Albany Memorial Hospital

St Peter's Health Partners

Community Health Needs Assessment 2016

Approved by the Albany Memorial Hospital Board of Directors:

June 22, 2016

Executive Summary

Overview:

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.

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."

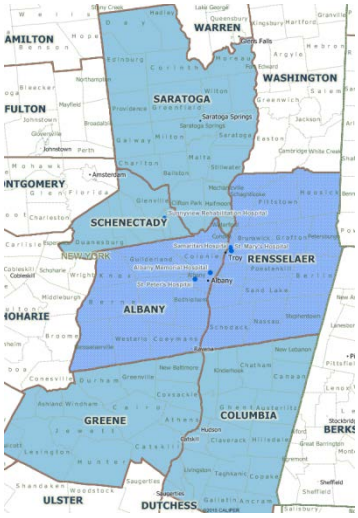
St. Peter's Health Partners' Mission guides everything we do. As we continue our healing ministry into the 21st century, we are called to both serve others and transform care delivery. We reinvest our resources back into the community through new technologies, vital health services, and access for everyone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

Definition and Brief Description of the Community Served



For the purposes of the Community Health Needs Assessment, Albany Memorial Hospital defines its service area as Albany and Rensselaer Counties which represent the home zip codes of 86% 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 Section II.

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 opiods 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

Albany Memorial Hospital, along with its SPHP sister hospitals, collaborated with other 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, Albany Memorial used data and information from this assessment relating to Albany and Rensselaer Counties which represent the home zip codes of 86% 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, 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 of 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, and St. Peter's Health Partners. 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
- 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.

Albany and Rensselaer County Workgroup members selected the following priorities:

I. **FOCUS AREA: CHRONIC DISEASE**
   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.

Governing Board Review

The Albany Memorial Hospital Board of Directors approved this Community Health Needs Assessment on June 22, 2016.

Communication

This Community Health Needs Assessment was made available to the many community members and organizations who participated in the process. Additionally, it is available on the Albany Memorial Hospital website (www.nehealth.com), the SPHP website (www.sphp.com) and the Healthy Capital District Initiative website (www.hcdiny.org). Paper copies may be requested by contacting:

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