - 1.1 Engage community organizations to utilize these facilities resulting in at least 3 organizations utilizing each facility per year. By December 2017, at least 3 organizations using each facility.
2. By December 31, 2017, at least six schools in Albany and Troy will adopt wellness policy editions and/or incorporate daily physical activity requirements into classroom time in order to increase regular physical activity among youth.
3. Develop biannual educational initiative informing residents in high need zip codes of free and low cost physical activity opportunities in their neighborhood such as open gym times, walking sites, sports leagues, etc. By December 2017, 300 educational materials distributed annually.

Organizational Partners:

1. Albany Department of Health, YMCA, City School District of Albany, Troy City School District, Cities of Albany and Troy, Healthy Schools NY, Capital District Community Gardens.
2. Albany Department of Health, Rensselaer Department of Health, YMCA, City School District of Albany, Troy City School District
3. Albany Department of Health, Rensselaer County Department for Youth, Sage College, Healthy Capital District Initiative, YMCA

Behavioral Health Community Health Improvement Plan

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%)ⁱ. 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 taskforce 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 1: 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 1: Educate the public about the risks of opiate abuse.

Tactics:

1. Students will have an opiate abuse module added to their existing substance abuse school-based programs or health classes. By December 2017, high schools in 6 school districts in Albany and Rensselaer Counties will have added an opiate abuse module to their existing substance abuse school-based programs or health classes.
2. Partners will promote Take Back Drug initiatives in their facilities and community settings, raising awareness of opiate abuse and encouraging people to dispose of their old prescription

drugs from their medicine cabinets properly. By December 2017, 75% of partner organizations will promote disposal programs for old prescription drugs.

St. Peter's Health Partners, including Samaritan Hospital, will promote these initiatives with patients and staff.

3. Advertise Drug Hotlines to increase enforcement, with over 40 signs posted and local newspaper coverage. By December 2017, 25% increase in utilization of Drug Hotlines.

Organizational Partners:

1. Rensselaer County Department of Mental Health, Albany County Stop DWI, Capital Region BOCES, Capital Region school districts & all task force partners available for classroom speaking requests.
2. All task force partners.
3. Rensselaer County Department of Mental Health, Capital Region Underage Drinking and Drug Use Prevention Coalition, Rensselaer County Stop DWI Program, Rensselaer County Sheriff

Strategy 2: Increase PCP knowledge of resources and best practices for opiate use and addiction.

Tactics:

1. 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.
 - a. This can include written materials, online education, and in-person sessions for CME.
 - b. Develop a brochure of the signs of prescriptive opiate abuse and the location and phone numbers of Suboxone, methadone, and detox providers.
 - c. Use OASAS resources and CME classes.
 - d. Streamline coordination and case management support to PCPs for relapsing patients.

St. Peter's Health Partners, including Samaritan Hospital, will distribute materials to their employed and affiliated providers and encourage their use. We will also encourage these providers to participate in related CME programs.

2. 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.

St. Peter's Health Partners, including Samaritan Hospital, will encourage their employed and affiliated providers to participate in available training programs for motivational interviewing and SBIRT techniques.

3. Discuss prescribing patterns with eligible health care providers, including dental providers who are high-volume opioid prescribers. By December 2017, 50% decrease in opioid prescriptions written in Albany and Rensselaer Counties.
 - a. Offer treatment recommendations for members who are receiving routine opiate prescriptions through telephonic or web-based consultation services.

Organizational Partners:

1. CDPHP, St. Peter's Health Partners, Albany Medical Center, primary care and specialty practices, Catholic Charities, Albany County Department of Mental Health, Rensselaer County Department of Mental Health, NYSDOH
2. Albany Medical Center, CDPHP, St. Peter's Health Partners, primary care and specialty practices, Catholic Charities, Albany County Department of Mental Health, Sage College, SUNY Albany, OASAS, Whitney M. Young, Jr. Health Services
3. CDPHP, Fidelis, MVP, Empire Blue Cross Blue Shield, United Healthcare

Strategy 3: Promote cross-system collaboration to optimize utilization and capacity of addiction services.

Tactics:

1. 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.
 - a. Provide educational information to CDPHP and Fidelis regarding available opiate abuse treatment resources.
 - b. Encourage the development of ancillary outpatient withdrawal services through task force identification of the location, lead organization and resources needed.
 - c. Identify high areas of need for doctors with X licenses; develop outreach materials clarifying the benefits of licensure and recruit doctors for licensure.

St. Peter's Health Partners staff, representing all SPHP hospitals including St. Mary's, will actively participate in the task force.

2. 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.

We will educate our employed and affiliated providers about these services.

3. Increase colocation of behavioral health professionals and case managers in primary care offices by 3 practices a year. By December 2017, 3 practices annually will have increased number of behavioral health professionals and/or case managers in primary care offices.

St. Peter's Health Partners is actively exploring opportunities for co-location and is committed to achieving this objective.

4. Increase the number of doctors trained and licensed to prescribe medications treating opiate addictions. By December 2017, increase the number of doctors trained and licensed to prescribe medications treating opiate addictions by 24.
 - a. Increase the number of doctors trained and licensed to prescribe Suboxone by 3 doctors per year. By December 2017, 3 doctors per year trained and licensed to prescribe Suboxone.
 - b. Increase the number of doctors who prescribe Vivitrol by 3 doctors per year. By December 2017, 3 doctors per year trained and licensed to prescribe Vivitrol.

St. Peter's Health Partners, through the SPHP Medical Associates, will actively work to solicit providers to become Suboxone and/or Vivitrol prescribers.

5. 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.
 - a. Train 100 individuals annually in the NYS Opioid Overdose Prevention Program. By December 2017, 100 individuals annually trained in NYS Opioid Overdose Prevention Program.
 - b. Pursue legislation to make Naloxone/Narcan have standing status so that it is available over the counter to readily treat an opiate overdose event.

SPHP staff will support these initiatives through education and outreach.

Organizational Partners:

1. CDPHP, Catholic Charities, Albany County Department of Mental Health, Rensselaer County Department of Mental Health, Albany Medical Center, St. Peter's Health Partners, Whitney M. Young, Jr. Health Services, Rensselaer County Department of Mental Health, Addictions Care Center of Albany, Inc.
2. Catholic Charities, Whitney M. Young, Jr. Health Services, Albany Medical Center, St. Peter's Health Partners
3. CDPHP, Whitney M. Young, Jr. Health Services, , St. Peter's Health Partners– SPARCS

4. St. Peter's Health Partners, CDPHP, Whitney M. Young, Jr. Health Services, primary care providers
5. AIDS Council, Whitney M. Young, Jr. Health Services, Catholic Charities, St. Peter's Health Partners, Albany Medical Center

Goal 2: Reduce tobacco use among people with mental illness.

Objective: Two mental health service provider facilities in the counties of Albany and Rensselaer Counties will create a tobacco-free environment and integrate practices that support employee and consumer cessation by January 1, 2015.

Outcome Indicators: Number of mental health service provider facilities that create a tobacco-free environment and integrate practices that support employee and consumer cessation.

Strategy: Provide needed information, technical assistance, and resources to MH facilities to enable them to create tobacco-free environments and to integrate practices that best support cessation for employees and consumers of service.

Tactics:

1. Convene a meeting with local partners to identify MH facilities with capacity and readiness to implement tobacco-free policies and practices and a plan for how to engage these facilities.
2. Provide ongoing training and technical assistance to identified facilities on the importance of addressing tobacco use among people with mental illness, and how to create a tobacco-free environment to include development of a tobacco-free grounds policy, and evidence-based cessation intervention.
3. Help facilities access existing community resources including no-cost tobacco-free signage, evidence-based cessation facilitator training, cessation materials and resources, Medicaid reimbursement for NRT, etc.

The Capital District Tobacco Free Coalition and the Center for Smoking Cessation, both programs of SPHP affiliate Seton Health, will lead this effort.

Partner Organizations:

Capital District Tobacco-Free Coalition, Center for Smoking Cessation at Seton Health, RCDOH, RCDMH, ACDOH, ACDMH

SECTION 6: DISSEMINATION OF PLAN TO THE PUBLIC

The public will be substantially engaged in this community health improvement process through a multi-staged program. First, the community health needs assessment will be posted on the websites of the Healthy Capital District Initiative and Albany and Rensselaer county hospitals. Samaritan Hospital will also post this community service plan on its website. In addition, these documents will be made available to the public in hard copy in the administrative office. Second, additional outreach will occur to expand task forces to include additional business and community members with a passion for these health issues. Third, community champions will be identified and incorporated in outreach and education activities to reinforce the benefits of recommended best practices and strengthen connections with community members. Fourth, a public awareness strategy will be rolled out in the first half of 2014 to illuminate the significance of each health need, regional activities undertaken to address these needs, effective self-management strategies, and to highlight community champions who are effectively managing their health.

SECTION 7: PROCESS TO SUSTAIN ENGAGEMENT

Each of the community health improvement focus areas will have a task force convened by HCDI. Samaritan Hospital will be represented on these committees which will coordinate implementation, track the progress and make changes as necessary. In addition, a committee will be set up within St. Peter's Health Partners to monitor and implement the activities for which SPHP hospitals are responsible.