ST PETER'S HEALTH PARTNERS

St Peter's Hospital

ST PETER'S HEALTH PARTNERS

Samaritan Hospital

ST PETER'S HEALTH PARTNERS

Albany Memorial Hospital

ST PETER'S HEALTH PARTNERS

St Mary's Hospital

ST PETER'S HEALTH PARTNERS

2016 Community Health Needs Assessment

2016-2018 Community Health Improvement Plan

2016 Community Service Plan

Prepared in cooperation with the Healthy Capital District Initiative, Albany and Rensselaer County Health Departments, Burdett Care Center and Albany Medical Center

Submitted in fulfillment of the requirements of the New York State Department of Health Prevention Agenda by St. Peter's Health Partners. Submitted in fulfillment of the requirements of the Internal Revenue Service (pursuant to the Patient Protection and Affordable Care Act of 2010) St. Peter's Health Partners. Adopted by vote of the SPHP Board of Directors on September 28, 2016.

New York State 2016 Community Health Needs Assessment and Improvement Plan and Community Service Plan

Cover Page

1. Counties covered:

Albany and Rensselaer Counties

2. Participating Local Health Department:

Albany County Health Department

Rensselaer County Health

3. Participating Hospitals:

St. Peter's Hospital, St. Mary's Hospital, Samaritan Hospital, Albany Memorial Hospital, Burdett Care Center, Albany Medical Center Hospital

4. Coalition/entity completing assessment and plan:

Community Health Needs Assessment – Healthy Capital District Initiative (HCDI), 175 Central Avenue, Albany, New York 12206, 518-486-8400

Prioritization and Plan – Albany-Rensselaer Prevention Agenda Work Group

1. What are the Prevention Agenda priorities and the disparity you are working on with your community partners including the local health department and hospitals for the 2016-2018 period?

Albany and Rensselaer County Workgroup members selected the following priorities:

I. **FOCUS AREA: CHRONIC DISEASE (Disparity)**
   a. **Reduce Obesity in Children and Adults (inclusive of risk factors and promotion of evidenced-based intervention programs)**
   b. **Asthma / tobacco cessation***

II. **FOCUS AREA: BEHAVIORAL HEALTH**
   a. **Prevent Substance Abuse (e.g. opioid)**
   b. **Strengthen Mental Health Infrastructure across Systems***

The existing Diabetes Task Force will continue their efforts to prevent Type 2 Diabetes, and help patients learn how to self-manage and live a healthy lifestyle. As learned during the Prioritization Meeting, obesity rates continue to increase. Given the connection between both diabetes and obesity, this task force will also add goals that are related to the reduction in obesity rates in Albany and Rensselaer Counties.

The existing Behavioral Health Task Force will focus on Substance Abuse and Opioid Prevention.

* Mental Health and Tobacco will receive direction from *DSRIP (Delivery System Reimbursement Incentive Payment Program)* Activities. DSRIP has initiatives for Mental Health facilities going Tobacco Free, and implementing Tobacco Cessation into treatment planning for those receiving Mental Health Treatment as well as a focused asthma program. The Integration of Behavioral Health and Primary Care is also a focal point of DSRIP. Activities conducted through these DSRIP projects will be documented through this priority area.

2. What has changed, if anything, with regard to the priorities you selected since 2013 including any emerging issues identified or being watched?

Priorities selected in 2013 included: Diabetes, Substance Abuse (Opiates and Tobacco) and Asthma. Since that time, the DSRIP PPSs have been formed and projects selected. Therefore, since asthma and tobacco, as well as the co-location of behavioral health and primary care, were selected projects of those organizations our group determined that we would focus on diabetes/obesity and well as the increasingly critical issue of opiate abuse.

3. What data did you review to identify and confirm existing priorities or select new ones?

The hospitals and county health departments in the six-county Capital Region to commissioned a full Community Health Needs Assessment prepared by the Healthy Capital District Initiative (HCDI). HCDI has conducted such community needs assessments since 1997, including a 2014 DSRIP community needs assessment conducted collaboratively for the two regional Performing Provider Systems. Information from this comprehensive compilation of public health data was used to identify the leading health issues for each county. Those needs which status indicators placed Albany and Rensselaer in the

bottom two quartiles for the State were selected as candidates for consideration as potential Community Health Needs.

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 Region, it was decided that building upon the 2013-2018 Prevention Agenda would provide the most comprehensive analysis of available public health needs and behaviors for the Region. The collection and management of these 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, when complimented by the recent Expanded Behavioral Risk Factor Surveillance System and Prevention Quality Indicators, provide health indicators that can be potentially impacted in the short-term. This is a distinct step forward over mortality data leading public health efforts in the past.

The Finger Lakes Health Systems Agency provided SPARCS (hospitalizations and ED visits) and Vital Statistics Data Portals that were utilized to generate county and ZIP code level analyses of mortality, hospitalizations, and emergency room utilization, for all residents, by gender, race and ethnicity. The timeframes used for the zip code analyses were 2009-2013 Vital Statistics and 2010-2014 Statewide Planning and Research Cooperative System (SPARCS) data. The 5-year period was chosen to establish more reliable rates when looking at small geographic areas or minority populations.

Additional data was examined from nearly 20 other sources which are enumerated in the Community Health Needs Assessment.

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

<u>4. Which partners are you working with and what are their roles in the assessment and implementation processes?</u>

Nearly 60 organizations were represented at the three prioritization sessions (See CHNA for a list). We also are continuing with our Behavioral Health and Substance Abuse Task Forces with regard to the implementation process. These were formed for the 2013 cycle and include representatives from the hospitals and health departments along with community based agencies and others involved and knowledgeable in the subject matter.
In addition, we actively participate in the DSRIP PPS: The Alliance for Better Health Care, LLC. While Albany Medical Center Hospital participates in theirs. This information is also brought to bear and coordinated with the planning.

5. How are you engaging the broad community in these efforts?

The broad community will be engaged in three ways: 1) through participation in the CHNA as part of the Siena Research Institute survey of the opinions and health needs of over 2,400 individuals region wide (over 400 each in Albany and Rensselaer Counties), 2) as clients and constituents of the member organizations of those participating in the work groups and as patients served by providers in the DSRIP PPS, and 3) through the opportunity to review and comment on the CHNA/CSP/CHIP and Implementation Plan as these are publicly posted and made widely available throughout the community.

6. What specific evidence-based interventions/strategies/activities are being implemented to address the specific priorities and the health disparity and how were they selected?

For the top two priorities, evidence-based interventions and strategies have been selected from the options available on the New York State Department of Health's Prevention Agenda website. These are:

- **Focus Area**: Reduce Obesity and Diabetes in Children and Adults
    - **Interventions**: Promote pre-diabetes screenings and education through the use of evidence based tools; Participation of adults in self-management programs. Implement nutrition and beverage standards in public institutions, worksites, school districts, and childcare centers. Promote Physical Activity in childcare centers, school districts, community venues, and worksites.
- **Focus Area**: Prevent Substance Abuse and other Mental, Emotional, and Behavioral Disease
    - **Interventions:** Provider Education of Addiction & Pain Management (Prescribing Guidelines, Community Resources (Prevention, Addiction Treatment & Recovery Support), Information to provide to patients regarding risk of harm and misuse. Promote safe storage & proper disposal of unused prescription medications (community education, increase disposal opportunities). New York State Opioid Overdose Prevention Training; Establish ambulatory detox service locations.

7. How are progress and improvement being tracked to evaluate impact? What process measures are being used?

Relevant community health metrics will be measured over the three-year period, with specific goals for pre-diabetes (education, program participation, adoption of nutrition and beverage standards, plans promoting physical activity) and substance abuse (training of prescribers, drug take backs, naloxone training and ambulatory detox programs.)

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SECTION 1: MISSION STATEMENT

"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."

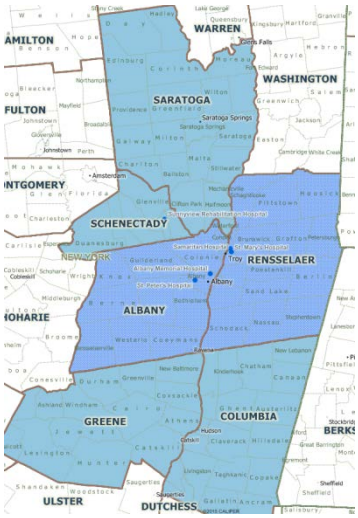
St. Peter's Health Partners' Mission guides everything we do. As we continue our healing ministry into the 21st century, we are called to both serve others and transform care delivery. We reinvest our resources back into the community through new technologies, vital health services, and access for everyone regardless of their circumstances.

We call our commitment to the community "Community Health and Well-Being Ministry." Community benefit is an organized and measured approach to meeting community health needs. It implies collaboration with a "community" to "benefit" its residents by improving health status and quality of life.

In our communities, St. Peter's Health Partners' many community health programs are restoring wholeness and well-being to people.

Year after year, St. Peter's Health Partners reinvests in communities with funding for charity care, primary care services, screenings, education, and research. And the commitment has risen in proportion to the needs.

SECTION 2: DEFINITION AND BRIEF DESCRIPTION OF COMMUNITY SERVED



For the purposes of the Community Health Needs Assessment, the St. Peter's Health Partners acute care hospitals define its service area as Albany and Rensselaer Counties which represent the home zip codes of over 70% of its patients.

	Albany	Rensselaer
Population	309,606	159,906
% White	73%	84%
% African-American	12%	7%
% Hispanic	6%	5%
% High School Graduates	93%	91%
Median Household Income	$60,414	$59,516

Much more information about the community demographics is contained in the HCDI Community Health Needs Assessment.

Review of the Previous Community Health Needs Assessment (2013)

Key findings of the 2013 CHNA included issues pertaining to Behavioral Health and Chronic Disease. Asthma and Diabetes were the specific health conditions within chronic disease that were selected to be addressed. Asthma in particular was selected due to the significant disparities evident among sub-populations.

- Behavioral Health: Area providers identified a service gap in the system with regard to tobacco and opiate abuse. The taskforce designed strategies to improve provider knowledge regarding: recognizing signs of abuse, discussing treatment options with addicts, and appropriate opiate prescriptions. We promoted 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 included incorporating cessation programs into overall mental health treatment and encouraging mental health facilities and campuses to enact tobacco-free policies.
    - Worked with seven actively engaged large behavioral health providers to institute tobacco free grounds, train clinical staff on evidenced based best practices and implement tobacco use policies
    - Over 400 individuals attended smoking cessation classes; Nearly 2,500 individuals were referred to the NYS Quit Line by SPHP hospitals and physician practices
    - Over 2,200 individuals were trained in delivery of Naloxone/Narcan to prevent heroin overdosing and sudden death
    - 2000 I-Care (Information and Resources for I-STOP prescribers) brochures were printed and distributed to opiod prescribers(also available electronically)
    - Dozens of locations participated in regularly scheduled drug "take back" days to remove opioids from consumer's homes.
- Diabetes: Our plan focused on reaching disparate communities to decrease the prevalence of diabetes and assist those currently living with the disease. Strategy tactics advanced a "Health in All Policies" approach. We worked to expand school and employee wellness programs and open public areas to the public for safe physical activity in order to meet individuals where they live, work and play. Lifestyle change and self-management strategies were promoted to

significantly improve quality of life and reduce treatment costs for those with diabetes. Creating a diabetes services resource guide (in both English and Spanish) for health care providers and consumers helped to build and strengthen partnerships that align to improve diabetes care. These strategies helped to foster an environment that engages individuals in prevention and self-management of diabetes.
    - Sodium in food prepared in the cafeteria at two of the SPHP hospitals was reduced by at least 12% affecting staff, visitors, students and contractors.
    - SPHP Employee Wellness program instituted affecting all 12,500 employees.
    - 5000 Diabetes Resource guides were printed and distributed to providers and consumers (also available electronically)
- Asthma: In the past three years, we worked to reduce the prevalence of uncontrolled asthma in high prevalence neighborhoods. The focus was on increasing the number of patients engaged in an asthma continuum of care and increasing the utilization of asthma action plans and controller medication. Strategies promoted community environments in enacting tobacco-free policies and engaging the community in smoking cessation programs.
    - Implemented lung centers associated with three of the SPHP emergency departments providing enhanced asthma/respiratory care to an average of 75 patients per month
    - SPHP instituted a free Asthma Education Project in targeted neighborhoods designed to provide patients and families with information to help manage childhood asthma. Skilled Community Health Workers meet with families in their homes to help them learn about asthma signs and symptoms, identify causes of asthma and provide tools to help them manage their child's asthma.
    - Our work with community agencies resulted in numerous communities implementing tobacco free parks and two housing authorities representing nearly 4,500 units becoming tobacco free. Albany County passed a 21 year old minimum purchase age of tobacco products.

Written Comments on Prior CHNA

The CHNA is well known in our community. Local health departments, as well as numerous community based agencies, have been involved throughout the process of selecting priorities and developing improvement plans. No specific written comments have been received.

Community Health Needs Assessment 2016

St. Peter's Health Partners collaborated with local health systems, county health departments and community based agencies to complete a six county (Albany, Rensselaer, Schenectady, Saratoga, Columbia and Greene) Community Health Needs Assessment, led by the Healthy Capital District Initiative (HCDI). HCDI is an incorporated not for profit which works with others in the community to determine ways in which the capital region could be more effective in identifying and addressing public health problems.

For the purposes of its CHNA, St. Peter's Health Partners used data and information from this assessment relating to Albany and Rensselaer Counties which represent the home zip codes of over 70% of its patients. Other health systems will be addressing the needs of remaining counties in the assessment based on their location and patient population.

Data

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 Region, it was decided that building upon the 2013-2018 Prevention Agenda would provide the most comprehensive analysis of available public health needs and behaviors for the Region. The collection and management of these 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, when complimented by the recent Expanded Behavioral Risk Factor Surveillance System and Prevention Quality Indicators, provide health indicators that can be potentially impacted in the short-term. This is a distinct step forward over mortality data leading public health efforts in the past.

The Finger Lakes Health Systems Agency provided SPARCS (hospitalizations and ED visits) and Vital Statistics Data Portals that were utilized to generate county and ZIP code level analyses of mortality, hospitalizations, and emergency room utilization, for all residents, by gender, race and ethnicity. The timeframes used for the zip code analyses were 2009-2013 Vital Statistics and 2010-2014 Statewide Planning and Research Cooperative System (SPARCS) data. The 5-year period was chosen to establish more reliable rates when looking at small geographic areas or minority populations.

Additional data was examined from a wide variety of sources:

- Prevention Agenda 2013-18 indicators
- Community Health Indicator Reports (2011-20130
- County Health Assessment Indicators (2011-2013)
- County Health Indicators by Race/Ethnicity (2011-2013)
- County Perinatal Profiles (2011-2013)
- Behavioral Risk Factor Surveillance System (BRFSS) and Expanded BRFSS (2013-14)
- Cancer Registry, New York State (2010-2012)
- Prevention Quality Indicators (2011-2013)
- Communicable Disease Annual Reports (2011-2013)
- The Pediatric Nutrition Surveillance System (PedNSS) (2010-2012)
- Student Weight Status Category Reporting System (2010-2014)
- New York State Office of Alcoholism and Substance Abuse Services Data Warehouse (2007-2014)
- Conference of Local Mental Health directors Behavioral Health Information Portal (2013)
- Hospital-Acquired Infection Reporting System (2010-2013)
- NYS Child Health Lead Poisoning Prevention Program (2010 birth cohort; 2011-2013)
- NYS Kids' Well-being Indicator Clearinghouse (KWIC) (2011, 2014)

- County Health Rankings (2016)
- American Fact Finder (factfinder2.census.gov) (2009-2013)
- Bureau of Census, American Community Survey (2009-2013)

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

Local data were compiled from these data sources and draft reports were prepared by health condition for inclusion in this community health needs assessment. Drafts were reviewed for accuracy and thoroughness by two staff with specialized health knowledge: Kevin Jobin-Davis, Ph.D. who has over 15 years of public health data analysis experience in the Capital Region; and Michael Medvesky, M.P.H. who has over 35 years of experience working with public health data in the New York State Department of Health in many roles including Director of the Public Health Information Group. Drafts of the sections were sent to local subject matter experts for review in the health departments of Albany, Rensselaer, Schenectady, Saratoga, Columbia and Greene Counties and in St. Peter's Health Partners, Albany Medical Center, Burdett Care Center, Ellis Hospital, Saratoga Hospital and Columbia Memorial. Comments were addressed and changes were incorporated into the final document.

Collaborative Partners

Engaging the community in the health needs assessment process was a priority for St. Peter's Health Partners. Broad community engagement began with the community health survey. The surveys offered multiple choice and open ended questions to learn about residents' health needs, health behaviors and barriers to care. Demographic information collected by the survey allowed review of information by age, gender, race/ethnicity and income.

Survey results were incorporated into the examination of health needs by the members of the 4 Capital Region Public Health Prioritization Workgroups (Albany-Rensselaer, Columbia-Greene, Saratoga and Schenectady). The Workgroups included community voices through representatives from consumers, community 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.

Prioritization Process

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

Albany Medical Center, Saratoga Hospital, Columbia Memorial Hospital and HCDI to ensure that health needs analysis, prioritization and community health plans were timely and of high quality. Members of these organizations worked to identify individuals to participate in the Capital Region Public Health Prioritization Workgroups.

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

- At least one of the county rates 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 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. Participants were provided with a Prioritization Tracking Tool to record their own comments and measure their thoughts on the severity, community values, and opportunity regarding each health indicator.

Upon completion of the data summaries, 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.

Albany-Rensselaer Public Health Priority Workgroup

The Albany Rensselaer Public Health Priority Workgroup was spearheaded by the Albany County Health Department, the Rensselaer County Health Department, Albany Medical Center, St. Peter's Health Partners and Burdett Care Center. Because the hospitals' catchment areas covered both counties, it was felt a joint-county Workgroup was appropriate. Three meetings were held on February 10, February 24, and March 18, 2016. During these meetings, HCDI presented heath indicators for each of the 5 Prevention Agenda Priority Areas, and facilitated Workgroup discussions. The Power Point data presentations used during these meetings were made available to the Workgroup members and the general public on the HCDI Website (http://www.hcdiny.org/). The Workgroup chose their priorities at the last Workgroup meeting. Organizations participating in the Albany-Rensselaer Public Health Priority Workgroup include:

- Albany County Department of Health
- Albany County Department of Social Services
- Albany County Department of Mental Health
- Albany Medical Center
- Albany Medical Center: DSRIP
- Albany Police Department
- Albany Rensselaer Cancer Program
- University at Albany School of Public Health
- Alzheimer's Association
- Belvedere Health Services, LLC
- Berkshire Farm Center & Youth Services
- Burdett Care Center
- Capital District Childcare Coordinating Council
- Capital District Physicians' Health Plan (CDPHP)
- Capital District Psychiatric Center- Office of Mental Health
- Capital District Tobacco-Free Coalition
- Capital District Transportation Committee
- Capital District YMCA
- Capitol Region BOCES
- Care Coordination Services
- Catholic Charities
- Catholic Charities: Commuity Maternity Services
- Center for Disability Services
- Colonie Senior Services Centers
- Commission for Economic Opportunity
- Community Care Behavioral Health Organization
- Conifer Park
- Fidelis Care Network
- Hometown Health Centers
- Hospitality House
- Independent Living Center of the Hudson Valley
- Interfaith Partnership
- Jewish Family Services of Northeastern NY
- LaSalle School
- Mental Health Empowerment Project
- National Association of Social Workers
- National Grid
- Next Wave

- Rehabilitation Support Services
- Rensselaer County Department of Health
- Rensselaer County Mental Health
- Rensselaer Park Elementary School
- Sage College
- Samaritan Radiation Oncology
- Senator Neil Breslin
- Senior Hope
- Senior Services of Albany and Cohoes Multi-Service Senior Citizen Center, Inc.
- St. Catherine's Center for Children
- St. Peter's Health Partners (Numerous departments)
- The Community Hospice
- The Food Pantries for the Capital District
- United Way of the Greater Capitol Region
- Unity House
- Upper Hudson Planned Parenthood
- Van Rensselaer Manor
- Village of Colonie Outreach
- Visiting Nurses Association of Albany

Almost all of these organizations serve medically underserved, low income or minority populations; many offer specific programs targeted towards these groups.

Healthy Needs of the Community

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.

Significant health needs to be addressed

Following review of the significant health needs in the community, the Workgroup (Burdett Care Center along with our community partners), determined that they 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) (Disparity) – Detailed Implementation Strategy beginning on page 16.**
- **Prevent Substance Abuse (focus on opioid abuse) – Detailed Implementation Strategy beginning on page 25.**
- **Asthma/Tobacco Cessation and Strengthen Mental Health Infrastructure across Systems** were also prioritized but are being addressed by the DSRIP (Delivery System Reimbursement Incentive Payment Program) Activities. DSRIP has initiatives for Mental Health facilities going Tobacco Free, and implementing Tobacco Cessation into treatment planning for those receiving Mental Health Treatment as well as a focused asthma program. The Integration of Behavioral Health and Primary Care is also a focal point of DSRIP.

The existing Diabetes Task Force will continue their efforts to prevent Type 2 Diabetes, and help patients learn how to self-manage and live a healthy lifestyle. As learned during the Prioritization Meeting, obesity rates continue to increase. Given the connection between both diabetes and obesity, this task force will also add goals that are related to the reduction in obesity rates in Albany and Rensselaer Counties.

Significant health needs that will not be addressed

The Work Group 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. The Work Group will not coordinate activities on the following health needs:

- **Adverse Birth Outcomes–** St. Peter's Health Partners 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. St. Peter's Health Partners will support their activities to the extent appropriate.
- **Lyme Disease** - The county health departments are taking the lead on this issue. St. Peter's Health Partners will support their activities to the extent appropriate.

Governing Board Review

The St. Peter's Health Partners Board of Directors approved this Community Health Needs Assessment, Community Health Improvement Plan and Community Service Plan on September 28, 2016.

Communication

This Community Health Needs Assessment and subsequent Community Health Improvement Plans were made available to the many community members and organizations who participated in the process. In addition, we work closely with the healthy community collaboratives in both Albany and Rensselaer Counties (Strategic Alliance for Health and Rensselaer County Wellness Committee. It is posted on the St. Peter's Health Partners website (www.sphp.com) and on each of the hospital's web sites. Paper copies may be requested by contacting:

St. Peter's Hospital
Administrative Offices
315 S. Manning Boulevard
Albany, NY 12208
518-525-6048

Comments about this document may also be sent to the address above, SUBJECT: CHNA Comments.

Prevent Chronic Diseases Action Plan

Focus Area 1- Reduce Obesity in Children and Adults

Goal	Outcome Objective	Intervention/ Strategies, Activities	Partner Resources	Partner roles	Process Measures	By When	Will Action Address Disparity?
Prevention Agenda Goal 1.1 Create Community environments that promote and support healthy food and beverage choices and physical activity.	Prevention Agenda Overarching Objective 1.0.1: Reduce the percentage of youth and adults who are obese from 28.5% in 2013-14 to 27.1% in 2018 (adults) and 18.0% in 2012-14 to 17.1% in 2018 (children). (Data Source: NYS BRFSS)	Implement nutrition and beverage standards in public institutions, worksites, school districts, and childcare centers.	**St. Peter's Health Partners** Adopted a Health and Wellness policy that impacts patients and employees. SPHP was awarded the *Creating Healthy Places* contract from the NYS Department of Health that seeks to: increase opportunities for physical activity, and improve access to nutritious foods both in the community and in schools. **Albany Medical Center** Adopted a robust, multi-faceted wellness program, which includes health and wellness policies that positively impact both patients, visitors and employees. **Albany County Department of Health** Albany County Strategic Alliance for Health specifically targets poor nutrition, lack of physical activity, and tobacco use the underlying risk factors for a variety of chronic diseases (including	**St. Peter's Health Partners** Encourage healthy living through St. Peter's Wellness Committee. Creating Healthy Schools: Provides technical assistance in developing implementing strategies for health and wellness policies within school districts. **Albany Medical Center** Promote healthy living and wellness through Albany Med's "Wellness: Healthy Choices, Healthy You" program; Sodium Reduction in Communities grant. **Albany County Department of Health** Provide technical assistance in designing and implementing nutrition and beverage standards	Number of schools that adopt and implement comprehensive and strong Local School Wellness Polices. Number of participants involved in Move, Learn, Heal and Eat initiatives. 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		

			diabetes, obesity, and cardiovascular disease). Health Systems Learning Collaborative: Albany County Department of Health works collaboratively with local federally qualified health center (i.e. Whitney M. Young Jr. Health Services) to improve and control hypertension and diabetes. Local IMPACT: Albany County Department of Health is implementing community and health system strategies to prevent and control obesity, diabetes, heart disease and stroke, and reduce health disparities among adults. Health Systems Learning Collaborative: Albany County Department of Health works collaboratively with local federally qualified health center (i.e. Whitney M. Young Jr. Health Services) to improve and control hypertension and diabetes. Local Initiatives for Multi-Sector Public Health Action (Local IMPACT): Albany County Department of Health is implementing community and health system strategies to prevent and control obesity,		number of persons impacted by standards.		

			diabetes, heart disease and stroke, and reduce health **Rensselaer County Department of Health:** Serves residents in Rensselaer County through physical health and mental health activities. **Healthy Capital District Initiative** Provides access to coverage and care, health planning expertise and supports health prevention programs across the Capital Region. Facilitates the Albany-Rensselaer Diabetes Task Force.	**Rensselaer County Department of Health:** Provide technical assistance to area worksites implementing healthy workplace strategies. **Healthy Capital District Initiative** Promote worksite wellness, and health and wellness policies. Review policies, and evidenced based practices.			
		Promote Physical Activity in childcare centers, school districts, community venues, and worksites.	**St. Peter's Health Partners** Awarded the *Creating Healthy Places* contract from the NYS Department of Health that seeks to: increase opportunities for physical activity, and improve access to nutritious foods both in the community and in schools. **Albany Medical Center:** Adopted a robust, multi-faceted wellness program, which includes health and wellness policies that positively impact both patients, visitors and employees.	**St. Peter's Health Partners** Encourage healthy living through Wellness Committee, *Community Soccer Program. Creating Healthy Schools and Communities* grant program. **Albany Medical Center** Promote healthy living as part of Albany Med's Wellness Program's "Move, Learn, Heal and Eat" initiatives – Fitness Center, Fitness Classes, and Fitness App, walking groups, etc.; exercise prescriptions given to patient populations.	Number of school districts that implement Comprehensive School Physical Activity Programs(CSPAP) Number of children participating in the evidenced based Soccer for Success program that promotes healthy lifestyle through: physical activity, nutrition, mentorship and family engagement.		

			Albany County Department of Health Albany County Strategic Alliance for Health specifically targets poor nutrition, lack of physical activity, and tobacco use the underlying risk factors for a variety of chronic diseases (including diabetes, obesity, and cardiovascular disease). Health Systems Learning Collaborative: Albany County Department of Health works collaboratively with local federally qualified health center (i.e. Whitney M. Young Jr. Health Services) to improve and control hypertension and diabetes. Local IMPACT: Albany County Department of Health is implementing community and health system strategies to prevent and control obesity, diabetes, heart disease and stroke, and reduce health disparities among adults. **Rensselaer County Department of Health** Serves residents in Rensselaer County through physical health and mental health activities.	**Albany County Department of Health** Provide technical assistance in promoting physical activity in community venues. **Rensselaer County** Promote physical activity and wellness through Community Outreach.	Number of plans adopted or opportunities available promoting physical activity (e.g. Complete Streets policies, joint use agreements, applicable worksite wellness initiatives).		

			Healthy Capital District Initiative Diabetes/Obesity Task Force Provides access to coverage and care, health planning expertise and supports health prevention programs across the Capital Region. Facilitates the Albany-Rensselaer Diabetes Task Force.	**Healthy Capital District Initiative Diabetes/Obesity Task Force** Promote & provide support to outreach activities throughout both counties.			

St. Peter's Health Partners (Albany-Rensselaer) Community Health Improvement Plan 2016-2018

Focus Area 2- Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings.

Goal	Outcome Objective	Intervention Strategies, Activities	Partner Resources	Partner roles	Process Measures	By When	Will Action Address Disparity?
Prevention Agenda Goal 1.1 Promote asthma activities in the community by providing in home support to adults and children who have asthma. Goal 3.2 Prevention Agenda Goal #3.2: Promote use of evidence-based care to manage chronic diseases. **Albany County**	(Albany County) Reduce hospitalizations for asthma ages 5 to 64 from 7.4/10,000 (2012-14) by 10% (6.7/10,000) – **Albany County** 6.5/10,000 (2012-2014) by 10% to 5.9/10,000.- **Rensselaer County** Reduce emergency department visits for asthma from 55.3/10,000 (2012-14) by 10% (49.8/10,000). – **Albany County** 26.4/10,000 (2012-2014) by 10% to 23.8/10,000.- **Renssealer County** (Data Source: NYS BRFSS)	Implement evidenced based asthma management guidelines between primary care practitioners, specialists and community based asthma programs to ensure regional population-based approach to asthma management by supporting DSRIP Project 3.d.ii. DSRIP Project 3.d.i.i. Description: Ensure implementation of asthma self-management skills including home environmental trigger reduction, self-monitoring, medication use and medical follow-up to reduce avoidable emergency department and hospital care. A special focus will be on children for whom asthma is a major driver of avoidable hospital use.	**Alliance for Better Healthcare (St. Peter's Health Partners)** The Alliance for Better Health Care is governed by a five member Board. The Alliance Members are: Ellis Medicine; Samaritan Hospital, which represents St. Peter's Health Partners; St. Mary's Healthcare Amsterdam; Hometown Health; and Whitney M. Young, Jr. Health Center. The Alliance was formed in response to a New York State Department of Health initiative called the Delivery System Reform Incentive Payment. **Albany County Department of Health** Albany County Strategic Alliance for Health specifically targets poor nutrition, lack of physical activity, and tobacco use as the underlying risk factors for a variety of chronic diseases (including asthma). Healthy Neighborhoods Program provides environmental hazard home assessments, education, and referrals to follow-up resources in high-risk communities. Certified Asthma Educator provides asthma self-management education and support for families referred by the Healthy Neighborhoods Program.	**Alliance for Better Healthcare (St. Peter's Health Partners)** 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. . Home-based self-management programs to include home environmental trigger reduction, self-monitoring, medication use and medication follow up. Educate health care providers about the Home Based Asthma program **Albany County Department of Health** Provide, coordinate, or link clients to resources for evidenced based trigger reduction home-based interventions (i.e. change indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke) via Healthy Neighborhood Program, for residents identified at risk for asthma, provide in-home certified asthma educator services.	Number of Healthy Neighborhood home visits conducted. Number of certified asthma educator home visits conducted. Track utilization of the Home Based Asthma Program. Track hospital and ED visits by diagnosis.	By December 31, 2018	

			Rensselaer County Health Department In collaboration with community based organizations Rensselaer County provides the Healthy Neighborhoods Program. Trained Healthy Neighborhoods Program educators schedule a home visit and identify environmental hazards by asking residents questions from a standardized assessment form. Residents are educated about these concerns and provided referrals and follow up resources. Free cleaning, safety, and health products are also distributed to improve the home living environment. **Healthy Capital District Initiative** Provides access to coverage and care, health planning expertise and supports health prevention programs across the Capital Region. Facilitates the Asthma Coalition that encompasses asthma providers from within the capital region. HCDI reviews and provides evidenced based practices, and professional development opportunities for this workforce.	**Rensselaer County Health Department** Provide, coordinate, or link clients to resources for evidenced based trigger reduction home-based interventions (i.e. change indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke) via Healthy Neighborhood Program. For residents identified at risk for uncontrolled asthma, provide in-home certified asthma educator services. **Healthy Capital District Initiative** Promote bi-directional referral to regional Healthy Neighborhood Programs and smoking cessation programs. •Provide continuing education and asthma training opportunities to Certified Asthma Educators (AE-C) and medical professionals. •Provide financial assistance to AE-C examination candidates. •Provide durable medical goods, environmental remediation products, and educational materials to home-based service providers.			
<u>Prevention Agenda Goal 3.1</u> Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal	<u>Prevention Agenda overarching objective 3.1.4:</u> 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 17% from 58.8%	Promote prediabetes screenings and education through the use of evidence based tools.	**St. Peter's Health Partners** Primary Care, Urgent Care, Behavioral Health, Endocrinology, Outpatient Nutrition Counseling, CDE Services and Hospital Providers **Burdett Care Center** Birthing Center located in Rensselaer County. Provides labor and birthing care; prenatal and childbirth	**St. Peter's Health Partners** Provide access to St. Peter's Hospital professionals to become trained on the Prediabetes Screening and resources available within the Rensselaer County community. **Burdett Care Center** Pre-natal providers will provide information/refer patients as appropriate. All patients with	Number of Healthcare Professionals educated on the Evidenced Based Screening tool. {http://www.cdc.gov/diabetes/prevention/pdf/prediabetestest.pdf} Number of community members educated on	December 31, 2018	

cancers, economically among disparate populations	(2011) to 61.7%. (Data Source: NYS BRFSS)		education classes and breastfeeding education classes and support groups. **Albany Medical Center** Primary Care, Urgent Care, Behavioral Health Endocrinology, and Hospital provider serving Rensselaer county. Affiliation with the Northeastern Diabetes Educators Association. **Rensselaer County Department of Health** Serves residents in Rensselaer County through physical health and mental health activities. **Healthy Capital District Initiative** Provides access to coverage and care, health planning expertise and supports health prevention programs across the Capital Region. Facilitates the Albany-Rensselaer Diabetes Task Force.	gestational diabetes are referred to nutritional counseling. Promote NDPP programs to appropriate patients. Implementing Baby Friendly Initiative; Strongly encourage all new mothers to breastfeed; Provide breastfeeding education and support groups. Attend community outreach events to encourage breast feeding. **Albany Medical Center** Provide professional diabetes education summit; provide assistance in development of educational materials; educate Albany Med primary care physicians. **Rensselaer County Department of Health** Educate and provide technical assistance to Primary Care Offices (Public Health Detailing). Outreach within the community, and producing marketing material that will include, but not limited to referral resources for nutrition counseling, and dieticians. **Healthy Capital District Initiative** The Diabetes/Obesity Task Force will assist in the development of the marketing materials and provide support for outreach programming.	prediabetes through outreach activities. Number of gestational diabetes referrals and receivers of nutritional counseling. Number of participants who attend the annual Diabetes Educators Summit. Number of Albany Medical Center primary care physicians educated on Prediabetes. Number of primary care offices receiving visits, materials. Number of marketing materials developed and distributed and locations.		

Prevention Agenda Goal #3.3: Promote culturally relevant chronic disease self-management education.	Prevention Agenda overarching objective 3.3.1: Reduce use of hospital for short-term complications of diabetes 18+ years by 3% (from 6.5/10,000 to 6.3/10,000. .- **Albany County** 7.7/10,000 (2012-14) to 7.4/10,000. .- **Rensselaer County** (Data Source: NYS BRFSS)	Participation of adults in self-management programs.	**St. Peter's Health Partners** St. Primary Care, Urgent Care, Behavioral Health, Endocrinology, Outpatient Nutrition Counseling, CDE Services and Hospital Providers. **Albany Medical Center** Primary Care, Urgent Care, Behavioral Health Endocrinology, and Hospital provider serving Rensselaer county. Affiliation with the Northeastern Diabetes Educators Association. **Albany County Department of Health** The New York State Department of Health (NYSDOH) leads the Local Initiatives for Multi-Sector Public Health Action (Local IMPACT) project, funded by the Centers for Disease Prevention and Control (CDC), to help prevent and control obesity, diabetes, heart disease and stroke, and reduce health disparities among adults. Albany County Department of Health was one of the counties awarded funding. **Rensselaer County Department of Health** Has certified NDPP Lifestyle coaches who will provide training in Rensselaer County. **Healthy Capital District Initiative** Provides access to coverage and care, health planning expertise and supports health prevention programs across the Capital Region. Facilitates the Albany-Rensselaer Diabetes Task Force.	**St. Peter's Health Partners** Provide funding for two professionals to be trained in NDPP to expand existing NDPP programs within Rensselaer County. Offer NDPP to employees, encourage patients to participate in NDPP. **Albany Medical Center** Promote lifestyle changes and prediabetes education; diabetes prevention and education sessions and brochures; increase # of CDEs. **Albany County Department of Health** Increase availability of NDPP, YDPP. Increase prediabetes awareness by community providers. Promote prediabetes screening, testing, and referral. **Rensselaer County Department of Health** Promote and provide NDPP Training. Strengthen Referral Systems to NDPP and other Evidenced Based Self-Management Programs. **Healthy Capital District Initiative Diabetes/Obesity Task Force:** Promote NDPP, Review and update Diabetes Resource Guide, Review Alternative Lifestyle Change programs.	Number of new sites providing Prediabetes NDPP and YDPP. Number of participants enrolled in the NDPP and YDPP. Number of participants in other (i.e. non-YDPP/NDPP chronic disease self-management programs that support Lifestyle Change, nutrition, exercise counseling). Number of Resource Guides circulated.	By December 31, 2018	

Promote Mental Health and Prevent Substance Abuse Action Plan

Focus Area 2- Substance Abuse and other Mental Emotional Behavioral Disorders

Goal	Outcome Objective	Intervention/ Strategies, Activities	Partner Resources	Partner Role	Process Measures	By When	Will Action Address Disparity?
Prevention Agenda Goal #2.1: Prevent underage drinking, excessive alcohol consumption by youth and adults, and reduce non-medical use of prescription pain medication, by youth and adults.	**Reduce ED Visits by 10% from 2013-15 to 2018.** Albany County 19.7 to 17.7/100,000. Rensselaer County 23.3% to 21.0/100,000. **Reduce Number of Overdose Deaths by 50% from 2015 to 2018.** Albany County 17 deaths to 8 deaths. Rensselaer County 7 deaths to 3 deaths.	*Provider Education of Addiction & Pain Management* • Prescribing Guidelines • Community Resources (Prevention, Addiction Treatment & Recovery Support) • Information to provide to patients regarding risk of harm and misuse.	**St. Peter's Health Partners** Primary Care, Urgent Care, Behavioral Health, Endocrinology, Outpatient Nutrition Counseling, CDE Services and Hospital Providers. **Albany Medical Center** Hospital with primary care behavioral health, pain management and physician education services. **Albany County Department of Health** Disseminates public health information regarding heroin and opioid addiction. **Albany County Department of Mental Health** per 2016 Local Service Plan for Mental Hygiene Services: Conducts assessment of mental hygiene and associated issues; Disseminates public health information regarding heroin and opioid addiction; and	**St. Peter's Health Partners** Educate both St. Peter's Health Partners & Community Providers regarding prescribing consistent with State & Federal guidelines. **Albany Medical Center**: Educate physicians regarding prescribing guidelines; participate in prescription drug monitoring program; host provider addiction/pain medicine conference. **Albany County Department of Health and Albany County Department of Mental Health** Promote prescriber training opportunities.	Number of trainings offered. Number of prescribers trained. Number of prescribing guidelines developed and distributed Number of community resource materials developed.	December 31, 2018	

			Provides and/or coordinates prevention, addiction treatment & recovery support services. **Rensselaer County Department of Health** Serves residents in Rensselaer County through physical health and mental health activities. **Healthy Capital District Initiative** Provides access to coverage and care, health planning expertise and supports health prevention programs across the Capital Region. Facilitates the Albany-Rensselaer Behavioral Health Task Force.	**Rensselaer County Department of Health** Promote provider training opportunities**.** **Healthy Capital District Initiative** Behavioral Health Task Force will develop community resource materials.			
		Promote safe storage & proper disposal of unused prescription medications. • Community Education • Increase Disposal opportunities	**St. Peter's Health Partners** Primary Care, Urgent Care, Behavioral Health, Endocrinology, Outpatient Nutrition Counseling, CDE Services and Hospital Providers. **Albany Medical Center** Hospital with primary care behavioral health, pain management and physician education services. **Albany County Department of Health** Disseminates public health information regarding safe storage & proper disposal of unused prescription medications.	**St. Peter's Health Partners** Promote Drug Take Backs and Proper Storage Materials. **Albany Medical Center** Provide public a mechanism for proper disposal of unused medications; promote proper storage. **Albany County Department of Health** Pilot medication disposal envelopes with local pharmacies.	Number of proper disposal education activities. Number of new permanent and temporary sites for Rx collection Total pounds of prescriptions collected.	By December 31, 2018	

				Collaborate with local law enforcement to increase permanent take back sites.			
			Rensselaer County Department of Health Serves residents in Rensselaer County through physical health and mental health activities.	**Rensselaer County Department of Health** Promote Drug Take Backs and Proper Storage.			
			Healthy Capital District Initiative Provide access to coverage and care, health planning expertise, and supports health prevention programs across the Capital Region. Facilitators of the Behavioral Health Task Force.	**Healthy Capital District Initiative** Behavioral Health Task Force will promote Drug Take Backs and Proper Storage			
		New York State Opioid Overdose Prevention Training	**St. Peter's Health Partners** Primary Care, Urgent Care, Behavioral Health, Endocrinology, Outpatient Nutrition Counseling, CDE Services and Hospital Providers.	**St. Peter's Health Partners** Host and publicize community Narcan Trainings.	Number of trainings provided.	By December 31, 2018	
			Albany Medical Center Hospital and primary care provider.	**Albany Medical Center** Educate and train law enforcement and emergency medical professionals on Narcan distribution.	Number of persons participating in Naloxone trainings.		
			Albany County Department of Health Disseminates public health information regarding safe storage & proper disposal of unused prescription medications.	**Albany County Department of Health** Refer patients and promote programs.	Number of Narcan administrations by provider.		

			Rensselaer County Department of Health In collaboration with both the health department and mental health department. Educators from both departments are certified to facilitate NYS Opioid Overdose Prevention Training. **Rensselaer County Department of Mental Health** Maintain responsibility and a commitment to the mental hygiene needs of our residents by monitoring and continuously improving the system of behavioral healthcare services delivered in the county. **Healthy Capital District Initiative** Provides access to coverage and care, health planning expertise and supports health prevention programs across the Capital Region. Facilitates the Albany-Rensselaer Behavioral Health Task Force.	**Rensselaer County Department of Health** Host, and provide Narcan Training. **Rensselaer County Department of Health** Host, and provide Narcan Training. **Healthy Capital District Initiative** Behavioral Health Task Force will design patient education materials about community resources.	Number of patient education materials developed.		
		Promote DSRIP Project 3aiv. Project Description: Development of Withdrawal Management (e.g. ambulatory detoxification, ancillary	**St. Peter's Health Partners** The Alliance for Better Health Care is governed by a five member Board. The Alliance Members are: Ellis Medicine; Samaritan Hospital, which represents *St. Peter's Health Partners*; St. Mary's Healthcare Amsterdam; Hometown Health; and *Whitney M. Young, Jr. Health Center*. The Alliance was formed in	**St. Peter's Health Partners** Establish four ambulatory withdrawal programs. Increase the number of X licensed primary care physicians.	Number of additional physicians with X license Number of programs established. Number of patients served by new programs.	By December 31, 2018	

		withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs. Establish Ambulatory Detox Programs	response to a New York State Department of Health initiative called the Delivery System Reform Incentive Payment Program (DSRIP). **St. Peter's Health Partners, St. Peter's Medical Associates, Catholic Charities, Whitney Young** Will develop withdrawal management services for substance use disorders (SUD) within community-based addiction treatment programs that provide medical supervision and allow simultaneous or rapid transfer of stabilized patients into the associated SUD services and provide/link with care management services that will assist the stabilizing patient to address the life disruption related to the prior substance use. **Albany County Department of Health** The Alliance for Better Health Care, the assigned Performing Provider System (PPS), serves a six county area in upstate New York (Albany, Fulton, Montgomery, and Rensselaer, Schenectady, and Saratoga counties).	**St. Peter's Health Partners, St. Peter's Medical Associates, and Whitney Young** Expand medication assisted treatment in primary care practices. **St. Peter's Health Partners, Project Safe Point, Catholic Charities, and Project Lead** Develop Care Coordination Services for patients receiving ancillary withdrawal services. **Albany County Department of Health** Refer patients and promote programs.			

			Albany County Department of Mental Health Provides oversight and planning for local ambulatory detoxification services (i.e. Albany County). **Rensselaer County Department of Health** Maintain responsibility and a commitment to the mental hygiene needs of our residents by monitoring and continuously improving the system of behavioral healthcare services delivered in the count.	**Albany County Department of Mental Health** Provide oversight and guidance regarding peer engagement. Assure consistency of ambulatory detoxification initiative with comprehensive local plan for alcohol/substance abuse services. **Rensselaer County Department of Health** Refer patients and promote programs.			