Albany Memorial Hospital

St Peter's Health Partners

Albany Memorial Hospital

Community Health Needs Assessment Implementation Strategy Fiscal years 2017-2019

Albany Memorial Hospital completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors on June 22, 2016. The CHNA was performed in adherence with certain federal requirements for not-for-profit hospitals set forth in the Affordable Care Act and by the Internal Revenue Service. The assessment took into account input from representatives of the community, community members, and various community organizations.

The complete CHNA report is available electronically at www.sphp.com. Printed copies are available at:

Albany Memorial Hospital
Administrative Offices
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Hospital Information and Mission Statement

Albany Memorial Hospital, with 165 licensed beds, is a community hospital, located in Albany, New York (Albany County). Following a merger with Northeast Health and Seton Health in October 2011, Albany Memorial 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 Trinity Health, one of the largest health care systems in the country.

In 1868, Albany Memorial Hospital opened as the Albany City Free Dispensary, providing healthcare for patients who were unable to pay. Over the next 82 years, the hospital had a total of five downtown Albany locations - including two on North Pearl Street. In 1957, Albany Memorial Hospital moved to its current location on Northern Boulevard.

Today, Albany Memorial Hospital provides comprehensive medical services including critical care, ambulatory surgery, diabetes management at our Diabetes Center and care for congestive heart failure through our Heart Program.

For the purposes of the Community Health Needs Assessment and Implementation Strategy, St. Mary's Hospital defines its service area as Albany and Rensselaer Counties which represent the home zip codes of 86% of its patients.

Mission

"We, St. Peter's Health Partners and Trinity Health, serve together in the spirit of the gospel as a compassionate and transforming healing presence within our communities. 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."

Health Needs of the Community

The CHNA conducted in 2016 identified seven significant health needs within the Albany Memorial Hospital community. A Public Health Prioritization Workgroup was formed to review data analyses prepared by the Healthy Capital District Initiative, a community collaborative which includes St. Peter's Health Partners, and to select the top priorities (including at least one disparity) to be addressed. Data presentations were given at the meetings to summarize available data on the leading problems in the service area. Health indicators were included in the prioritization data presentations if:

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

Health indicators that met the criteria were included in the data presentations for each of the five NYS Prevention Agenda Priority 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 90 New York State health indicators across the 5 Prevention Agenda Priority Areas were presented. Available data on prevalence, emergency department visits, hospitalizations, mortality and trends were included for each indicator. Equity data for gender, age, race/ethnicity, and neighborhood groupings were presented as available.

After the presentation of each set of health indicators, a discussion was held to answer any questions or for individuals to share their experiences with the health condition in the population. Participants did a preliminary vote on the importance of the condition in the community based on three qualitative dimensions: the impact of the condition on quality of life and cost of health care; community awareness and concern about the condition; and the opportunity to prevent or reduce the burden of this health issue on the community.

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

The significant health needs identified included:

- **Diabetes/Obesity:** Both Albany and Rensselaer Counties are significantly higher in comparison to NYS, excluding NYC, commonly referred to as Rest of State (ROS), for short term complication (18+yrs) hospitalizations, Rensselaer fell into the 4th risk quartile; the diabetes short term complication hospitalization trend has been increasing since 2008. Albany showed a 35% increase in adult obesity between 2003 and 2014, while Rensselaer showed a 13% increase; the prevalence of obesity increases with age in both counties.
- **Asthma/Tobacco Use:** Prevalence is higher than ROS; ED visits significantly higher for both young children and adults; High risk neighborhoods are 3 to 5 times higher than ROS rates for both ED visits and hospitalizations. Current smoking prevalence higher for Rensselaer compared to ROS; Males have a prevalence rate 1.2 to 1.5 higher than females; Rensselaer's current Smoking prevalence increased from 2008-09 to 2012-13;
- **Substance Abuse:** Substance abuse mortality trends for both counties increased from 2009-11 through 2011-13;Albany had higher opiate ED visits and similar opiate hospitalization rates than ROS; Rensselaer had slightly lower ED and hospitalization rates than ROS; Both counties showed a major increase in opiate ED rates between 2013 and 2014, but decreases in the opiate hospitalization rates; Males had 2.3 to 3.5 times higher substance abuse mortality,1.0 to 1.3 times the substance abuse ED and hospitalization rates, and 1.5 to 1.9 times the opiate ED and hospitalization rates than females; Black non-Hispanics had about 1.5 times the drug-related hospitalization rates compared to their white non-Hispanic counterparts; High risk neighborhoods had 1.1 to 1.4 times the substance abuse mortality, 2 to 4.5 times the substance abuse ED visit and hospitalization rates, and 1.7 to 4.7 times the opiate ED and hospitalization than ROS; there was an over 90% increase in clients receiving Heroin Dependency Treatment at Capital Region OASAS certified treatment programs between 2011 to 2014.
- **Mental Health:** Both counties had a higher % of adults with poor mental health compared to ROS; Rensselaer fell into the 4th risk quartile and Albany the 3rd risk

quartile; The % of adults with poor mental health days increased in both counties between 2008-09 and 2013-14; An estimated 19% of both county's adult population had a mental illness; 4% had a serious mental illness;

- **Adverse Birth Outcome:** Albany and Rensselaer counties have slightly higher to significantly higher percentages of preterm and low birth weight births. Albany and Rensselaer counties are in the 4th Risk quartile for preterm births compared to all NYS counties; Albany is also the 4th risk quartile while Rensselaer is in the 3rd quartile for low birth weight births. Albany and Rensselaer counties have a slightly increasing trend for both % of preterm births and % of low birth weight births
- **STD's**: Albany County has significantly higher rates of gonorrhea compared to the ROS and fell into the 4th risk quartile; Albany County had significantly higher male and female chlamydia rate compared to the ROS and fell into the 4th risk quartile; Rensselaer County had significantly higher female rates, chlamydia has been an increasing trend for both counties since 2004.
- **Lyme disease:** Annually, Albany and Rensselaer Counties have 823 cases of Lyme disease. Rensselaer County has 3 times the amount of cases seen in Albany County. Both Albany and Rensselaer counties fall into the 4th risk quartile. Rensselaer County has the 3rd highest Lyme disease case rate of all NYS counties.

Hospital Implementation Strategy

Significant health needs to be addressed
Albany Memorial Hospital, along with our community partners, will focus on developing and/or supporting initiatives and measure their effectiveness, to improve the following health needs:

- **Reduce obesity in children and adults (prevent diabetes) –** Detailed need specific Implementation Strategy on page 6.
- **Asthma/Tobacco Cessation–** Detailed need specific Implementation Strategy on page 8.
- **Prevent Substance Abuse (focus on opioid abuse) –** Detailed need specific Implementation Strategy on page 10.
- **Strengthen Mental Health Infrastructure Across Systems –** Detailed need specific Implementation Strategy on page 12.

Significant health needs that will not be addressed
Albany Memorial Hospital acknowledges the wide range of priority health issues that emerged from the CHNA process, and determined that it could effectively focus on only those health needs which it deemed most pressing, under-addressed, and within its ability to influence. Albany Memorial Hospital will not take action on the following health need:

- **Adverse Birth Outcomes–** SPHP, of which Albany Memorial is a part, is participating in the Safe Motherhood Initiative which implements evidenced based practices in the hospital and the community to prevent maternal and infant morbidity and mortality.

- **STD's -** The county health departments are taking the lead on this issue. SPHP will support their activities.
- **Lyme Disease** - The county health departments are taking the lead on this issue. SPHP will support their activities.

This implementation strategy specifies community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending 2019, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2017-2019			
HOSPITAL FACILITY:	Albany Memorial Hospital (St. Peter's Health Partners)		
CHNA SIGNIFICANT HEALTH NEED:	Obesity/Diabetes		
CHNA REFERENCE PAGE:	59, 79	**PRIORITIZATION #:**	1

BRIEF DESCRIPTION OF NEED: Both counties are significantly higher in comparison to NYS, excluding NYC (ROS) for short term complication (18+yrs) hospitalizations, Rensselaer fell into the 4th risk quartile; the diabetes short term complication hospitalization trend has been increasing since 2008. Albany showed a 35% increase in adult obesity between 2003 and 2014, while Rensselaer showed a 13% increase; the prevalence of obesity increases with age in both counties.

GOALS: Decrease Obesity and Diabetes by:

1. Increasing screening rates for pre-diabetes especially among economical disparate populations.
2. Promoting culturally relevant chronic disease self-management education.
3. Creating community environments that promote and support healthy food and beverage choices and physical activity.

OBJECTIVES:

1. Increase the percentage of adults 18 years and older who had a test for high blood sugar or diabetes within the past three years by 5% from 58.8% (2011) to 61.7%. (Data Source: NYS BRFSS)
2. Increase by at least 5% the percentage of adult pre-diabetics who have taken a course or class to learn how to manage their condition.
3. Reduce the percentage of youth and adults who are obese.

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Provide access to St. Peter's Health Partners professionals to become trained on pre-diabetes screening and resources available within the Rensselaer County community.
2. Provide funding for 2 professionals to be trained in pre-diabetes Diabetes Prevention Program (DPP) to expand DPP programs within Rensselaer County. Offer NDPP to employees, encourage patients to participate in DPP.
3. Encourage healthy living through St. Peter's Wellness Committee; pursue Healthy Vending policy. Creating Healthy Schools Program: Provide technical assistance in developing implementing strategies for health and wellness policies within school districts. With partners, develop a community "Soccer for Success" program.

ANTICIPATED IMPACT OF THESE ACTIONS:

1. Increase knowledge of practitioners leading to increased screening of patients.
2. Increased number of certified DPP professionals which will increase the number of DPP programs in the community and increase access.
3. Improve environments where people learn, work and play. Increases access to healthy activities.

PLAN TO EVALUATE THE IMPACT:

1. Number of healthcare professionals educated on the evidenced based screening tool. Number of community members educated on pre-diabetes through outreach activities. Number of marketing materials distributed and locations
2. Number of participants enrolled in the DPP programs. Number of participants in other (i.e. non-YDPP/NDPP chronic disease self-management programs that support Lifestyle Change.
3. Number of organizations that adopt and implement nutrition and beverage standards (e.g. healthy meeting and events policies, healthy vending policies, applicable worksite wellness programs) including number of persons impacted by standards. Number of schools that adopt and implement comprehensive School Wellness Polices.
4. Number of plans adopted or opportunities available promoting physical activity (e.g. Complete Streets policies, joint use agreements, applicable worksite wellness initiatives). Number of school districts that implement Comprehensive School Physical Activity Programs (CSPAP). Number of children participating in "Soccer for Success" Program.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

Staff time and expertise; funding to support NDPP training and Soccer to Success program.

COLLABORATIVE PARTNERS:

Albany and Rensselaer County health departments, Albany Med, Capital District YMCA, Healthy Capital District Initiative Obesity/Diabetes Task Force (above organizations plus American Diabetes Association, Capital District Physicians' Health Plan, Capital Roots, Cornell Cooperative Extension, Golub Corp- Price Chopper, Northeast NY Diabetes Educators, Stratton VAMC/AADE/ Northeastern NY Diabetes Educators (NENYDE), University at Albany).

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2017-2019			
HOSPITAL FACILITY:	Albany Memorial Hospital (St. Peter's Health Partners)		
CHNA SIGNIFICANT HEALTH NEED:	Asthma/Tobacco Cessation		
CHNA REFERENCE PAGE:	74, 68	**PRIORITIZATION #:**	2

BRIEF DESCRIPTION OF NEED: Prevalence is higher than ROS; ED visits significantly higher for both young children and adults; High risk neighborhoods are 3 to 5 times higher than ROS rates for both ED visits and hospitalizations. Current smoking prevalence higher for Rensselaer compared to ROS; Males have a prevalence rate 1.2 to 1.5 higher than females; Rensselaer's current smoking prevalence increased from 2008-09 to 2012-13;

GOAL: Reduce asthma triggers through the implementation of an asthma self-management program. Decrease the prevalence of cigarette smoking by adults 18 and older who have low socioeconomic status and/or poor mental health by use of tobacco cessation services.

OBJECTIVE:

1. Expand asthma home-based self-management programs to include home environmental trigger reduction, self-monitoring, medication use and medication follow up.
2. Provide education to clinical staff on evidenced based management of asthma and promote professional certification for asthma educators.
3. Implement the US Public Health Services Guidelines for treating tobacco use.
4. Facilitate referrals to the New York State Smokers Quitline through direct connectivity for referrals from the electronic health record.

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Development of a Home Based Asthma program that will arrange for patient visits in their homes by a Respiratory Therapist, Registered Nurse and Community Health Worker to provide appropriate asthma education.
2. Educate health care providers about the Home Based Asthma program and the availability of smoking cessation resources that are available to them.

ANTICIPATED IMPACT OF THESE ACTIONS:

1. The Home Based Asthma Program is expected to reduce ED and hospital utilization through better disease management of asthma.
2. Decrease the number of adults who smoke

PLAN TO EVALUATE THE IMPACT:

1. Track utilization of the Home Based Asthma program.
2. Track hospital and ED visits by diagnosis.
3. Track referral information on smoking cessation and impact on smoking reduction.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Leadership staff to work on various task forces.
2. Time for providers and staff to receive training.

COLLABORATIVE PARTNERS:

Ellis Hospital, Capital Care, Albany and Rensselaer County Health Departments, The Healthy Capital District Initiative

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2017-2019			
HOSPITAL FACILITY:	Albany Memorial Hospital (St. Peter's Health Partners)		
CHNA SIGNIFICANT HEALTH NEED:	Substance Abuse (particularly opioid abuse)		
CHNA REFERENCE PAGE:	155	**PRIORITIZATION #:**	3

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

GOAL: Reduce non-medical use of prescription pain medication

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

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Provide education to all prescribers throughout SPHP regarding addiction and pain management (including prescribing guidelines, community resources and information to provide to patients regarding risk and harm/misuse) using state and federal guidelines
2. Promote safe storage and proper disposal of unused prescription medications
3. Host and publicize community Naloxone trainings (overdose reversal)
4. Establish ambulatory detox programs

ANTICIPATED IMPACT OF THESE ACTIONS:

1. Reduction of number of opioids prescribed; reduction of opioids in community
2. Reduction of opioids in the community
3. Reduce deaths due to overdose
4. Increase treatment options

PLAN TO EVALUATE THE IMPACT:

1. Number of provider education events, number of prescribers trained
2. Number of new and permanent and temporary sites for Rx collection; total pounds of prescriptions collected
3. Number of Naloxone trainings provided; Number of persons participating in trainings.
4. Number of programs established; number of patients served by new programs; number of additional physicians with X license.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

Staff resources, education and training expenses, marketing expenses; development of 4 ambulatory detox programs

COLLABORATIVE PARTNERS:

Albany and Rensselaer County Health and Mental Health Departments, Albany Med, Whitney Young, Jr. Health Center (FQHC), Project Safe Point, Project LEAD (Law Enforcement Assisted Diversion), Catholic Charities, Healthy Capital District Initiative Behavioral Health Task Force (above organizations plus Capital District Physician Health Plan (CDPHP}, Capital Region BOCES, Project Safe Point, The Addictions Care Center).

CHNA IMPLEMENTATION STRATEGY
FISCAL YEARS 2017-2019

HOSPITAL FACILITY:	Albany Memorial Hospital (St. Peter's Health Partners)		
CHNA SIGNIFICANT HEALTH NEED:	Strengthen Mental Health Infrastructure Across Systems		
CHNA REFERENCE PAGE:	155	**PRIORITIZATION #:**	4

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

GOAL: To support collaboration among leaders, professionals and community members in working with Mental/Emotional/Behavioral (MEB) prevention, health promotion, treatment and recovery across the continuum of Behavioral Health, Substance Abuse and Primary Care providers.

OBJECTIVE: Improve the mental health of the community by:

1. Using a trauma-informed model of care approach, the Adverse Childhood Experiences Study (ACES) questionnaire will be utilized across a variety of settings to assess patients risk for physical and behavioral health problems.
2. Develop a curriculum to train providers and staff in the trauma-informed care approach.
3. Identify strategies to assist patients who are at higher risk for poor health outcomes based on their ACE score.

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

5. Leadership staff from SPHP are participating on various workgroups to develop this concept.
1. SPHP will partner with various internal and community resources to develop a network of support for patients at risk.
2. Expand efforts to implement a Collaborative Care approach in primary care which integrates behavioral health within a physician practice.
3. SPHP in partnership with the Alliance for Better Health Care will provide cultural and linguistic training on MEB promotion prevention and treatment to key providers and staff.
4. Share data with the Alliance for Better Health Care and out partners on MEB health promotion, prevention and treatment to identify best practices.

ANTICIPATED IMPACT OF THESE ACTIONS:

1. Implementation of these concepts will promote MEB health and reduce hospitalizations and Emergency Department visits. We would also expect to see an increased utilization of behavioral health services in the outpatient setting.

PLAN TO EVALUATE THE IMPACT:

1. Impact to be evaluated over the next there years by evaluating the effect of these interventions on decreasing hospitalizations and Emergency Department visits for both physical and behavioral health disorders.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Leadership staff to work on committees
2. Time for providers and staff to participate in training.

COLLABORATIVE PARTNERS:

Rensselaer County Department of Mental Health (Lead Agency),Belvedere Services, Ellis Hospital, Hometown Health, Hospitality House, Transitional Services Association, Montgomery County Mental Health, Capital Area Council of Churches, DePaul Housing, Family Counseling, Northern Rivers Montgomery County Jail, HFM Prevention Council, Mohawk Opportunities, Katal Center, St. Peter's Addiction Recovery, Upper Hudson Planned Parenthood, Whitney Young, Capital Care, Catholic Charities St. Mary's Hospital Amsterdam, Samaritan Hospital Behavioral Health, Shelters of Saratoga, Hudson Mohawk Recovery Center, Unity House, Commission on Economic Opportunity, LaSalle School Albany SUNY School of Social Welfare, Hope House, City Mission Schenectady, CDPHP

Adoption of Implementation Strategy

On September 28, 2016 the Board of Directors for Albany Memorial Hospital, met to discuss the 2017-2019 Implementation Strategy for addressing the community health needs identified in the 2016 Community Health Needs Assessment. Upon review, the Board approved this Implementation Strategy and the related budget.

Name & Title