2019-2021 collaborative Community Health Needs Assessment (CHNA), Implementation Strategy (IS), Community Health Improvement Plan (CHIP), and Community Service Plan (CSP)

for Schenectady County

and its Hospitals

Schenectady County
Public Health Services

Schenectady Coalition for a Healthy Community

Submitted in fulfillment of the requirements of the **New York State Department of Health** Prevention Agenda by Schenectady County Public Health Services, Ellis Hospital (d/b/a Ellis Medicine), and Sunnyview Rehabilitation Hospital. Submitted in fulfillment of the requirements of the **Internal Revenue Service** (pursuant to the Patient Protection and Affordable Care Act of 2010) by Ellis Hospital (d/b/a Ellis Medicine). CHNA and Implementation Strategy adopted by vote of the Ellis Hospital Board of Trustees on October 1, 2019. Submitted November 15, 2019.

To comment in writing on this document pursuant to the Patient Protection and Affordable Care Act (PPACA) of 2010

please contact Ellis Hospital at https://www.ellismedicine.org/pages/contact.aspx

or write to Director of Community Relations, Ellis Hospital Administration, 1101 Nott Street, Schenectady, New York 12308

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Available at: http://www.hcdiny.org/content/sites/hcdi/2019_CHNA/2019_HCDI-Community-Health-Needs-Assessment.pdf

New York State 2019-2021 Community Health Needs Assessment, Community Health Improvement Plan and Community Service Plan

A. New York State Required Cover Page

1. County covered:

Schenectady County

2. Participating Local Health Department:

Schenectady County Public Health Services, 107 Nott Terrace, Schenectady, New York 12308, 518-386-2810

3. Participating Hospitals:

Ellis Hospital (d/b/a Ellis Medicine), 1101 Nott Street, Schenectady, New York 12308, 518-243-4000

Sunnyview Rehabilitation Hospital, 1270 Belmont Avenue, Schenectady, New York 12308, 518-382-4500

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 – Schenectady Coalition for a Healthy Community (SCHC)

B. Executive Summary

1. What are the Prevention Agenda priorities and the disparity you are working on with your community partners including the LHD and hospital(s) for the 2019-2021 period? (See section E.1, pages 50-61)

The final selected top two Prevention Agenda Priorities and Focus Areas are:

1) Priority Area: Prevent Chronic Diseases, Focus Area: Tobacco Prevention, and

2) Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders, Focus Area: Mental and Substance Use Disorders Prevention.

Both priorities reflect disparities; tobacco use occurs disproportionately among low-income individuals and in low-income neighborhoods, while mental disease and drug use diagnoses occur disproportionately in low-income neighborhoods.

2. What data did you review to identify and confirm existing priorities or select new ones? (See sections C.1.c and d., pages 14-22 and E.1, pages 50-61)

Data reviewed consisted of publicly available health and hospital data collected from twenty data sets (see list on page 20), gathered and interpreted for the six-county Capital Region by staff data experts at the Healthy Capital District Initiative (HCDI). These data sets include detailed hospital-diagnosis-specific treatment and outcomes reports from the Statewide Planning and Research Cooperative System (SPARCS), local health survey measures from the Expanded Behavioral Risk Factor Surveillance System (eBRFSS), and Prevention Agenda Tracking Dashboard reports. In almost all cases, data are valid at the county level, with several data sets at the sub-county level. Sub-county data at the ZIP code level is attributed by "neighborhood," based on generally agreed neighborhood designations. The HCDI analysis provided comparisons to two benchmarks: the Capital Region six-county average, and the New York State excluding New York City (NYS excl. NYC) average. HCDI also developed a quantitative ranking

system which evaluated data on five dimensions of: 1) absolute number, 2) relative number (to NYS excl. NYC benchmark), 3) impact on health, 4) trend over time, and 5) disparity. The publicly available, and locally interpreted, data were supplemented by local consumer data and opinions gathered through a telephone survey of households in the six-county region. The survey samples gathered valid data for the region as a whole, for each county in the region, and for a subset of low-income consumers across the region. Finally, the public engagement process included open discussion during three meetings over two months, with formally scheduled time for advocates to "pitch" their proposed priority, including the introduction of new and additional data.

3. Which partners are you working with and what are their roles in the assessment and implementation processes? How are you engaging the broad community in these efforts? (See sections C.2.c, pages 31-32, E.1, pages 50-61, and E.3.e, pages 71-72)

In addition to working through HCDI and all of the hospitals and public health departments in the six-county Capital Region for data collection and interpretation, Schenectady County and its hospitals again took a highly inclusive and collaborative approach to engaging community partners in the assessment and implementation policy. Since even before the pioneering "UMatter Schenectady" community survey and joint Local Health Department/hospital CHNA/CHIP/CSP in 2013, Schenectady's health planning efforts have revolved around the multi-agency Schenectady Coalition for a Healthy Community (SCHC). Founded in 2008 to promote community involvement in the State-mandated consolidation of Schenectady's hospitals, membership in SCHC has expanded to cover most of the not-for-profit provider and community service agencies in the county, as well as applicable local government agencies. Representatives from 28 agencies and organizations (see page 55) actively participated in the assessment and prioritization process. These included the local public health department and the local community services (mental health/substance use) agencies, the hospitals, the only federally qualified

health center (FQHC) in the county, faith-based organizations, a Spanish-speaking community organization, not-for-profit health plans, and such non-traditional partners as a community garden, the chamber of commerce, and the public library. As further described in the detailed Work Plan (pages 63-73 and Appendix B) all of the lead health care agencies and many of the community agencies have accepted active roles in implementation of the selected interventions. In particular, Capital District Tobacco Free Communities will be engaged in the Tobacco Prevention priority area, while certified substance use providers such as New Choices Recovery Center and Hometown Health Centers will actively inform work on the Substance Use Disorders priority. Individual participant organizations will be engaging their consumers and community members.

4. What specific evidence-based interventions/strategies/activities are being implemented to address the specific priorities and the health disparity and how were they selected? (See sections E.2, pages 61-63, E.3, pages 63-65 and 69-72, and Appendix B)

Evidence-based interventions were selected directly from those offered in the Prevention Agenda. For the Tobacco Prevention priority they are: 1) Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms (3.1.2) and 2) Promote Medicaid and other health plan coverage benefits for tobacco dependence counseling and medications (3.2.4). For the Prevent Mental and Substance Use Disorder priority they are: 1) Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine (2.2.1), 2) Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers (2.2.2), 3) Establish additional permanent safe disposal sites for prescription drugs and organized take-back days (2.2.5), and 4) Integrate trauma informed approaches in training staff and implementing program and policy (2.2.6). As with the priorities, the interventions were selected from among those offered in the Prevention Agenda through a stakeholder-involved, iterative

process. Meetings in June and July (see Appendix A) engaged invited stakeholders and then the full SCHC membership in reviewing alternatives and selecting those to be implemented.

5. How are progress and improvement being tracked to evaluate impact? What process measures are being used? (See sections E.2 and E.3, pages 61-73 and Appendix B)

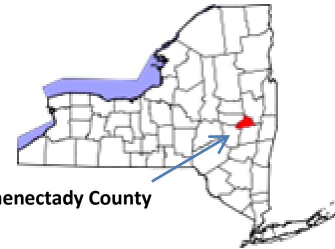
Progress and improvement will be tracked through two methods – process measures and outcomes measures. The process measures are enumerated in the Work Plan (pages 61-63) and in Appendix B. In most cases they measure the numbers of meetings, trainings, or education programs, and then the number of attendees at each. These will reflect levels of interest, e.g., work group meetings and attendees, but may also be considered useful analogs for clinical and community preparedness and community health, e.g., number of providers trained in Buprenorphine administration, number of enrollees in "The Butt Stops Here" who are on Medicaid, or number of people receiving MAT while in jail. Although outcomes measures are obviously the better indicators of community health, they are frequently claims-based and subject to substantial time lags. With Ellis Hospital acquiring a new EHR system across all inpatient and outpatient locations and services, there is a potential for development of more timely outcomes data for the substantial portion of clinical services in the community performed by Ellis.

C. Community Health Assessment

1. Definition and Description of Community Served

a. Demographics of Population Served

Schenectady County (2018 estimated population: 155,350) is, geographically, the second smallest county in upstate New York. It consists of five towns, two primarily rural and three primarily suburban, surrounding the centrally-located City of Schenectady (2018 estimated population: 65,575). The county is located immediately west of the State Capital of Albany and many of its residents commute to jobs in Albany and the other counties comprising New York's Capital Region.



Relative to the other five counties in the Region, Schenectady reflects a number of county-specific socio-demographic measures as identified in the 2019 Regional CHNA (see Volume Two). These include:

- Schenectady County was the Capital Region's most urban county (755.7 pop./sq. mile);
- Schenectady County had the 2nd lowest median age (39.8 years) in the Capital Region;
- Schenectady County had the largest percentage of population aged 14 years of age or younger at 18.0%, while 15.6% of the County population was 65+ years of age;
- In the Capital Region, Schenectady County had the 2nd largest non-White population at 22.0%, and the largest Hispanic population at 6.6%;
- The Hamilton Hill neighborhood had the largest non-White population (67.7%) as well as the largest Hispanic population (16.5%);
- Schenectady's poverty rate of 12.0% was lower than that of NYS (15.5%);
- The Hamilton Hill neighborhood had the highest neighborhood poverty rate (47.4%).

Schenectady County Public Health Services (SCPHS), a unit of county government, is responsible for all public health and environmental health activities and enforcement throughout the city and county. The county contains a single non-profit acute care hospital – Ellis Hospital (also known by the trade name Ellis Medicine), and a single federally qualified health center (FQHC) – Hometown Health Center. There is also a non-profit specialty hospital (Sunnyview Rehabilitation Hospital) which is a member of the Albany-based St. Peter's Health Partners (Trinity Health) system.

As of July 2019, the entire City of Schenectady is designated a Health Professional Shortage Area (HPSA) for the Medicaid eligible population for Primary Care, Mental Health, and Dental Health.

Since the 1970s, eight Census Tracts in the Hamilton Hill/Mont Pleasant neighborhoods, which are immediately adjacent to the Ellis McClellan Street Health Center, had been designated as a HPSA for the Medicaid eligible population for Primary Care. In 2013, the entire City was designated a HPSA for Mental Health and Dental Health. In the spring of 2019, the New York State Primary Care Office, operating from the Center for Health Workforce Studies at the University at Albany, successfully applied to the federal Health Resources and Services Administration (HRSA) for expansion of the Primary Care HPSA designation to cover the entire City of Schenectady. There is one Medically Underserved Population (MUP) – the homebound population of Schenectady County (ID #06211). Hometown Health

Center, the Ellis Dental Health Center, and the Ellis Outpatient Mental Health Clinic have all been designated by HRSA as National Health Service Corps practice sites.

	Schenectady County	City of Schenectady	New York State
Population	155,350 (2018)	65,575 (2018)	19,542,209 (2018)
Persons per square mile	756.6 (2010)	6,135.5 (2010)	411.2 (2010)
Persons under 18 years	21.6% (2018)	20.7% (2018)	20.9% (2018)
Persons 65 years and over	16.9% (2018)	13.4% (2018)	15.9% (2018)
White alone	78.5% (2018)	59.4% (2018)	69.6% (2018)
Black or African American alone	12.0% (2018)	20.9% (2018)	17.7% (2018)
Bachelor's degree or higher (age 25+)	30.8% (2013-17)	22.3% (2013-17)	35.3% (2013-17)
Median value, owner-occupied housing	$164,100 (2013-17)	$110,8000 (2013-17)	$293,000 (2013-17)
Median household income	$61,315 (2013-17)	$43,174 (2013-17)	$62,765 (2013-17)
Persons in poverty	12.8% (2018)	21.0% (2018)	14.1% (2018)

Figure C1: Schenectady County, City, and State Demographics
Source: US Census Bureau, State and County QuickFacts, as accessed April 23, 2019; note that Census data from this source vary slightly from HCDI data reported in the text above

Schenectady County is directly served by one DSRIP Performing Provider System (PPS), the Alliance for Better Health (AFBH), and is adjacent to the service area of the Albany Medical Center PPS.

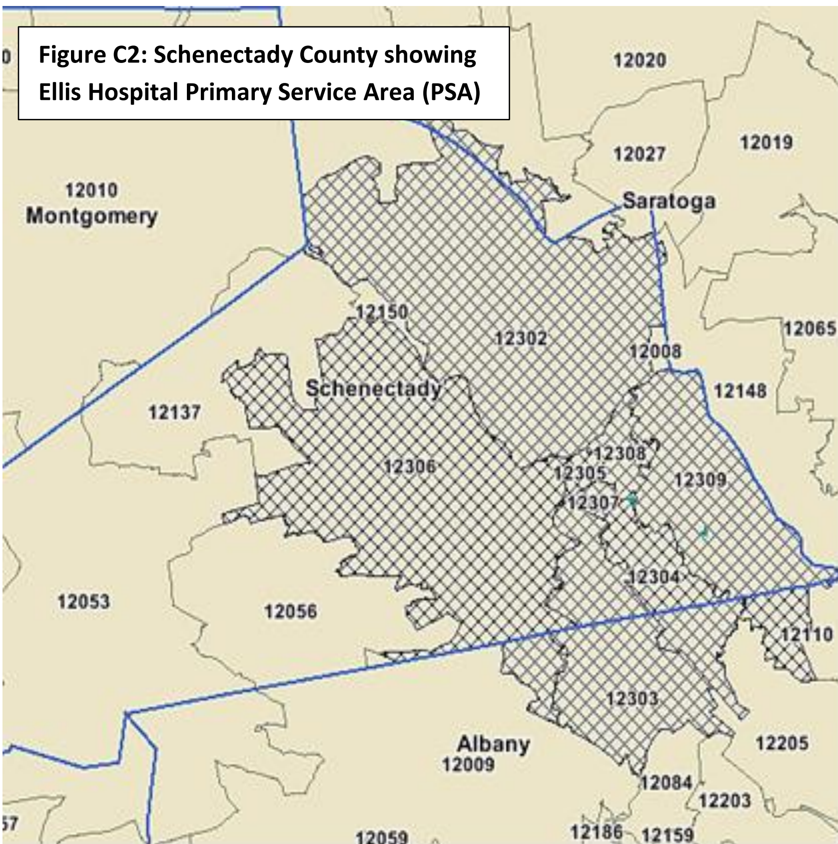


Figure C2: Schenectady County showing Ellis Hospital Primary Service Area (PSA)

For the purposes of determining community needs pursuant to the requirements of the Patient Protection and Affordable Care Act of 2010, Ellis Hospital defines the "community" it serves as consisting of Schenectady County, including the City of Schenectady and the Towns of Duanesburg, Glenville, Princetown, Niskayuna, and Rotterdam. There are several reasons for this definition:

The geography of Schenectady County is very similar to the Primary Service Area (PSA) of the hospital. Ellis uses an industry-standard definition (the contiguous ZIP codes in which the first 60% of the hospital's inpatients live) to determine its PSA. Ellis' PSA consists of the entire range of 123nn ZIP codes (12302, 12303, 12304, 12305, 12306, 12307, 12308, and 12309), which constitutes all of the City of Schenectady and most of the population of the rest of Schenectady County. (The design of the ZIP code system is not aligned with county or other political boundaries. The rural westernmost portion of Schenectady County is not included in the ZIP code-defined PSA due to low population, while certain

areas of Albany and Saratoga Counties do fall within the Schenectady ZIP codes.) Although Ellis actively serves people within its Secondary Service Area (SSA), the geographic boundaries of those additional ZIP codes (the additional contiguous ZIP codes in which the next 20% of inpatients live, for an approximate total of 80% of inpatient volume) stretch across five counties and include portions of the service areas of at least six other hospitals. Retaining a focus on the Schenectady community will permit development of an actionable implementation plan which can target cohesive populations.

Population and health data are commonly available by county. The New York State Department of Health and other State government agencies maintain data by county, the Healthy Capital District Initiative provides comparison data by county within the region, and data collected by the United States Census are frequently at the county and city level. Although convenience is not in and of itself a reason to define "community," the availability of solid data, including baseline and comparison data, will provide a better basis for planning, and an externally-verifiable source for outcome measures.

Ellis has established strong partnerships with other healthcare and community service organizations which are located in and serve Schenectady County. The "Medical Home Group," a loose affiliation of community organizations created at the time of the three-hospital consolidation in 2008, has since evolved into the Schenectady Coalition for a Healthy Community; 60 community groups including businesses, local government agencies, healthcare and social services providers and community agencies, faith-based organizations, and advocacy groups whose leaders meet quarterly at Ellis. By focusing "community" on a population well served by a coordinated array of physical health, behavioral health, and community service organizations in coordination with strong local government agencies, a community-wide action plan can leverage the hospital's implementation plan through the efficient and effective use of multiple resources.

Selection of Schenectady County as the "community" is consistent with regulatory requirements to assure inclusion of "medically underserved, low-income, or minority populations" (sec. 1.501(r)-3(b)(3)), as these populations represent a greater share of the population in Schenectady County than they would if diffused among the five counties of the Secondary Service Area.

b. Health Status of the Population and Distribution of Health Issues

Residents of the City of Schenectady are generally less affluent and less healthy than residents of the surrounding towns, while residents of the County as a whole are less affluent than the State as a whole; however the County's poverty rate is below that of the State (see Figure C1).

For example, the median household income for the City, at $43,174, is only about two-thirds that of the County as a whole ($61,315), which is below that of the State ($62,765). The poverty rate in the City (21.0%) is nearly 40% higher than that of the County as a whole (12.8%). State Health Department data (2008-09) show that hospitalizations for conditions which could have been treated in the community ("prevention quality indicators") range as high as 202% of the expected rate in certain City neighborhoods, but are as low as 49% of the expected rate in the rural towns. In one dramatic disparity confirmed by more recent (2012-16) SPARCS hospital discharge data, emergency department visits for asthma range from 229.3/10,000 in the City's Hamilton Hill neighborhood (12307) to 24.5/10,000 in the nearby suburb of Niskayuna (12309).

Overall, Schenectady County residents are slightly more likely than the average New York State resident to have health insurance, to see a doctor, and to see a dentist; and significantly more likely to visit an Emergency Department for mental health care (see Figure C3). The vast majority of primary medical care and dental care for low-income residents is provided by the Hometown Health FQHC and the community practices of the Ellis Medical Group. Both have achieved recognition by the National Committee for Quality Assurance (NCQA) as Patient-Centered Medical Homes (PCMH).

	Schenectady County	**New York State**
Adults 18-64 with health insurance (2016)	91.8%	88.6%
Adults with regular health care provider (age-adjusted, 2016)	84.6%	83.4%
Adults who visited dentist w/in 1 year (age-adjusted, 2013-14)	69.7%	69.3%
Mental disease/disorder primary dx ED visit rate per 10,000 (age-adjusted 2014-16)	235.8	185.4

Figure C3: Schenectady County and State Health Insurance and Health Access Measures
Source: HCDI, 2019 Capital Region Community Health Needs Assessment

Other descriptors of the health status of Schenectady's population come as comparisons with State-wide rates as calculated by HCDI in the 2019 Capital Region Health Needs Assessment (see Volume Two). As noted, comparisons are made to the "NYS excl. NYC" rate, which covers the 57 counties (upstate and Long Island) that do not constitute the City of New York.

Chronic Disease

- Schenectady County's adult asthma prevalence of 12.9% was higher than NYS excl. NYC (10.4%);
- Schenectady's asthma emergency department (ED) visit rate (56.7/10,000), and ED visit rate for the 1-4 year old population (122.6) were higher than NYS excl. NYC (47.6, 105.8);
- Hamilton Hill had 5.2 times the asthma ED visit rate and 2.1 times the asthma hospitalization rate as NYS excl. NYC;
- Schenectady's adult smoking rate of 19.9% was higher than NYS excl. NYC (17.0%) but a slight decrease from its rate in 2013-14 (20.3%);
- The County's CLRD ED visit rate (116.2/10,000), hospitalization rate (24.4) and CLRD mortality rate (39.7/100,000) rate were higher than NYS excl. NYC (71.9, 23.7, and 35.0);
- Hamilton Hill had 5 times the CLRD ED visit rate, while City/Stockade had 2.7 times the CLRD hospitalization rate compared to NYS excl. NYC;
- Schenectady County's adult obesity rate of 28.5% (30,744 adults), and child and adolescent obesity rate of 18.8% (4,725 children) were both higher than NYS excl. NYC (27.5%, 17.3%);
- Schenectady County's adult diabetes prevalence of 9.0% was higher than NYS excl. NYC (8.5%);
- Schenectady's diabetes mortality rate of 18.3/100,000 was higher than NYS excl. NYC (15.3);
- The County's diabetes short-term complication hospitalization rate (5.2/10,000) was higher than NYS excl. NYC (4.1);
- The Hamilton Hill neighborhood had 6.5 times the diabetes ED rates, and 3 times the diabetes hospitalization rates compared to NYS excl. NYC;
- Schenectady's heart attack hospitalization rate of 18.0/10,000 was higher than NYS excl. NYC (14.8);
- The County's congestive heart failure hospitalization (21.6/10,000) and mortality (19.9/100,000) rates were higher than NYS excl. NYC (21.4 and 16.9);
- Schenectady's stroke hospitalization (27.0/10,000) and mortality (31.2/100,000) rates were higher than NYS excl. NYC (23.1 and 28.6);

- The Hamilton Hill neighborhood had 1.4 times the coronary heart disease hospitalization rate, 1.8 times the congestive heart failure hospitalization rate, and 1.6 times the stroke hospitalization rate compared to NYS excl. NYC;
- Schenectady's colorectal screening rate of 76.2% was better than NYS excl. NYC (69.7%), while the county's colorectal cancer mortality rate (13.1/100,000) was slightly worse than NYS excl. NYC (12.9);
- Schenectady's mammography screening rates were lower than NYS excl. NYC for women 50-74 years of age (78.6% vs. 79.2%);
- Schenectady County had higher female breast cancer incidence (144.8/100,000) and late stage incidence (51.5) than NYS excl. NYC (139.5, 43.0).

Healthy and Safe Environment

- Schenectady's incidence rate of elevated blood lead levels (10+ug/dl) in children under 6 years of age of 14.9/1,000 was over twice as high as NYS excl. NYC (6.0);
- The County's lead screening rates for children 9-17 months (76.9%) and 2 screens by 36 months (59.2%) were both higher than NYS excl. NYC (71.7%, 55.9%);
- The percent of Schenectady's low income population with low access to a supermarket of 5.72% was higher than NYS excl. NYC (3.93%);
- Schenectady's assault ED visit (62.1/10,000) and hospitalization (3.1) rates were higher than NYS excl. NYC (35.0, 2.2);
- The Hamilton Hill neighborhood had 6.3 times the assault ED visits and 5.7 times the assault hospitalization rates compared to NYS excl. NYC.

Healthy Women, Infants, and Children

- Schenectady's teen (15-17 years) pregnancy rate of 21.5/1,000 was markedly higher than NYS excl. NYC (9.9), but has decreased 35% from 2009 to 2016;
- The Hamilton Hill neighborhood's teen pregnancy (15-19 years) was 5.5 times higher NYS excl. NYC;
- Schenectady County had a slightly higher late or no prenatal care rate (4.6%) compared to NYS excl. NYC (4.4%);
- Schenectady's rate of premature births (< 37 weeks gest.) of 9.8% was higher than NYS excl. NYC (9.1%);
- The County's rate of low birthweight (< 2.5 kg.) of 8.8% was higher than NYS excl. NYC (7.7%);
- Schenectady County's infant mortality rate of 9.1/1,000 live births was higher than NYS excl. NYC (5.0);
- The Hamilton Hill neighborhood had 1.4 times the rate of premature and 2 times the rate of low birthweight births compared to NYS excl. NYC;
- For Schenectady's children (0-21 years) on public insurance, the well-child visit rate of 67.7% of having the recommended number of visits was lower than NYS excl. NYC (72.7%).

Infectious Disease

- Schenectady's gonorrhea case rates in the 15-44 year population of 418.5/100,000 for females and 321.0 for males were markedly higher than NYS excl. NYC (197.1 and 230.0);

- Schenectady's chlamydia case rate for women 15-44 years of 1,943/100,000 was higher than NYS excl. NYC (1,352); with a 25% increase from 2009 to 2013;
- The County's gonorrhea rate increased 130% and the chlamydia rate 25% from 2013 to 2017;
- Schenectady's 65 + years population had a lower influenza vaccination rate (55.5%) than NYS excl. NYC (59.6%).

Mental Health and Substance Abuse

- About 14.9% of adult Schenectady residents indicated that they had 14 or more poor mental health days in the past month, which is higher than NYS excl. NYC (11.2%);
- Schenectady's mental disease and disorder ED visit rate (235.8/10,000), and hospitalization rate (97.1/10,000) were higher than NYS excl. NYC (147.8, 64.1);
- Schenectady's suicide mortality rate of 11.7/100,000 was higher than NYS excl. NYC (9.6), but was a 7% decrease since 2011-13;
- The self- inflicted injury ED visit rate for Schenectady residents 15+ years of age of 12.6/10,000, and self-inflicted injury hospitalization rate of 9.5/10,000 were higher than NYS excl. NYC (7.1 and 5.3);
- The City/Stockade neighborhood had 4.8 times the mental disease and disorder ED visit rates, and 5.2 times the mental disease and disorder hospitalization rates than NYS excl. NYC;
- Schenectady residents had higher rates of opioid overdose mortality (20.8/100,000), and opioid overdose ED visits (81.2) compared to NYS excl. NYC (19.4, 79.7);
- Schenectady County's opioid overdose mortality rate increased over 200%, and the ED visit rate increased 160% from 2013 to 2017;
- Hamilton Hill had 2.7 times the opiate-related ED visit rate and opiate-related hospitalization rate than NYS excl. NYC;
- Schenectady's cirrhosis mortality rate (9.1/10,000) was higher than NYS excl. NYC (7.2).

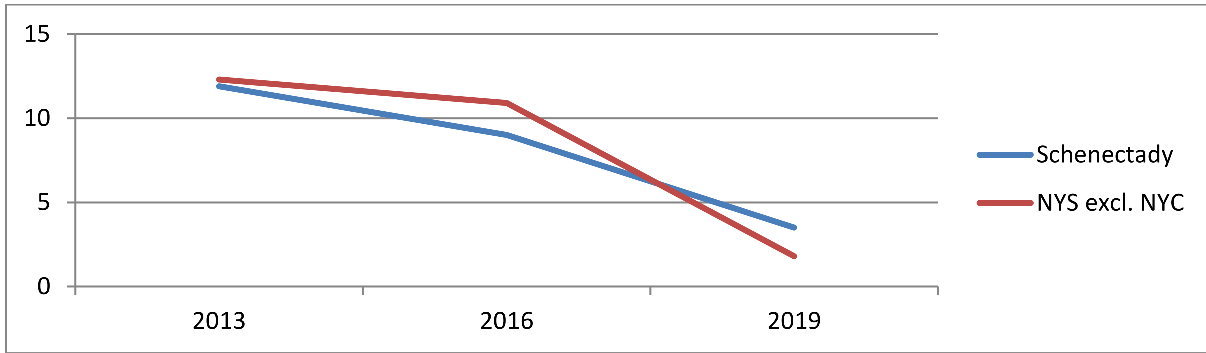
c. Current Data, and Changes Over Time

Data on the significant Prevention Agenda Priority Area elements have been collected over time by HCDI and incorporated into the 2013, 2016, and 2019 Community Health Needs Assessment reports. As described below ("How the Data Were Obtained," pages 20-22), multiple data sources are used, and all have varying amounts of lag time between occurrence and publication. Typically, the most "current" data are two or three years old, with small area data being averaged over multiple years in order to be meaningful. It is clear that the time lag between implementation of an intervention and the reporting of impacted measures reflects a weakness of all health data reporting.

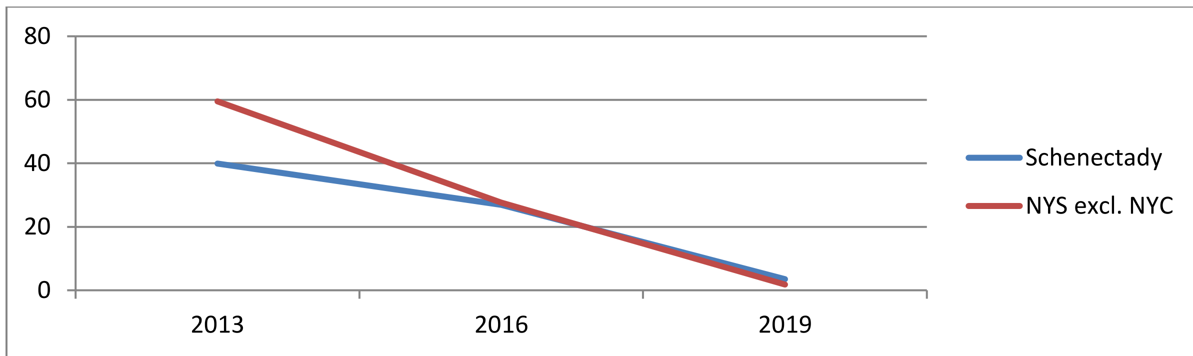
Although many measures have been refined and modified through the years, certain basic measures are available for comparison over time. Examples of these are shown below in basic graphic format covering the thirteen selected Schenectady-specific Prevention Agenda Focus Areas. (See section 2.b. "NYS Prevention Agenda Priority and Focus Areas" on pages 28-31 for information on the selection methodology and process.) Unless otherwise noted, data are taken from the HCDI CHNA documents, and are shown by the year of the CHNA in which they were reported (2013, 2016, 2019), not the actual year of data collection.

Prevention Agenda Priority Area: Prevent Chronic Diseases

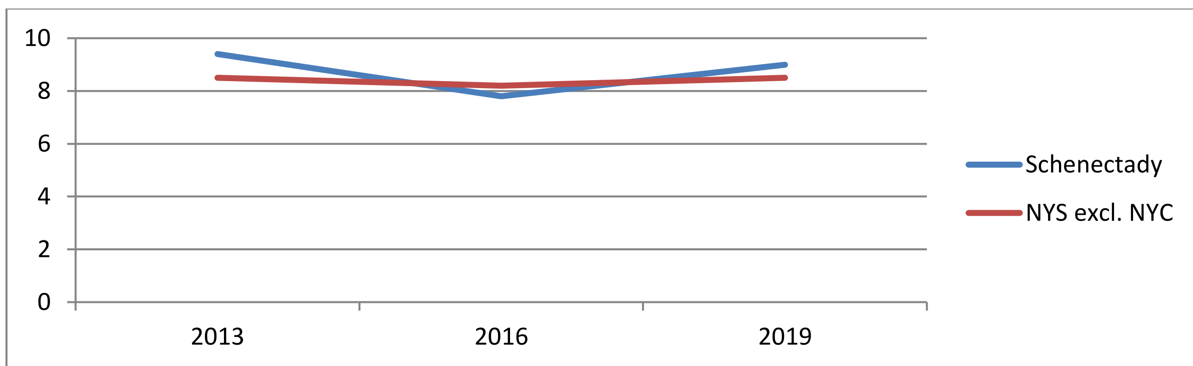
(Figure C4) Issue: Asthma – Age-adjusted Asthma Hospitalization Rate per 10,000



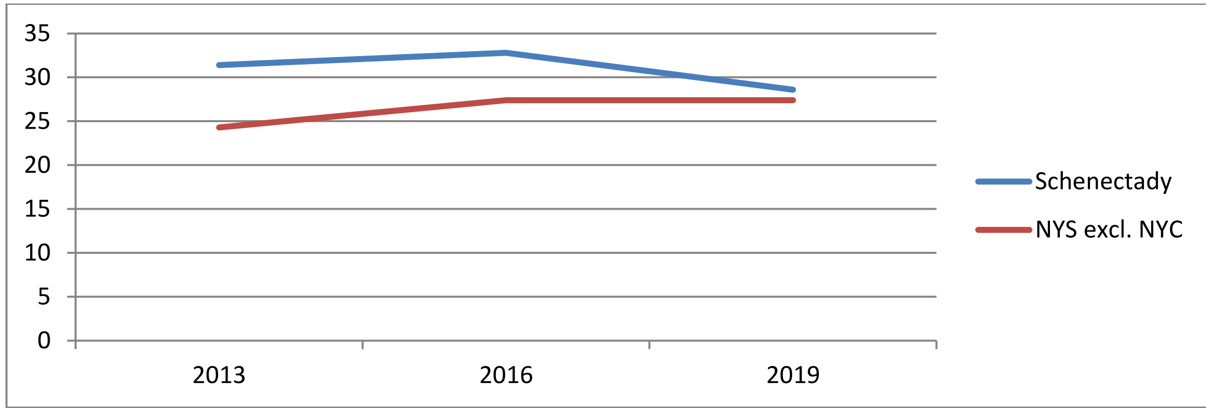
(Figure C5) Issue: Respiratory Diseases – Age-adjusted COPD/CLRD Hospitalization Rate per 10,000



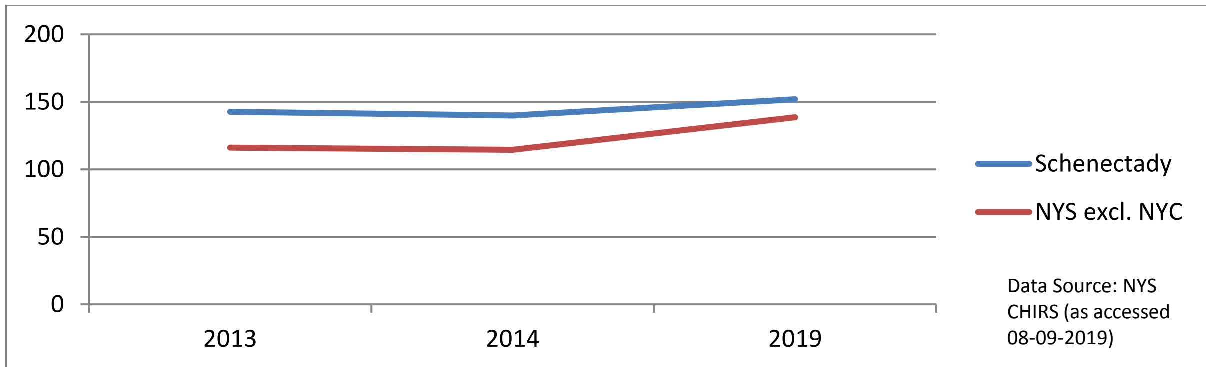
(Figure C6) Issue: Diabetes – Age-adjusted Percentage of Adults Who Have Diabetes



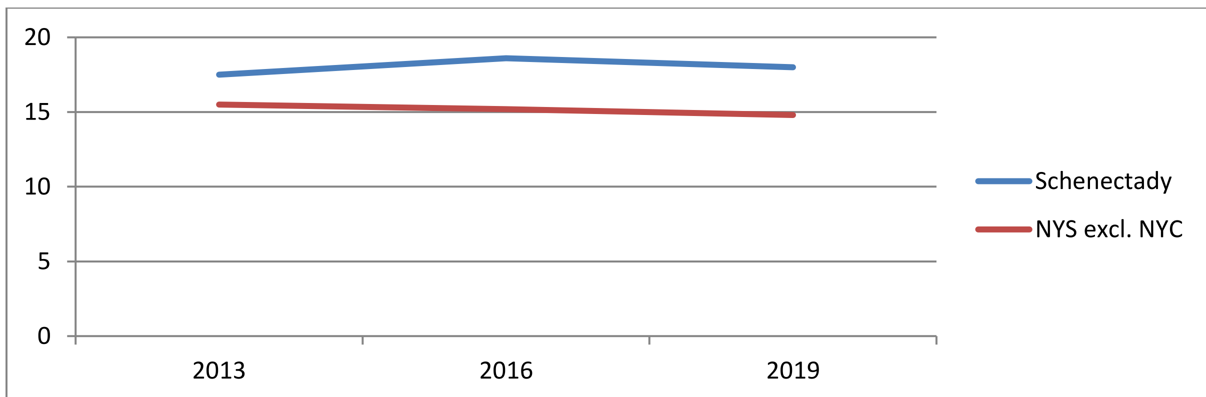
(Figure C7) Issue: Obesity – Percentage of Adults Who Are Obese



(Figure C8) Issue: Kidney Disease – Chronic Kidney Disease Hospitalization Rate per 10,000 (any diagnosis)

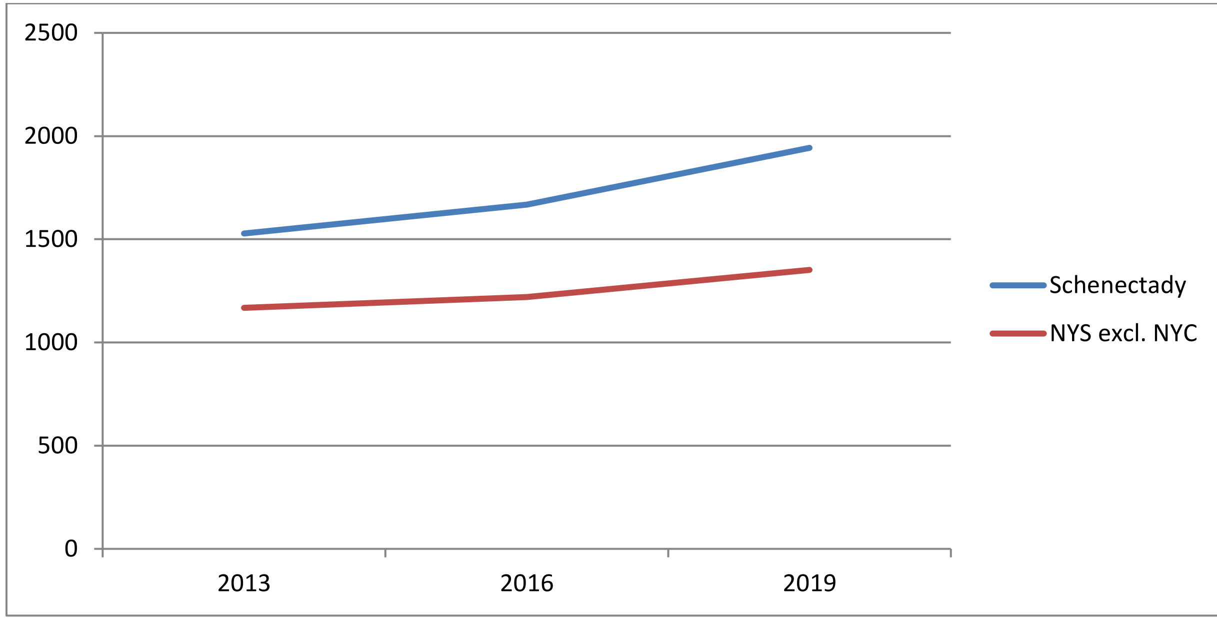


(Figure C9) Issue: Cardiovascular Disease – Age-adjusted Heart Attack Hospitalization Rate per 10,000

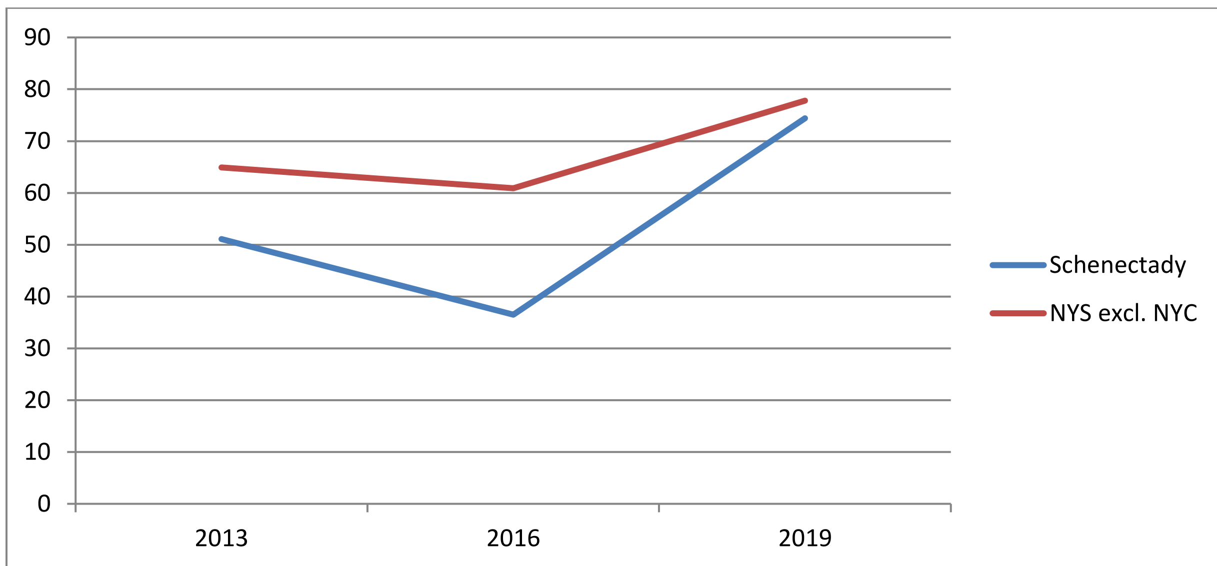


Prevention Agenda Priority Area: Prevent Infectious/Communicable Diseases

(Figure C10) Issue: HIV and STDs – Rate of Chlamydia in Women Ages 15-44 per 100,000 Women

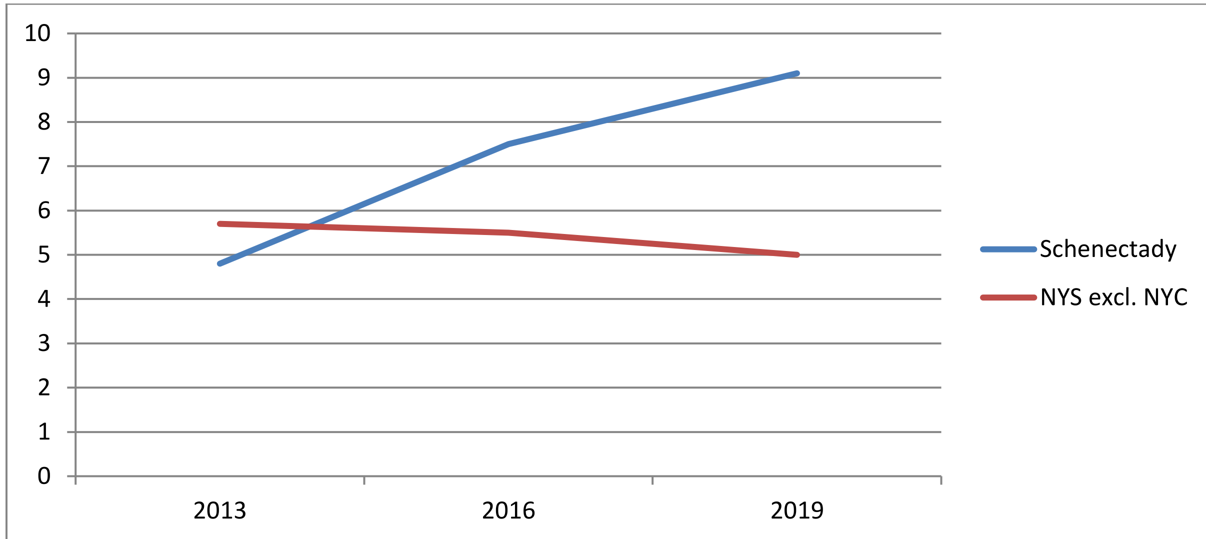


(Figure C11) Issue: Lyme Disease - Rate of Lyme Disease per 100,000 population

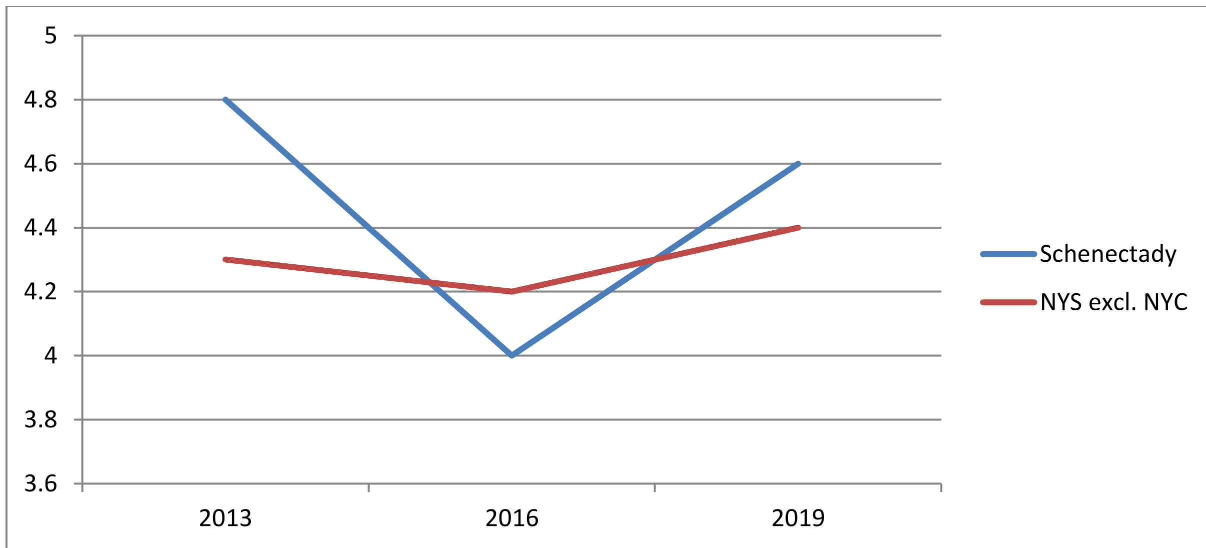


Prevention Agenda Priority Area: Promote Healthy Women, Infants, and Children

(Figure C12) Issue: Poor Birth Outcomes – Infant Mortality per 1,000 Live Births

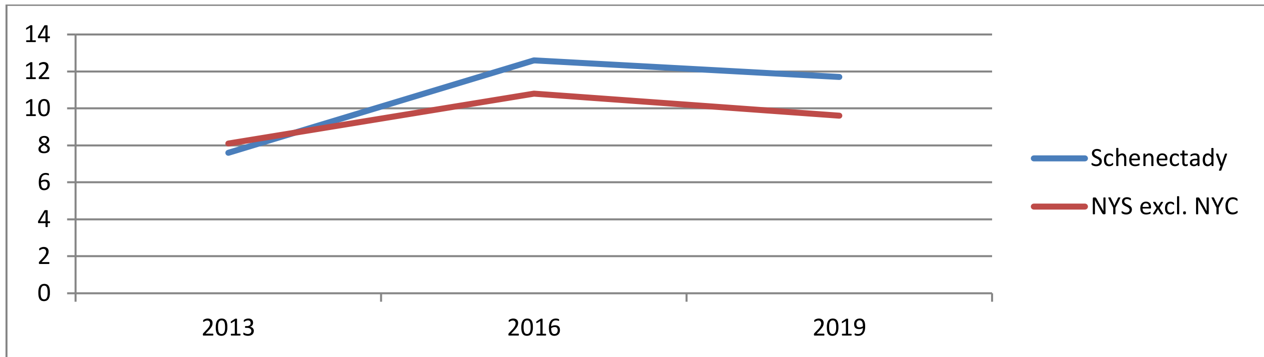


(Figure C13) Issue: Prenatal Care – Percent of Births with Late or No Pre-natal Care

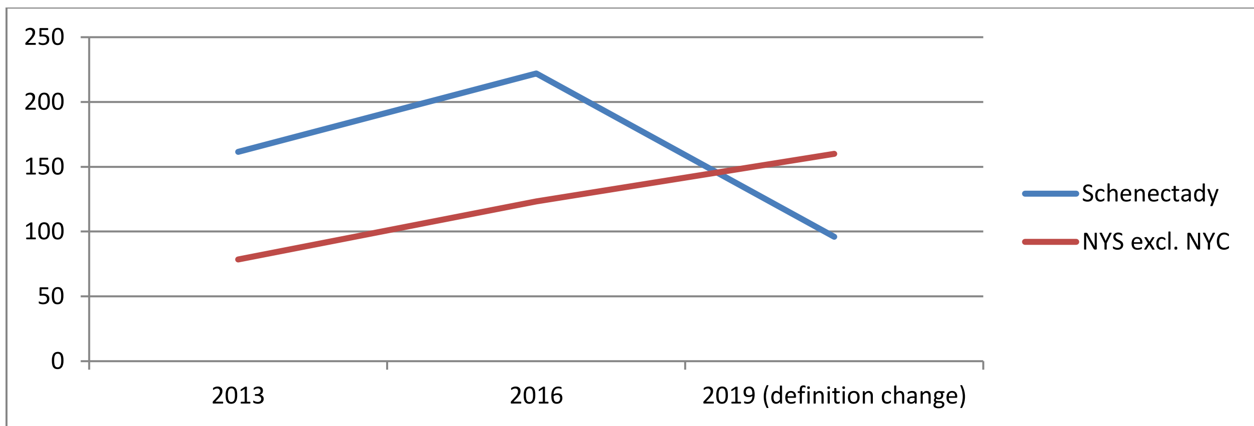


Prevention Agenda Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders

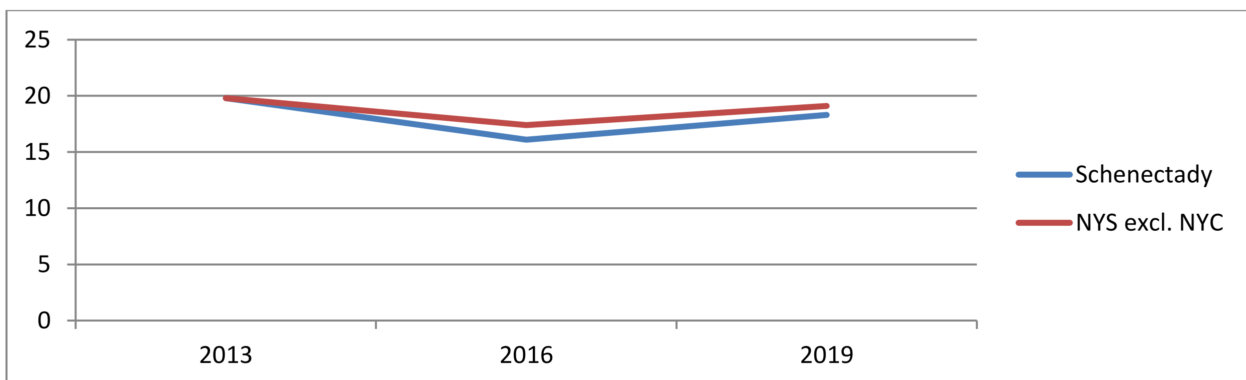
(Figure C14) Issue: Mental Diseases and Suicide – Age-adjusted Suicide Mortality Rate per 100,000



(Figure C15) Issue: Substance Use – Newborn Drug-Related Hospitalization per 10,000 Newborn Discharges



(Figure C16) Issue: Alcohol Use – Percent of Binge Drinking within Past Month among Adults



d. How the Data Were Obtained

Data for the Schenectady County CHNA were obtained by the Healthy Capital District Initiative (HCDI) and published in the Capital Region CHNA document which constitutes Volume Two of this report. 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 recent 2013-2018, and new 2019-2024 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 and are very likely to continue to be supported. This provides reliable and comparable data over time and across the state. While the 2019-2024 Prevention Agenda objectives and indicators have been developed, the present Prevention Agenda Dashboard still contains 2013-2018 indicators with corresponding data (as of May 2019). These measures, when complemented 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. The Common Ground Health 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 time frames used for the ZIP code analyses were 2012-2016 Vital Statistics and 2012-2016 Statewide Planning and Research Cooperative System (SPARCS) data. The five-year period establishes more reliable rates when looking at small geographic areas or minority populations. Additional data were examined from a wide variety of sources:

- Prevention Agenda 2013-18 Dashboard of Tracking Indicators (2016)
- Community Health Indicator Reports Dashboard (2014-2016)
- County Health Indicators by Race/Ethnicity (2014-2016)
- County Perinatal Profiles (2012-2014; 2014-2016)
- Vital Statistics Annual Reports (2014, 2015, 2016)
- Behavioral Risk Factor Surveillance System (BRFSS) and Expanded BRFSS (2016)
- Cancer Registry, New York State (2011-2015)
- Prevention Quality Indicators (2014-2016)
- Communicable Disease Annual Reports (2013-2017)
- The Pediatric Nutrition Surveillance System (“PedNSS”) (2014-2016)
- Student Weight Status Category Reporting System (2014-2016)
- County Opioid Quarterly Reports (April 2017-October 2018)
- NYS Opioid Data Dashboard (2016-2017)
- NYS Child Health Lead Poisoning Prevention Program (2013 birth cohort; 2014-2016)
- NYS Kids’ Well-being Indicator Clearinghouse (KWIC) (2012-14, 2017)
- County Health Rankings (2019)
- American Fact Finder (factfinder2.census.gov) (2017)
- Bureau of Census, American Community Survey (2012-2016)

These data sources were supplemented by a Siena College Research Institute Community Health Survey. The 2018 Community Health Survey was conducted in December 2018 by the Siena College Research Institute. The survey was a representative sample of adult (18+ years) residents of the Capital Region.

The survey included 1,204 (MOE +/- 3.4%) total interviews made up of a phone sample, oversample of low income residents, and a small online sample. This consumer survey was conducted to learn about the health needs, barriers and concerns of residents in the Capital Region.

Local data were compiled from these data sources and draft sections were prepared by health condition for inclusion in this community health needs assessment. Drafts were reviewed for accuracy and thoroughness by two HCDI staff with specialized health data knowledge. The 2019 Capital Region Community Health Needs Assessment Draft was then sent to local subject matter experts for review in the County Public 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, as well as being placed on the HCDI website for public review and comment. Comments were addressed and changes were incorporated into the final document.

Every year, the New York State Department of Health (NYSDOH) provides updated information on major health indicators for each county. NYSDOH still provides county-level information on 2013-2018 Prevention Agenda indicators and objectives that can be used for tracking Prevention Agenda-based efforts, while working on the development and public accessibility of the 2019-2024 Prevention Agenda Dashboard. To supplement available information, this report focuses on more detailed information, such as analyses by ZIP code level, gender, race, ethnicity and trends over the past decade. In order to present meaningful information for smaller areas or subgroups, data for several years are combined. Thus, most information presented is based on three or five years of combined data. Still, some areas had too few cases to estimate rates accurately. Within the Volume Two regional CHNA document, after presenting information on demographics and cause of death for the Capital Region, a summary of general health status is presented, including information on health care access and usage. This is followed by sections specific to each of the five New York State Prevention Agenda Priority Areas. Topics within each Priority Area contain a brief synopsis of the condition and why it is of concern. Prevention Agenda objectives are presented and compared to statistics for New York State, excluding New York City, the Capital Region, and the six Capital Region counties. If available, trend data as well as information by gender and race/ethnicity are presented. Indicators include mortality, natality, and emergency department (ED) visit and hospitalization rates. Additional information from disease registries, administrative data, and the Expanded Behavioral Risk Factor Surveillance System are also included.

ZIP code groups were chosen as a small-area breakdown because there were insufficient data for the primary alternative, census tracts. The groups were selected based on a minimum of 2,000 residents and meaningful groupings generally following municipal boundaries and at sub-municipal neighborhoods in urban areas. Detailed tables are available in the Volume Two appendices for: ZIP code neighborhood groupings by county; county socio-demographics (age, race/ethnicity, poverty) by neighborhood; county birth indicators by neighborhood; leading causes of death and premature death by county; county hospitalization rates by race and gender; county ED visit rates by race and gender; county hospitalization rates by neighborhood; county emergency department rates by neighborhood; county mortality rates by neighborhood; county and neighborhood prevention quality indicators (PQI); county health rankings; county-specific results of the ranking of Public Health Issues using a methodology developed by HCDI; and 2018 Capital Region Community Health Survey results. For most indicators, age-adjusted rates are presented in the tables. Age-adjustment considers the differing age distributions within populations to calculate rates that can be used for comparison purposes. Direct standardization was used for this report. The advantage of this method is that comparisons of Capital Region data can be made with Prevention Agenda objectives for most indicators. Prevention Agenda and NYSDOH indicators have been

age-standardized to the United States 2000 population, thus age-adjusted rates presented in this report are standardized similarly. Also, most comparisons are made between Capital Region data and data for the 57 counties in New York State which are not within the City of New York (referenced as "NYS excl. NYC"). This is a well-accepted methodology to allow comparison with typically more similar populations, excluding the sometimes unique population dynamics of the nation's largest city.

In 2012-2016, the most recent demographic profile available, the Capital Region (which includes Schenectady and five nearby counties) was home to approximately 957,200 residents, equally distributed between males and females, with counties ranging from Urban (Schenectady-756 pop./sq. mile) to Rural (Greene-73 pop./sq. mile). The Region's mean age of 39.9 years was higher than that of New York State (NYS). About 17% of the population was 14 years of age or younger, while 16% was 65 years of age and older. Approximately 16% of the Capital Region's population was non-White and 4.8% Hispanic. The Region's median household income of $63,758 was higher than NYS. Its poverty rate of 11.1% was lower than NYS. Over 15% of the Region's children less than 18 years of age were below poverty. About 7.9% of the Capital Region's population 25 years of age or older had less than a high school education. The health of Capital Region residents was generally consistent with other New York counties outside New York City, although Capital Region residents had a higher overall age-adjusted mortality rate as well as a higher % of deaths that were premature (<65 years) than NYS excl. NYC. However, the Region's rate of Years of Potential Life Lost (YPLL) was lower than NYS excl. NYC. Chronic diseases were the leading causes of death in the Capital Region, with heart disease, cancer, chronic lower respiratory disease (CLRD), and stroke being the major causes. Injuries were the major cause of death in the child, adolescent, and young adult populations. Health care access indicators show the Capital Region having fewer barriers to care than NYS excl. NYC. Capital Region residents, both children and adults, had higher health insurance coverage rates compared to NYS excl. NYC. A higher percent of Capital Region residents also had a regular health care provider. The Capital Region's primary care system also seemed to be working well compared to NYS excl. NYC. When looking at preventable hospitalizations, Capital Region residents had much lower rates than residents from NYS excl. NYC did. Total Emergency Department visit rates, as well as total hospitalization rates were also lower in the Capital Region compared to NYS excl. NYC.

2. Identification of Significant Health Needs and Main Health Challenges

a. Discussion of Risk Factors

Behavioral, Environmental, and Socioeconomic Risk Factors

Information regarding Schenectady County's behavioral, environmental, and socioeconomic risk factors is available from a number of sources; two of the most prominent being the United States Census Bureau's American Community Survey (ACS) and the New York State Health Department's Expanded Behavior Risk Factor Surveillance System (eBRFSS). Both full reports are available on the HCDI website: http://www.hcdiny.org/content/sites/hcdi/ebfrss_chart_books/Schenectady.pdf and http://www.hcdiny.org/content/sites/hcdi/sociodemographic/Schenectady_Sociodemographic_2012-2016.pdf .

Schenectady County is a fairly typical example of an older industrial city surrounded by "bedroom" suburbs and rural areas. Some data appear to be compressed; as the County's small geographic size means that urban factors account for a relatively greater share of countywide measures.

Behavioral Risk Factors (Source: eBRFSS)

- The percentage of adults aged 18-64 years who saw a doctor for a routine checkup within the past year is lower in Schenectady than in the Capital Region or New York State as a whole
- The percent of adults who are obese is significantly higher in Schenectady County than in the Capital Region or New York State as a whole
- The percent of adults who are current smokers is slightly higher (worse) in Schenectady than in the Capital Region, while both are higher that New York State as a whole
- The percent of cigarette smoking among adults who report poor mental health is higher in Schenectady than in the Capital Region or New York State as a whole
- The percent of adults who have taken a course or class to learn how to manage their chronic disease of condition is much lower in Schenectady than in the Capital Region or New York State as a whole
- The percent of adults aged 47-68 years reporting ever being tested for Hepatitis C is lower in Schenectady than in the Capital Region or New York State as a whole

Environmental Risk Factors (Sources: ACS and eBRFSS)

- Hamilton Hill in the City of Schenectady, the smallest neighborhood by area, had nearly double the percentage of population below Federal Poverty Level as compared to other Schenectady County neighborhoods
- Adjacent to Hamilton Hill, the Goose Hill/Union neighborhood (the physical location of Ellis Hospital and of Sunnyview Rehabilitation Hospital) demonstrated a similar array of elevated population risk factors
- The neighborhoods of Schenectady County demonstrated the largest percentages of both non-white and impoverished populations among all neighborhoods of the Capital Region
- The percentage of adults experiencing housing insecurity within the past 12 months is higher in Schenectady than in the Capital Region, but lower than the Statewide number
- In addition to Hamilton Hill, both the Stockade and Upper State St. neighborhoods had double the Capital Region percentage of population with less than a high school education
- Although most Schenectady residents consider their neighborhoods safe for walking, both the raw and age-adjusted percentages are lower than for the Capital Region or New York State as a whole
- The suburban Town of Niskayuna had two interesting and notable risk factors likely resulting from a heavy concentration of highly-educated but foreign-born scientists and engineers – percentage of population with use of language other than English at home, and speaking English "less than very well"

Socioeconomic Risk Factors (Source: ACS and eBRFSS)

- Since 2010, Schenectady County has increased in population density as well as non-white and Hispanic composition

- The percentage of adults who did not receive needed medical care because of cost is higher in Schenectady than in the Capital Region, but is lower than the Statewide number
- There have been decreases in the percentage of population without high school completion, as well as an increase in college attainment since 2010
- There have been decreases in the percentage of population below Federal Poverty Level, with less than a high school education, and those that are disabled since 2010
- Compared to the other counties in the Capital Region, Schenectady County is more racially/ethnically diverse as well as more impoverished; with a greater percentage of disabled individuals; and less high school attainment
- Compared to New York State, Schenectady County is less racially/ethnically diverse, as well as impoverished; high school-educated; and with a greater percentage of disabled population and more proficient in the English language

Primary / Chronic Disease Needs of Uninsured / Low-Income / Minority Populations

It has been the intent of the various surveys and data collection exercises to identify community-wide health needs. It is clear, however, that the specific needs of uninsured, low-income, and/or minority populations are recognized in these reports and responded to in the accompanying Plans and Strategies.

Two specific community reports focused exclusively on these specific populations. The "Capital Region, Mohawk, and Hudson Valley DSRIP Community Needs Assessment" conducted by HCDI in December 2014 followed the requirements of the New York State Department of Health's Delivery System Reform Incentive Payment (DSRIP) program by exclusively studying the needs of the Medicaid beneficiaries who were to be served by DSRIP. The document is available here: http://staging.abhealth.us/wp-content/uploads/2018/07/community_needs_assessment.pdf. The "Schenectady County Community Needs Assessment" produced regularly (most recently in November 2018) by the Schenectady Community Action Program (SCAP) is a government-required study of the needs of low-income residents of the community, who are the clients of the federally-funded SCAP. The document is available here: https://scapny.org/wp-content/uploads/2019/02/SCAP_2018Assessment.pdf .

The findings of these documents directly parallel the findings of community-wide studies such as those contributing to this CHNA/IS/CHIP/CSP document.

Key findings of the DSRIP document were:

> "The Community Needs Analysis determined that service use was significantly impacted by widespread barriers to primary care when and where consumers need it. Insufficient care coordination is a major health service use driver as it puts greater demands on the Medicaid and Uninsured population to manage their care than they have the capacity to fulfill. This is particularly true for consumers with behavioral health or multiple chronic conditions as personal health characteristics. Avoidable utilization of hospital services is most concentrated in super-utilizers who are more likely to have substance abuse, behavioral health, or multiple chronic conditions and live in the highest need neighborhoods of the region.

1. IMPAIRED ACCESS TO NEEDED CARE

a. Rates for Medicaid members using primary care are lower than Benchmarks in all 10 counties, while preventable ED use is higher in all 10 counties. There are few local Patient Centered Medical Homes (PCMH) currently certified.

b. Medicaid members and uninsured cannot find primary care services available at times or locations they need. Common themes expressed in consumer surveys, local listening sessions, and focus groups of this population was that life barriers prevented access to primary care and clinics at times and locations convenient to the provider. Expanded office hours and urgent care are not available where these people live. Lack of transportation, working two jobs and risking of losing them if taking time off for health appointments, child care responsibilities, and lack of informal supports make the ED the only place to obtain care in many high need neighborhoods. Poor access to care was reflected in worse rates than New York State in all counties for diabetes screening, three cancer screenings, chlamydia screening and in half the counties prenatal care, which leads to high risk and high cost low birth weight deliveries.

c. Triage screening for appropriate ED use is not practical in the current delivery system. When people arrive at the ED evenings and weekends currently, the only service option available is the ED itself. Even during normal business hours when other services could be available, there is insufficient Triage space or processes to screen and divert people that may need less costly services.

2. CARE COORDINATION BARRIERS TO EFFECTIVE CARE

a. Lack of Coordination by Providers increases demands on consumers to take up the slack. Their ability to self-manage chronic conditions is measurably impaired by:

> i. Presence of moderate or significant behavioral health conditions, life management skills, stable housing, and informal supports are all challenged by mental impairments and/or substance use disorders. This diminished capacity to self-manage is frequently exceeded by the demands expected by the current delivery system to manage complex chronic conditions.
>
> ii. Presence of multiple chronic physical conditions The complexity of and knowledge needed to effectively manage several co-morbid conditions, medications, primary and specialist appointments, and daily life places demands that exceed capacity of the general population. The dually eligible have added age and/or disability demands and reduced capacity, placing them at higher risk. In the community, increased knowledge and engagement combined with effective informal supports are necessary to avoid ED use and admissions, including community health workers and navigators where needed. This subpopulation tends to be white, educated – and overwhelmed.

b. Coordination of Behavioral Health and Physical Health Services is difficult within current delivery system. Medicaid members and uninsured with both physical and behavioral health conditions are currently treated for either one or the other condition. The current delivery system does not make treating both (i.e. the whole person) easy, or in some cases possible with current regulations and delivery silos. People with a diagnosed and treated behavioral health condition are frequently admitted for a physical condition. Likewise, under-diagnosed

depression and anxiety complicate the treatment of physical conditions and lead to excess ED visits and admissions, as does under treatment due to medication barriers and fears. When referrals between settings are made, both providers and the consumers agree that appointments take too long to secure, reducing their likelihood of being kept and often too far in the future to be effective. Substance use disorders are particularly high impact, especially in combination with either physical or mental impairments.

3. HOSPITAL USE CONCENTRATED IN A FEW SUPER-UTILIZERS

a. Eleven percent (11%) of Medicaid members and uninsured represent over half of ED visits, almost 40% of admissions, and all 30 day readmissions. These individuals were defined as having more than 2 ED visits in 6 months and/or a 30 day readmission in the last 3 years. Super-utilizers are twice as likely to have significant behavioral health conditions, twice as likely to have multiple chronic conditions, and three times as likely to have been treated for substance abuse.

b. These super-utilizers are clustered in several high need neighborhoods. Neighborhoods like the South End in Albany and Hamilton Hill in Schenectady have high proportions and numbers of these super-utilizers, along with poverty rates almost double the regional average and a more diverse racial mix. Other high need neighborhoods like Troy/Lansingburgh and Amsterdam have elevated rates of anxiety and depression driving ED and inpatient use.

c. There are higher than expected proportions of Socio Demographic Status (SDS) indicators in this subpopulation. There were 6% higher poverty rates, 4% higher English language learner rates, 3% higher rates of foreign born, 3% higher rates for education less than high school graduate, and 3% higher unemployment rates in the zip codes where they live. We also found much higher numbers of Hispanics than in the overall Medicaid/Uninsured population (11.3% vs. 5.9%) and higher numbers of Blacks (17.4% vs. 15.5%)."

Similarly, key findings of the 2018 SCAP document are:

- "There have not been statistically significant changes in Schenectady County's overall population over the past ten years. While the total population is not projected to change dramatically over the next decade, it is projected that there will be notable changes in the population age profile for persons 45-54 and 65-74 years of age. By 2020, it is projected that there will be a 19% decrease amongst the age cohort of 45-54 years (from 2010). Conversely, the 65-74 age cohort is expected to increase by 55%. The number of non-United States citizens residing in Schenectady County is over 5,500, with 64.1% residing in the City of Schenectady.

- The largest percentage of county residents living in poverty is in the City of Schenectady. However, poverty in the county's other communities has been increasing. While 73% of those in poverty reside in the city, this is down five percentage points from the 78% reported in SCAP's 2015 Community Needs Assessment. Additionally, while 79.5% of children in poverty are in the city, this is 12.5 percentage points less than the 92% reported in the 2015 assessment. NYS School Report Card data for all school districts show an increase in the percent of economically disadvantaged students. While the percent and number of economically disadvantaged students remains highest for the Schenectady City School District, this district experienced the smallest increase between 2013-2014 and 2016-2017.

- Many residents that are employed struggle to afford basic needs. According to the United Way's 2018 ALICE Report, over half of all households in Schenectady County are below the "ALICE" threshold; they are "Asset Limited, Income Constrained, Employed."

- At 10%, the City of Schenectady's unemployment rate is higher than both the county (7.4%) and NYS rates (7.5%). Within the city, the highest unemployment rate, 21%, is in the Hamilton Hill neighborhood. County-wide, 39.5% of residents over the age of 25 have only a high school diploma or less. (2012–2016 American Community Survey)

- Homelessness continues to be significant. According to Schenectady County's 2018 Point in Time count, a total of 393 people (of which 38 were chronically homeless) in 268 households were either unsheltered (11 people), in emergency shelter (345 people) or in transitional housing (37 people). The total count of 393 is 119 over the 2017 Point in Time count of 274. The most recent HMIS (Homeless Management Information System) quarterly report for Schenectady County indicates services to 2,773 people experiencing homelessness or at risk of homelessness, a significant increase compared to 2,245 people one year earlier. 68% of adults and 21.4% of children served report at least one physical, emotional or other health condition, with 536 adults served reporting conditions that meet the criteria to be considered a disability.

- Lack of safe and affordable housing within the City of Schenectady continues to be a primary concern. Contributing factors include cost burden and substandard older housing stock.

- There are 9,128 children under age five living in Schenectady County, 2,073 of which live in poverty. There are 38 licensed child care centers in the county with a total of 3,094 slots for infant to school-age children. None of these centers offer evening, overnight or weekend care, with only three offering care for mildly/moderately ill children. There is a shortage of 247 slots needed in child care centers for children under three, a shortage of 152 slots needed in family child care homes for children under three, and a shortage of 3,193 slots needed in school-age programs. Families struggle with the cost of care, whether they receive a subsidy or not. Lack of child care options leads to employee absence. Low-income families need access to quality early childhood development services.

- The Schenectady Coalition for a Healthy Community has identified Preventing Chronic Disease and Promoting Mental Health & Preventing Substance Abuse as priority areas of need requiring focus through 2018.

- In a total of nine focus groups conducted as part of SCAP's assessment process, residents and stakeholders identified the following as primary needs: Affordable & Safe Housing, Jobs that Pay a "Livable" Wage, Child Care (including on call, 2nd and 3rd shifts), Affordable/Accessible Youth Programs, Mental Health Support, Transportation, Peer Support, Improved Neighborhood Safety, Parent Education Support, and Domestic Violence Support. Customer needs are multifaceted. While customers of SCAP are aware that resources exist, accessibility and awareness of what services and supports are available were identified as key areas in need of improvement.

- The top three most pressing needs identified by 165 customers/community members surveyed were: Safe & Affordable Housing (50% identified as top need), Child Care Services (9% identified

as top need) and Youth Programming (7% identified as top need). The five areas of need identified most as one of the top three most pressing needs were: Safe & Affordable Housing, Education Services, Nutrition/Hunger Services, Transportation Services and Child Care Services. The top three most pressing needs identified by 59 staff completing needs assessment surveys were: Safe, Affordable Housing (70% identified as top need), Child Care (29% identified as top need) and Transportation (23% identified as top need)."

b. NYS Prevention Agenda Priority and Focus Areas

As described to a greater extent in section E.1. "Identification of Two Priorities – Process, Criteria, Community Engagement" starting on page 50, a structured process was used to move from the 170 regionally tracked public health "Indicators" to 30 quantitatively ranked public health "Issues" and then to 13 selected Schenectady-specific Prevention Agenda Focus Areas which were eventually prioritized to the community's top two priorities.

During the Schenectady Coalition for a Healthy Community's meetings on February 14, March 7, and March 14, 2019, 13 selected Issues falling within four of the five 2019-2014 New York State Prevention Agenda Priority Areas were discussed and evaluated in substantial detail. The complete presentation (http://www.hcdiny.org/content/sites/hcdi/2019_prioritization_meetings/Schenectady_Priority_Presentation-2019.pdf) is summarized below:

Prevention Agenda Priority Area: Prevent Chronic Diseases

Issue: Asthma

Asthma is ranked sixth in Schenectady using the quantitative methodology. Absolute measures such as Percent of Adults with Asthma, Asthma ED Visit Rate, and Asthma Hospitalization Rate are generally worse than the Capital Region and NYS excl. NYC. Trends are mixed; some show improving and some show worsening measures since the prior CHNAs. Disparities exist, but are generally less than regional disparities. The Hamilton Hill Asthma ED Visit Rate is 3.2 times the countywide average.

Issue: Respiratory Diseases

Respiratory Disease is ranked 14th (Smoking) and 17th (COPD/CLRD) in Schenectady using the quantitative methodology. Absolute measures such as Percent of Smokers, Lung Cancer Incidence, and COPD/CLRD Hospitalizations are generally worse than the Capital Region and NYS excl. NYC. Trends again are mixed, but some show measures getting worse since the prior CHNAs, while the Statewide and Capital Region trends are improving. Disparities exist, and are similar to regional disparities. The Hamilton Hill and Stockade neighborhoods' COPD/CLRD Hospitalization Rate is more than twice the countywide average.

Issue: Diabetes

Diabetes is ranked eighth in Schenectady using the quantitative methodology. Absolute measures such as Percent of Adults with Diabetes and Diabetes Short-term Complications

Hospitalization Rate are worse than the Capital Region and NYS excl. NYC. Trends show most measures getting worse since the prior CHNAs (with the exception of improvement in the rate of short-term complications), while the Statewide and Capital Region trends are improving. Disparities exist, and are similar to regional disparities. The Hamilton Hill Diabetes Short-term Complications Hospitalization Rate is the worst in the Capital Region.

Issue: Obesity

Obesity is ranked 20th in Schenectady using the quantitative methodology. Absolute measures such as Percent of Obese Adults and Percent of Obese School Children are worse than the Capital Region and NYS excl. NYC. Trends show some measures improving since the prior CHNAs, but the measure of Adults Engaged in Leisure Time Physical Activity has declined. The Schenectady City Schools are in the worst Capital Region quartile for student obesity.

Issue: Kidney Disease

Kidney Disease is ranked second in Schenectady using the quantitative methodology. Absolute measures such as Hospitalization Rate and Mortality Rate are worse than the Capital Region and NYS excl. NYC. Trends show measures worsening since the prior CHNAs. Disparities exist, but are less than regional disparities. The Hamilton Hill Kidney Disease Hospitalization Rate is twice the countywide average.

Issue: Cardiovascular Disease

Cardiovascular Disease is ranked 16th (Coronary Heart Disease), 14th (Congestive Heart Failure), and fourth (Stroke) in Schenectady using the quantitative methodology. Absolute measures such as CHD Hospitalization Rate, CHD Mortality Rate, CHF Hospitalization Rate, CHF Mortality Rate, Stroke Hospitalization Rate, and Stroke Mortality Rate are generally worse than the Capital Region and NYS excl. NYC. Trends show most measures improved. Disparities exist, and are similar to regional disparities. The Stockade Neighborhood has the highest rate of heart attack hospitalization and the highest rate of stroke hospitalization in the Capital Region.

Prevention Agenda Priority Area: Prevent Infectious/Communicable Diseases

Issue: HIV and STDs

Sexually Transmitted Disease is ranked 10th in Schenectady using the quantitative methodology. Absolute measures such as Gonorrhea and Chlamydia case rates are significantly worse than the Capital Region and NYS excl. NYC. Trends show that the Gonorrhea case rate more than doubled (128%) and the Chlamydia case rate increased by 25% over the past five years; NYS excl. NYC rates also increased, but not as much.

Issue: Lyme Disease

Lyme Disease is ranked fourth in Schenectady using the quantitative methodology, although the measures are limited and the absolute numbers are small. There were 115 cases in Schenectady

in 2017. The case rate fell below the NYS excl. NYC rate for 2017, 2014, and 2013; and above the comparison rate for 2016 and 2015.

Prevention Agenda Priority Area: Promote Healthy Women, Infants, and Children

Issue: Poor Birth Outcomes

Poor Birth Outcomes are ranked 11th in Schenectady using the quantitative methodology. Absolute measures are mixed; the Percent of Premature Births was lower (better) that the Capital Region or NYS excl. NYC, while the Percent of Low Birth Weight babies was higher (worse). Trends show the Percent of Premature Births improving since the prior CHNAs. Disparities exist, but are less than regional disparities. There were twelve infant deaths in 2017.

Issue: Prenatal Care

Prenatal Care is ranked 13th in Schenectady using the quantitative methodology. As with Poor Birth Outcomes, absolute measures are mixed: the Percent of Early Prenatal Care is similar to that of the Capital Region and NYS excl. NYC, Late or No Prenatal Care is worse, and Adequate Prenatal Care is better. The trend in Late or No Prenatal Care showed improvement until 2014, and then worsening thereafter. Disparities exist, but are less than regional disparities.

Prevention Agenda Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders

Issue: Mental Diseases and Suicide

Mental Disease and Suicide are ranked numbers one (Mental Health) and six (Suicide) in Schenectady using the quantitative methodology. More than 17,000 Schenectady residents report 14 or more Poor Mental Health Days in the last month. Absolute measures such as Percent of Adults with Poor Mental Health Days, Mental Disease and Disorder ED Visit Rate, and Suicide Mortality Rate are worse than, and some significantly worse than, Capital Region and NYS excl. NYC rates. Schenectady County's Mental Disease and Disorder ED Visit Rate is among the five worst in the entire State, while the Stockade Neighborhood is the worst in the Capital Region. Almost all trends – including Poor Mental Health Days, Mental Disease and Disorders ED Visit Rate, and Suicide Mortality Rate – are getting worse since the previous CHNA. Disparities exist, but are similar to or less than regional disparities. Suicide rates are highest in the Town of Rotterdam and the Rural West ZIP codes, along with the City's Hamilton Hill and Stockade Neighborhoods, an unusual example of a measure being worse in some suburban/rural neighborhoods than in most parts of the City of Schenectady.

Issue: Substance Use

Drug Use is ranked ninth in Schenectady using the quantitative methodology. There were 21 deaths resulting from drug use in 2017. Absolute Opioid Overdose measures of ED Visit Rate, Hospitalization Rate, and Mortality Rate are worse than the Capital Region and NYS excl. NYC rates, and fall into the third and fourth quartiles statewide. Trends show most measures significantly worsening since the prior CHNAs; a four-fold increase in ED Visit Rate and a five-fold

increase in Mortality Rate since 2012; starting in 2016 the Schenectady Opioid Mortality Rate has exceeded the NYS excl. NYC rate. Disparities exist, and are similar to regional disparities, with White Non-Hispanic rates the highest. Although the Hamilton Hill Neighborhood has the highest (worst) ED Visit Rate in the Capital Region, the Rural West ZIP code again appears among the top four.

Issue: Alcohol Use

Alcohol Use is ranked 12th in Schenectady using the quantitative methodology. Absolute measures are mixed; the Percent of Adults who Binge Drink is similar to the Capital Region and NYS excl. NYC, but is increasing; while Alcohol-related Motor Vehicle Injury and Mortality Rate is lower than the comparisons and has been constantly improving since 2009. The Stockade Neighborhood had the highest Cirrhosis Mortality Rate in the Capital Region, three times the countywide average.

c. Policy Environment

Schenectady County Public Health Services

The mission of Schenectady County Public Health Services (SCPHS) is to support, sustain, and improve the well-being of people in Schenectady County, New York.

Schenectady County Public Health Services (SCPHS) was officially organized as a full-service County-wide health department in January 1991. Until that time, there had been a Health Department in the City of Schenectady and part-time Health Officers in each of the five towns. The City department was incorporated into SCPHS and virtually the entire City staff joined the new organization and formed the core of a County-wide health department.

SCPHS is organized into four main service units: Prevention and Patient Services, Environmental Health, Children with Special Needs, and an Administrative Unit that provides overall administrative oversight and financial management.

As a full service public health department, SCPHS is engaged in a broad range of public health services and policy interventions. The Prevention and Patent Services unit provides maternal and child health services including the Women, Infants and Children (WIC) supplemental nutrition program. TB screenings are offered through the SCPHS clinic and services are provided at Ellis Family Health Center by SCPHS nurses. STD services are subcontracted to Hometown Health Center and completed in their clinic. Additionally, SCPHS operates a nationally credentialed Healthy Families America model program called Healthy Schenectady Families. The communicable disease team manages outbreaks as part of routine department activities. Also, a school based dental outreach program is subcontracted to the local FQHC and provides dental screening, cleaning, and sealant application.

The Children with Special Needs unit administers the Early Intervention program serving children ages 0 to 3, the pre-school education program that serves children ages 3 to 5, the Child Find Program, and the Children with Special Health Care Needs program. The Environmental Health Unit conducts multiple programs including regulatory activities related to restaurant inspections, lead safe housing, water

safety and sanitation, rabies, and indoor air quality. The Administrative Unit includes the Medical Examiner program for the county.

Ellis Medicine/Ellis Hospital

The mission of Ellis Medicine (the trade name for Ellis Hospital) is: "To meet the health *and wellness* needs of our community with excellence." (*Emphasis* added.) Prior to 2012, the Mission Statement had been: "To meet the healthcare needs of our community with excellence."

Ellis provides a full array of acute and long-term physical and mental health services to people throughout the region, participating fully in Medicare, Medicaid, commercial, and Exchange insurances and providing Financial Assistance for uninsured, low income individuals. Eligible Ellis locations have been designated as National Health Service Corps practice sites.

Ellis participates with other non-profit partners (including St. Peter's Health Partners, St. Mary's Healthcare Amsterdam, Hometown Health Center (FQHC), and Whitney M. Young Jr. Health Center (FQHC)) in the Innovative Health Alliance of New York State (IHANYS) a Medicare Shared Savings Program Accountable Care Organization (MSSP ACO) and the Alliance for Better Health (AFBH) a Medicaid Delivery System Reform Incentive Program Performing Provider System (DSRIP PPS).

Ellis is comprised of five health care campuses (Ellis Hospital (general hospital and 24/7 Emergency Department), Ellis McClellan Street Health Center (primary care and outpatient services), Ellis State Street Health Center (outpatient mental health), Bellevue Woman's Care Center (women's specialty care including maternity and Special Care Nursery), and Medical Center of Clifton Park (24/7 urgent care and outpatient services)); eight primary care practices (Schenectady (4, including pediatric), Glenville, Ballston Spa, Clifton Park, and Malta); an 82-bed skilled nursing facility; a dental practice including dental surgery; outpatient and inpatient mental health services for adults, children, and adolescents; two Residencies (Family Medicine and General Dental); the Belanger School of Nursing; and several specialized services including specialty practices and blood draw stations. Ellis is the sole corporate member of the Visiting Nurse Service of Northeastern New York (VNS NENY), a Certified Home Health Agency (CHHA) which provides acute and long-term in-home care.

Sunnyview Rehabilitation Hospital

The mission of Sunnyview Rehabilitation Hospital is "To improve the lives of persons with disabilities and the lives of their families."

Sunnyview provides physical medicine and rehabilitation services to individuals throughout the State and beyond, participating fully in in Medicare, Medicaid, commercial, and Exchange insurances. Sunnyview offers scholarships to offset the cost of its wellness programs.

Sunnyview is comprised of one main campus (inpatient and outpatient services) and three satellite outpatient therapy locations. Rehabilitation services are provided to all ages. Sunnyview has a wellness center which is open to the public and offers discounted memberships to those in need. Sunnyview also offers multiple community programs including adaptive sports clinics and support groups for persons with disabilities. Sunnyview is a member of St. Peter's Health Partners who provide a full continuum of care across multiple counties in upstate New York.

d. Other Unique Community Characteristics

A significant minority population in the City of Schenectady is comprised of Guyanese of West Indian descent. The result of secondary migration from New York City promoted by a previous Mayor along with primary migration from Guyana, the influx is credited with reversing years of population decline in the City. Schenectady County Public Health Services led multiple initiatives to identify and address health disparities relating to the West Indian population. Research conducted by physicians at Ellis Medicine revealed specific health issues regarding the West Indian population. In particular, the unexpected prevalence of diabetes among non-obese Guyanese males is the subject of journal articles (see for example: Hosler, Pratt, Sen, Buckenmeyer, Simao, Back, Savadatti, Kahn, Hunt, "High Prevalence of Diabetes Among Indo-Guyanese Adults, Schenectady, New York," Preventing Chronic Disease 2013; 10:120211) and helped lead to awarding of a federal Racial and Ethnic Approaches to Community Health (REACH) grant to SCPHS in 2010. The initial planning stage of the REACH grant funded an extensive community survey of diabetes prevalence, pilot training of a dozen indigenous diabetes health promoters, an elementary school diabetes prevention education program, and a diabetes health screening program for at-risk West Indian residents. The West Indian Diabetes Action Coalition utilized a MAPP process to develop a Community Action Plan (CAP). Unfortunately, shifting priorities at the Centers for Disease Control (CDC) ended funding for the project before its implementation phase. In 2014, SCPHS was awarded a "Partnerships to Improve Community Health" (PICH) grant, funded by the CDC. One of the goals of this grant was to increase screening rates for type-2 diabetes in the West Indian population that are seen at Ellis Family Health Center, an Ellis Medicine Primary Care site.

3. Summary of Existing Health Care Assets, Facilities, and Resources

Focus Area #1: Tobacco Prevention

- **Alliance for Better Health** DSRIP 4bi project is focused on tobacco use cessation. St. Peter's Health Partners Community Health Programs is the lead partner for this project.
- **American Cancer Society** Quitting resources.
- **American Lung Association** Issues reports and maintains websites on various tobacco control issues and resources.
- **Capital Care/Community Care** Providers treat tobacco use.
- **Capital District Tobacco Free Communities** Working in Albany, Rensselaer, and Schenectady Counties to eliminate exposure to second hand smoke, decrease social acceptability of tobacco use, promote cessation of tobacco use, and prevent initiation of tobacco use among youth and young adults.
- **CDPHP Health Plan** Provides insurance coverage for therapies to help people quit smoking
- **City Mission of Schenectady** Hosts a 12 month addiction freedom program (Bridges to Freedom). The Courage to Quit is a faith-based smoking cessation group that participants can join at any time. The program uses elements from The Butt Stops Here Program. The sessions are conducted by a mission staff member and include cessation materials; when available nicotine replacement therapy is provided.
- **Ellis Medicine** Tobacco Treatment – "The Butt Stops Here" The program fee is $45, Medicaid participants pay a $20 fee, and it is free for MVP members, CDPHP members, and Ellis Medicine employees. The program is six weeks and includes a workbook, relaxation CD, and two weeks of nicotine patches or gum.

- **Fidelis Care** Provides insurance coverage for therapies to help people quit smoking.
- **Five Corners Family Practice** E-referral to the NYS Smokers' Quitline, and the 5 A's in their EMR. Provide cessation services to their patients.
- **Hometown Health Centers** Developed a workflow for tobacco treatment.
- **LiveHelp Chat/Smoking** One-on-one online chat service staffed by real people, provided by the National Cancer Institute. Speak with a smoking cessation counselor for help with quitting smoking. Talk with an information specialist about cancer or clinical trials and hear recorded information about cancer.
- **MVP Healthcare** Provides insurance coverage for tobacco cessation medicine and products. Partners with Ellis Medicine to offer "The Butt Stops Here" smoking cessation class.
- **Mohawk Opportunities** St. Peter's Health Partners Community Health Programs has previously worked on tobacco initiatives with them.
- **New Choices Recovery Center** Tobacco cessation support group. Tobacco treatment workflow was created.
- **New York State Smokers' Quit Line** 1-866-697-8487 - Free and confidential service that provides effective stop smoking services to New Yorkers who want to stop smoking.
- **Schenectady County Municipal Housing Authority** Promotes smoke-free housing – effective July 2018, there is no smoking in any Schenectady Municipal Housing building.
- **Schenectady County Public Health Services** Healthy Neighborhoods Program provides home health and safety information to clients in their homes - tobacco cessation resources included.
- **St. Peter's Health Partners Community Health Programs** DSRIP 4bi and Health Systems for a tobacco free NY (funded by the NYS DOH Bureau of Tobacco Control), that partner with health sites, mental health sites, and community based organizations on systems level tobacco initiative changes such as implementing treatment policies. SPHP Community Health Programs also developed and coordinates The Butt Stops Here tobacco cessation support groups.
- **SUNY Schenectady County Community College** Tobacco free policy example for other institutions.
- **Union College "**Get Ready to Stop Smoking" Webinar, learn about the negative impact of smoking and why it's so hard to quit. Create an individualized quit plan. Complete a self-assessment tool to identify your personal smoking triggers, plan coping strategies and learn about tools and resources available to help you quit. Policy example for other institutions.

Focus Area #1: Specialized Electronic Nicotine Delivery System Resources Guide

- **Surgeon General** The Surgeon General's website on e-cigarette use among youth and young adults. There are resources on this website in English and Spanish for various audiences. http://bit.ly/31F6Dgo
- **The Community Guide** The Community Preventive Services Task Force recommends interventions that increase the unit price of tobacco products to reduce tobacco use. Increasing the price of tobacco products reduces the total amount of tobacco consumed; reduces the prevalence of tobacco use; increases the number of tobacco users who quit; reduces initiation of tobacco use among young people; and reduces tobacco-related morbidity and mortality. Interventions include public policies at the federal, state, or local level that increase the purchase price per unit of sale. The most common policy approach is legislation to increase the excise tax on tobacco products, though legislative actions and regulatory decisions may also be used to levy fees on tobacco products at the point of sale http://bit.ly/2IOch7k
- **"Scholastic" Infographic** of vaping trends http://bit.ly/2XbqpRb

- **"Children" Journal** "Following guideline recommendations to promote tobacco prevention in adolescent primary care, we developed a patient-facing clinical support tool. The electronic tool screens patients for use and susceptibility to conventional and alternative tobacco products, and promotes patient - provider communication. The purpose of this paper is to describe the iterative stakeholder engagement process used in the development of the tool." http://bit.ly/2MVwcGr
- **University of Vermont, Family Medicine Clerkship Student Projects** University of Vermont's College of Medicine student's completed clerkships pertaining to various topics of interest. These two links are of students who focus on small scale interventions at local schools to educate youth on e-cigarettes. http://bit.ly/2IoL77J http://bit.ly/2MWIT3R
- **Rescue Agency** "Jeff Jordan presents Rescue's tips for reaching teens at risk for vaping. While we've seen a huge decline in teen cigarette smoking over the past two decades, a dramatic rise in vaping is putting our progress at risk. The electronic nicotine device (ENDS) trend began with e-cigarettes and mods in 2014 and 2015, evolving into JUUL use in 2017 and 2018. While this is becoming a growing public health concern, little is known about the youth who are using JUUL, and whether or not they are the same as the teens who experimented with earlier e-cigarettes. This new video will help you understand which subgroups of teens are vaping as well as what is motivating their behavior. It will also compare the psychographics from teen vapers in 2015 to those in 2017 to understand whether they are part of the same trend, or the consequence of two different trends." https://www.youtube.com/watch?v=dTnkt9_NSlk&feature=youtu.be
- **Food and Drug Administration "The Real Cost" Campaign Resources** "FDA launched its first tobacco prevention campaign, "The Real Cost," in 2014 to educate at-risk teens on the harmful effects of cigarette smoking. In 2018, the campaign expanded to educate teens on the dangers of e-cigarette use and had previously expanded to educate rural boys on the harms of smokeless tobacco in 2016." https://therealcost.betobaccofree.hhs.gov/?g=t
- **Stanford Medicine e-cigarette toolkit** Free e-cigarette curriculum set up in module format to provide factual information. Covers the content of e-cigarettes, strategies used to make them appealing by manufacturers, deceptive marketing strategies and more. https://stan.md/2MQJdRJ
- **American Lung Association** Two-page document highlighting what schools should know about e-cigarettes and the issue at large. http://bit.ly/2XeyOmU
- **Grant County Health District (Washington State)** Two-page handout showing images of vaping devices and their cartridges to increase awareness that they are easy to conceal as flash drives or other items by students. English: http://bit.ly/2Fc8JKL Spanish: http://bit.ly/2Fgn8WB
- **"Smoking Evolved?" Perceptions and Use of JUUL Products Amongst College Students** Ty Meka writes about the surge of e-cigarette users in the US and the how the popularity of JUUL has risen. Meka conducted a survey on a college campus to determine student perceptions and usage of JUUL products. Meka concludes and suggests how perceptions of e-cigarettes, based on the survey's results, can be shifted through educational campaigns. https://www.semanticscholar.org/paper/%E2%80%9CSmoking-Evolved%E2%80%9D-Perceptions-and-Use-of-JUUL-Meka/60e1cb8103365fe63c426e15cc560a22ab0e0848

Focus Area #2: Mental and Substance Use Disorders Prevention

- **Alcoholics Anonymous** 24 Hour Line 518-463-0906. AA hotline offered by Schenectady National Alliance on Mental Illness. AA group listings.
- **The American Foundation for Suicide Prevention** Addresses the public health issue of suicide by educating about suicide and suicide prevention. Hosts a support group for suicide loss.

- **Associates in Mental Health and Neuropsychology** Offers individual, group, and family therapy. Neuropsychological assessments available for children, adolescents, and adults. Open by appointment only.
- **Bethesda House of Schenectady** Services include an adult clothing room (one visit per month), free laundry services, showers, housing assistance (help finding apartments, assistance with security deposit and eviction prevention), National Grid Assistance, nutrition education, HIV/AIDS testing, veterans' resource center, free community meals, food pantry, and support groups.
- **Boys & Girls Club of Schenectady** Partners with youth, parents, schools and other community stakeholders to implement at least one of three approaches: academic enrichment and school engagement; targeted dropout prevention; and intensive intervention and case management.
- **Campbell House** Offers multiple psychological services. Offers a Social Skills Group for autistic children on Wednesday ages 7-10 and Friday ages 5-6.
- **Capital Counseling** Covers a wide variety of counseling topics; accepts Medicaid/Medicare/Fidelis.
- **Catholic Charities Project Safe Point** Serving individuals from a Harm Reduction Perspective. Providing nonjudgmental person-centered care. Long standing community case management provider. Access to syringe exchange and rehabilitation readiness through Project Safe Point.
- **CDPHP Health Plan** Access and Triage: 24 hour telephonic behavioral health assessment, triage and referral services for CDPHP members. Services including inpatient mental health, inpatient detox and substance abuse rehab, ambulatory opioid detox, partial hospital and intensive outpatient, outpatient mental health and substance abuse. Effective 7/1/2016, administration of NYS Medicaid HARP services.
- **Center for Solutions** Provides mental health services to the community, including psychotherapy, medication evaluation/management, anger management counseling, mental health assessments, and substance abuse evaluations.
- **City Mission of Schenectady** "Bridges to Freedom" - one year discipleship and recovery program. Programs also exist for individuals attempting to reenter society after time in jail or prison.
- **Conifer Park Inpatient and Outpatient Services** In-patient and outpatient services for individuals seeking addiction recovery.
- **Drug and Abuse Hotline** 1-800-662-4357 - A free, confidential treatment referral and information service for individuals and families struggling with substance disorders.
- **Ellis Medicine** Emergency, inpatient, and psychiatric care. Crisis Information and Referral Hotline open 24/7. Inpatient Adult and Adolescent Mental Health facilities, outpatient Adult and Child/Adolescent (ages 4-18) Mental Health Services
- **Ellis Medicine Outpatient Mental Health - The Living Room – Crisis Diversion Services.** Offering Schenectady County residents, 18+, walk-in services, Monday-Friday, 12pm - 8pm, located within the Ellis State Street Health Center at 1023 State Street. A safe place for guests facing mental health crises to seek help as an alternative to the Emergency Department. It is staffed by a Licensed Clinical Social Worker, Care Manager and Peer Specialist.
- **Ellis Medicine Child and Adolescent Outpatient Treatment Services** A safe environment for children seeking mental health treatment.
- **Family and Child Service of Schenectady** Offers Medicaid service coordination, family/caregiver support services, family therapy, a yearlong employment program, the homemaker program (long term care assistance – house cleaning, medication management, etc.), and counseling services.
- **Fidelis Care** Offers the Children's Health and Behavioral Health Program for Medicaid Managed Care members under the age of 21. This enhanced Medicaid Managed Care benefit package offers a wide range of children and family treatment support services and children's home and community based services for qualifying members and their caregivers.

- **Four Winds Hospital Inpatient and Outpatient Mental Health** Inpatient and outpatient mental health treatment services for children, adolescents and adults.
- **Heroin Anonymous** 518-227-0294 - Call or text the number for crisis support with heroin. Support group for those struggling with heroin addiction and want to be sober.
- **Hometown Health Centers** A comprehensive Behavioral Health program, providing counseling, support services, substance abuse and HIV counseling to established patients. Our staff Psychiatrist and Licensed Social Worker (LMSW) offer behavioral health services to children (over the age of five) and adults.
- **HOPENY Alcoholism, Drug Abuse, and Gambling Hotline** Provides well trained professionals to talk to, crisis intervention and motivation, information, and referrals.
- **MVP Healthcare** Information for patients on behavioral health.
- **Narcotics Anonymous** 888-399-5519 - Call for support about Narcotics addiction.
- **National Suicide Prevention Lifeline** 800-273-8255
- **New Choices Recovery Center** Clinical and residential services available for adults struggling with addiction.
- **New York State Prevention of Heroin and Prescription Drug Abuse** 1-800-846-7369 - Call or text to get help with drug addiction including heroin and opioid help. Learn the prevention services, steps to get help, and support needed to get you or a loved one back on track.
- **Northeast Parent and Child Society** Behavioral Health Center is available to both adults and children for counseling services and medication management.
- **Northern Rivers Behavioral Health Services** A community-based system of social work and psychiatric services designed to support the diverse range of behavioral health needs for children, adults, and families while providing opportunities for awareness, growth, empowerment, and healing. Services include: behavioral health centers, mobile crisis and school-based behavioral health.
- **Peter Young Support Program** Provides case management, employment, housing, and substance abuse counseling to establish a “glide path to recovery.”
- **Planned Parenthood** Depression and Anxiety Screening; Referrals to therapy; Medication treatment for people 18 years and older. Community Education programs that include linkages between victimization and substance abuse. Crisis counseling for victims of sexual assault and intimate partner violence
- **Samaritan Counseling Center** Offers individual, couples, and family counseling.
- **“The Samaritans” Suicide Prevention Hotline** Suicide Prevention phone hours: Mon.-Fri. 9am-10pm, Sat. and Sun. 1pm-10pm.
- **Schenectady Community Action Program** Homelessness intervention by assisting individuals in finding permanent housing and preventing evictions. - Offers housing at the Sojourn House for women with children or who are pregnant. Participates in Rapid Rehousing program (involves case management and rent assistance). Also runs the Shelter Plus Care program for homeless individuals with a mental health diagnosis, HIV/AIDS, or a substance abuse issue (assists with housing). Offers clothing vouchers for the City Mission Clothing Room. Free income tax preparation available. Assists with many kinds of applications (SNAP, HEAP, etc.)
- **Schenectady County Office of Community Service** Offers a comprehensive array of services across the disability groups of mental health, substance abuse and mental retardation/developmental disabilities for the citizens of Schenectady County. The office operates the County’s adult and children’s SPOA (Single Point of Access) and AOT (Assisted Outpatient Treatment) programs and contracts out direct service provision to a network of provider agencies.

- **Schenectady County ARC** Offers Article 28 Clinic and an Article 16 clinical services, day services, employment services, and residential services for individuals with an intellectual or developmental disability.
- **Schenectady Mental Health Associates** Offers individual, couples, marital, and family counseling. Accepts most insurance.
- **Schenectady County Public Health Services** Maternal and child health services, a prevention program for lead poisoning, and programs for children with special needs. Healthy Schenectady Families is a home-visiting education program about parenting for pregnant or newly parenting individuals (must be a Schenectady resident; no income eligibility requirements).
- **Schenectady County Public Library System** Provides free access to books, DVD's, and periodicals on a wide variety of health related topics. There are nine locations in the county, which have access to a database. The database provides health related information and assistance to patrons who are trying to look up health information, or looking for connections to community based organizations.
- **Sexual Assault and Victim Advocacy Service Hotline of Planned Parenthood** 24 hour hotline for crisis counseling and advocacy. Whether it happened 10 minutes ago or 10 years ago, the hotline is there for support.
- **Soldier On** Provides veterans who are homeless with emergency and transitional housing, case management, medical and mental health services, substance abuse treatment, and peer support.
- **St. Peter's Health Partners Addiction Recovery Center** Recovery outpatient clinic, psychosocial assessment, psychiatric evaluations and medication monitoring, individual, group and couple's counseling.
- **Sunnyview Rehabilitation Hospital** 115 -bed rehabilitation hospital specializing in acute rehabilitation serving patients from across the Northeast and beyond. Comprehensive inpatient and outpatient physical therapy and rehabilitation programs, including services for people recovering from strokes and traumatic brain injuries.
- **Union Counseling Behavioral Health Center** Outpatient mental health agency providing a wide range of services.

D. Actions Taken to Address Significant Health Needs Identified in 2013 and 2016 (With Selected Impact Metrics)

Schenectady's 2013 Community Health Needs Assessment identified fifteen health needs. The 2016 CHNA focused more specifically on two health needs: 1) Chronic Disease (Obesity and Diabetes) and 2) Mental Health (Suicide and Mental/Emotional/Behavioral (MEB) Infrastructure). The 2016 CHNA, however, continued to identify all fifteen (later consolidated to fourteen through combination of the interconnected Obesity/Diabetes and Food Insecurity topics) health needs from 2013 as remaining in need of attention.

During 2013 through 2018 Ellis Hospital, Sunnyview Rehabilitation Hospital, Schenectady County Public Health Services, and their community partners took actions to address such needs, commensurate with the priority of each need and the availability of resources. Actions included the following:

- Chronic Disease – Obesity and Diabetes:
  - Ellis embarked on a two-pronged approach to issues of diabetes and obesity: 1) specific diabetes education programs were developed and delivered in the community and 2) weight loss and physical exercise programs were implemented for varying target groups.

- Ellis and partners piloted the "Learn to Live Well" diabetes program for parishioners and community members at the Zion Lutheran Church; the four-session curriculum included a presentation by Ellis certified diabetes educators.
- Ellis staff met with representatives from the City Mission and the local Hindu Temple to explore diabetes programming through their organizations.
- In 2014, Schenectady County Public Health Services received a "Partnerships to Improve Community Health" (PICH) grant which supported increased screening for diabetes in high risk populations. Ellis was a subcontractor under the grant.
- The PICH grant also supported training of Ellis Diabetes Care staff as Lifestyle Coaches for the National Diabetes Prevention Program (DPP), which is offered at Ellis Medicine locations starting in October 2016. In late 2018, the Ellis DDP program received recognition from the Centers for Disease Control (CDC).
- An embedded Diabetes Care Manager was placed at Ellis Family Health Center as part of the PICH grant to work on policies and systems related to diabetes management in a primary care setting, including referrals to the Diabetes Self-Management Education program.
- With assistance from Ellis Medicine IT staff, a registry of patients with diabetes was developed for Ellis Family Health Center to facilitate improved care.
- Ellis staff and local college students met with neighborhood associations to conduct a community asset mapping; this inventory is to be used to assess the viability of a city-wide physical activity program.
- Ellis held a physical activity Field Day for local youth in partnership with Union College.
- Ellis engaged its own employees in competitive walking events and other weight-loss activity; participation counts toward reductions in health insurance premiums.
- The Healthy Food Access Workgroup, renamed the Diabetes/Obesity workgroup, met three times during 2017. Average attendance for the meetings was 13 people. This group's main focus during the year was to steer the food access focused work of the "Partnerships to Improve Community Health" (PICH) grant which had been awarded to Schenectady County Public Health Services. This group worked with six food pantries in Schenectady County to increase the availability of healthy options distributed to clients. This includes increasing options for fruits and vegetables as well as whole grains and low-fat dairy. Implementation efforts at food pantries include "policy, systems and environmental" (PSE) improvements. Examples of these PSE strategies include signage to promote the food groups with a nutrition message, moving items on shelves to highlight fruits and vegetables at eye level, and improving the displays for fresh produce to make the food pantries look more like a market. Recipes and cooking demonstrations were also done at food pantries to increase the likelihood of clients choosing the healthier options. Each pantry that is engaged in this work in Schenectady County is doing a different combination of interventions to increase the availability of healthy options because each pantry uses a slightly different model to deliver foods to clients. Some pantries are a choice model, where clients get to choose all the foods they take with them while some provide pre-packed food boxes and some are a mix of both models. The different pantry models lend themselves to different interventions working better than others. The Diabetes/Obesity

Impact Metrics

Schenectady's obesity rates for adults, students, and children are worse than the NYS excl. NYC rates.

Adult rates improved by 12% since the 2016 CHNA, but student rates stayed the same and child rates got worse.

workgroup assisted pantries in deciding what interventions would work best for their model. Given the completion of the grant period, and the ability of member organizations to pursue evidence-based food policies, the Workgroup discontinued meeting after 2017.

- During 2018, six food pantries continued to sustain policy, systems and environmental changes to offer healthier food options to food pantry clients. These interventions include signage to indicate healthy options with a nutrition message, moving healthy items to eye level on shelving, and improving displays of fresh produce to make them look more appealing. Recipes and food demonstrations are also done at food pantries increasing the likelihood of clients choosing healthier options they may not be as familiar with. Each pantry that is engaged in this work in Schenectady County continues to have a different combination of interventions to increase the availability of healthy options because each pantry uses a slightly different model to deliver foods to clients. In 2018, new work began with four (three overlapping with previous work) food pantries in Schenectady County to offer chronic disease-specific food packages. Food packages for diabetes and hypertension are given out to clients indicating they have someone in their family with either condition or someone at risk for the conditions. The food packages include healthier options to assist in the management or prevention of diabetes and hypertension through nutrition. Examples of foods in the diabetes/hypertension packages include whole wheat pasta, brown rice, no sugar added canned fruit and no salt added canned vegetables. Information about the conditions and management of them is also included in the food packages. Clients can get the food packages each time they come to the food pantry by indicating their interest in the program when asked. In addition the food, a Registered Dietician from Cornell Cooperative Extension, Schenectady County provided technical assistance to the food pantries to modify the food packages and provides nutrition education at each of the food pantries one time a month. Individuals who are experiencing food insecurity are being identified through this work by screening individuals at community based organizations and health insurers and referring them to food pantries that are offering healthy options and chronic disease specific food packages if they have that need.

Impact Metrics

Schenectady's rate of short-term diabetes complications is worse than NYS excl. NYC, but improved by 45.9% since the 2016 CHNA.

The rates of diabetes mortality and of diabetes hospitalization are also worse that NYS excl. NYC, and both got worse since the 2016 CHNA.

- In October 2016, Ellis Diabetes Care started the first Diabetes Prevention Program (DPP) in the community in a number of years. The DPP is a lifestyle change program to prevent diabetes. It runs 16 consecutive weeks and then monthly maintenance sessions for the remainder of a year. In 2018, there were 2 classes started. The first class started in April 2018 and had an average attendance of 14 participants; this group was in the maintenance phase at the end of the year. A second class started in September 2018 and has an average attendance of 12 participants. As of December 31, 2018, this class is in the initial 16 weeks, meeting once a week. In July 2018, Schenectady's DPP was granted preliminary recognition from the CDC and continued to submit data every six months to the CDC in order to reach full recognition, which was granted at the end of 2018. CDC-recognized programs are able to apply for reimbursement through Medicare. Ellis Medicine will pursue Medicare reimbursement for DPP services once a sufficient volume of Medicare-covered participants is achieved.

- In addition to the DPP, Ellis Diabetes Care also offers Diabetes Self-Management Education (DSME) programs for individuals already diagnosed with diabetes. They receive referrals from Ellis practices but also community based organizations and other medical providers in the community. One of our goals is increase referrals to DSME and increase the number of individuals who follow through on their referral and attend at least one session of DSME. From January 2018 - December 12, 2018, DSME received 641 referrals from all sources. During that same time period, 372 initial DSME sessions were attended. Compared to 2016-2017 data, raw referral numbers stayed very similar, 647 in 2016-2017 and 641 in 2018; however conversion into first visits increased substantially. In 2016-2017, referral to initial visit conversion rate was 26%. In 2018, referral to initial visit conversion rate jumped to 58%. This could be due to a number of factors including providers explaining the program better to their patients at the time of referral and referrals getting scheduled faster. The increased conversion rate means that more patients are getting the benefit of learning management skills for their diabetes.
- SCPHS provided funding through the PICH grant to train Ellis Medicine staff as “lifestyle coaches” to deliver the DPP. SCPHS also supported the promotion of the classes through advertisements in the local newspaper and sharing flyers with local partners. The PICH grant was able to purchase incentives for the program to help people to continue coming to the program.
- Ellis Medicine provides staff for running both the DPP and DSME programs, both of which are housed in Ellis Diabetes Care. They also provide resources to promote these programs in the community and to their employees. Ellis Diabetes Care collects all the data that is needed for these programs and monitors progress with referrals. Sunnyview Hospital also provides referrals to the DPP and DSME programs.
- Funding from the Community Foundation for the Greater Capital Region to support the continued work with food pantries is helpful in keeping momentum for these activities moving forward. The funding supports education for food pantry clients, the purchase of healthier food options, and support from Cornell Cooperative Extension, Schenectady County. Ellis Medicine's multiple primary care offices and outpatient education services provide direct interface with community members who are food insecure and could benefit from accessing healthy foods at the local food pantries. Ellis Care Managers also have these interactions with their patients and provide these referrals to community based organizations including food pantries. CDPHP recently started utilizing their Care Managers to screen for food insecurity and make appropriate referrals based on the outcome. Utilizing the medical community as a point of entry for access to community members who can benefit from various community programs has been a helpful partnership to have. City Mission's Empower Health program has also been instrumental in screening for food insecurity in the community and providing referrals to food pantries as needed. The food pantries are very interested in this work and see the importance of offering healthy options for their clients. Pantries understand that many of their clients are utilizing the pantries on a monthly basis as a part of their food budgeting and thus the food that they receive is a big part of their diets every month. The nutrition expertise that Cornell Cooperative Extension (Schenectady County) brings was very important in moving the work with the food pantries forward.

- Mental Health and Substance Abuse - Suicide and Mental/Emotional/Behavioral Infrastructure:
  - The Schenectady County Office of Community Services (the local government's mental health and substance use disorders unit) and Ellis undertook a collaboration to form work groups evaluating mental health needs.
  - In collaboration with researchers from the Schenectady County Public Health Services and students at Union College, a project to focus on the CHNA-identified excess number of drug-addicted newborns in Schenectady received Ellis Institutional Review Board (IRB) approval to conduct chart reviews of newborns with a positive drug screen.
  - The study evaluated the most commonly abused drugs and demographics of the newborns' mothers. Because of the small sample size, no final conclusions were reached.
  - In 2015, Ellis and SCPHS worked with HCDI which is compiling mental health and substance use data from such standardized survey tools as BRFSS and School Climate Survey to analyze among the Capital Region counties. The survey information continues to flag the newborn drug-related diagnosis rate in Schenectady County as a critical issue compared with the region, although the single year rate did dip slightly (6.3%) between 2012 and 2013. Other indicators for which Schenectady County exceeds the regional rate are Post Traumatic Stress Disorder (3.8% vs. 3.1%) and Substance Abuse-other (9.3% vs. 7.7%). Specific Schenectady neighborhoods, however, greatly exceed regional rates on multiple indicators; for example the Schenectady Stockade rates exceed regional rates on 14 of 18 indicators, while the dementia rate in Scotia/Glenville is 83% above the regional rate.
  - During 2016, the Ellis Outpatient Mental Health Clinic applied for and received designation as a National Health Service Corps (NHSC) practice site.
  - The Schenectady Coalition for a Healthy Community (SCHC) initiated a Mental/ Emotional/Behavioral (MEB) Workgroup in the fall of 2016 to discuss suicide prevention efforts in the community. This group met twice during late 2016 and early 2017. In March 2017, SCHC and Schenectady County Office of Community Services held a Suicide Prevention Day of Dialogue that brought together coalition partners, State leaders, community based organizations, members of the community to discuss the issue of suicide in the community and what can be done to prevent it. About 30 individuals attended the forum. The second half of the day was spent on training the group in the evidence-based suicide prevention training call "Question, Persuade, Refer." It was important to give participants practical skills to take back to use in their organizations or lives as well as start the broader conversation about suicide prevention in the community. From this Day of Dialogue, Schenectady County Office of Community Services has decided to re-engage a previously formed Suicide Prevention Coalition. This group will look at county level data and develop strategies to improve suicide prevention efforts including training in the community. This group met for the first time during January 2018. The coalition is still interested in offering Mental Health First Aid trainings in the community as an additional evidence-based intervention; however the cost of doing so has become a barrier.
  - Ellis Medicine has assisted in planning workgroup meetings as well as providing input during these groups. Their access to primary care doctors as well as mental health professionals

Impact Metrics

Schenectady's mental disease and disorders hospitalization rate is worse than NYS excl. NYC, but improved 7.4% since the 2016 CHNA.

Schenectady's suicide mortality rate is worse than NYS excl. NYC, and got 6.4% worse since the 2016 CHNA.

remains of key importance in moving this work forward. Sunnyview Hospital and St. Peters Health Partners also participate in the workgroups of the coalition and support trainings by sending staff when relevant.

- The Schenectady community recognizes suicide prevention as an important topic to investigate. A specific strength we have in this area is topic expertise. We have a coalition member who retired from the New York State Suicide Prevention Center and thus has vast knowledge in this topic they are able to share. This person is also certified to teach in a number of suicide prevention trainings including: ASIST (Applied Suicide Intervention Skills Training), Safe TALK (Suicide Awareness For Everyone Tell Ask Listen Keep Safe), and QPR (Question, Persuade, Refer).
- A challenge we faced in 2018 was getting momentum going for the topic of suicide prevention and prevention of MEB disease. The community understands the magnitude of the issue but doesn't feel confident in the prevention efforts. This was addressed by introducing the topic of Adverse Childhood Experiences (ACEs) and trauma prevention to the coalition. These topics impact the development of MEB diseases and suicide rates but have root causes that are broader than just suicide. The goal of presenting higher upstream causes was to have coalition members identify the topics they can work on that will ultimately affect suicide rates. This will be further explored in 2019 as well as additional suicide prevention specific trainings.
- The Ellis Pediatric Health Center received a three-year (extended to four years) $354,500 grant from the New York State Office of Mental Health to implement the Healthy Steps Program supporting at-risk families with children from birth to three years old. The grant enabled hiring a Healthy Steps Specialist who is engaged in expanding awareness of the Adverse Childhood Experiences (ACEs) concept throughout the community. During 2018, Ellis began to explore potential opportunities to sustain the program after the grant terminates in 2020.
- The Office of Community Services provided Trauma-Informed Care training two times for Schenectady County Foster parents, one on March 26, 2018 (15 participants) and one on October 30, 2018 (also 15 participants). Additionally, OCS trained Ellis Medicine's Outpatient Adult Mental Health Clinic staff on Trauma-Informed Care and Suicide Prevention on August 8, 2018; 45 participants attended that training. A Trauma-Informed Care training class was hosted by the University at Albany School of Social Welfare on March 12, 2018; 10 people from Schenectady County attended. The title was "Trauma Past Trauma Present: Understanding and Applying Important Skills in Trauma Informed Phase Oriented Treatment." The trainer was Dr. Allison Jackson.
- Schenectady City School District is also engaged in work around trauma, creating trauma-sensitive schools. In May 2018, Schenectady High School held a Mental Health Fair in the evening for both students and parents. Numerous community resources were shared and then a screening of the film "Resilience" was held with a discussion panel after. Over 100 people attended the event.
- The Dual Recovery Task Force, led by the Office of Community Services, met a total of nine times during 2018 with an average attendance of 16 individuals. The Dual Recovery Task Force includes providers from both Mental Health and Substance Abuse, making an important connection for treating those with dual diagnoses. The group had 13 different presentations at their meetings about community resources for those with a dual diagnosis. Programs that presented ranged from outpatient mental health clinics, to harm reduction services and housing. These presentations by community providers are an important step in

promoting their programs and making sure the community is aware of all available resources.

- In 2018, the trauma informed care workgroups that were established in 2017 merged into one group under the new title of "Trauma-Informed Community Workgroup." This group met a total of eight times: February 21 (14 attendees), February 27 (7 attendees), June 22 (5 attendees), June 26 (14 attendees), July 31 (10 attendees), August 28 (15 attendees), October 30 (18 attendees) and November 26 (12 attendees). This group held a brainstorming session in June 2018 to determine a mission, vision, goals and common definitions of trauma language (trauma-informed care, ACEs, toxic stress, and resilience). One of the goals of the group was to determine a baseline of trauma-informed practices each participating organization is using. This baseline would help determine next steps for training needs of Community Based Organizations. The group decided to utilize Coordinated Care Services, Inc.'s tool called the "Trauma-Informed Care Organizational Self-Assessment Tool" (TIC OSAT) for each organization. During the fall of 2018, 11 organizations represented on the workgroup completed surveys using the TIC OSAT. The survey divides results into staff and leadership. Leadership at the 11 organizations completed 36 surveys and staff completed 175. The TIC OSAT software generates reports for each organization and an overall report combining all organizations. The workgroup analyzed the results at a meeting in November 2018 and determined that workforce development around trauma-informed care was where the work of the group should start. This will be further explored in 2019. One exciting resource that the group will use, and some have used already, is an online learning program called "Introduction to Adverse Childhood Experiences for Healthcare Professionals." It was developed by the Alliance for Better Health's (the local DSRIP PPS) MEB workgroup and is broken down into three modules that can be taken all together or at different times. The course provides a pre- and post-test to assess knowledge. The Office of Community Services will also be utilized in 2019 for their expertise and ability to provide additional training on trauma topics workforce development.
- A "Safe TALK" training class was held on August 27, 2018 at the main branch of the Schenectady County Library where 30 people were trained. This training was hosted by Northern Rivers and the Schenectady County Office of Community Services.
- Schenectady County Office of Community Services leads the Schenectady County Suicide Prevention Coalition which was reestablished in 2017 following a period without meeting. The group has representation from the Schenectady Coalition for a Healthy Community, as well as others who are not represented in the larger coalition, for a total listserv mailing list of 50 individuals. During 2018, there were four meetings of the Suicide Prevention Coalition. The dates and attendance are as follows: June 5 (40 attendees), August 20 (25 attendees), October 15 (15 attendees), and November 13, (15 attendees). The Suicide Prevention Coalition established four priority areas to work on as a group. These include: 1) change and eliminate stigma, 2) increase community involvement, 3) encourage networking between providers of service and the community, and 4) increase peer services. The coalition established workgroups around these topics areas and is working to determine next steps for the workgroups. The coalition has struggled to maintain involvement over time, and brainstorming about how to address this issue has occurred during meetings of the group. At the next meeting in 2019, a mission statement and goals will be developed by the group to better be able to market the coalition to partners. The Substance Use Disorder Prevention Coalition is another group working on MEB and substance use prevention in the community. The coalition is co-led by the Schenectady County Office of Community Services and New Choices Recovery Center. The group met four times in 2018: January 5 (25

attendees), April 6 (24 attendees), August 1 (35 attendees), and October 29 (18 attendees). The group developed and distributed a resource list for partners to promote the existing mental health and substance use disorder resources in the community. Additional activities include promoting community events, such as recovery networks, and drug take back days, and reviewing data to set priorities for 2019.
  - On July 25, 2018, a Mental Health First Aid Training was held in Schenectady with 32 participants. This training was offered for free through Mental Health Association in New York State (MHANYS). Cost of these trainings is a barrier to offering them more often; however when they are available for low or no cost, the Schenectady Coalition for a Healthy Community promotes them to the group. They are also promoted through the Suicide Prevention Coalition and its workgroups.

- Asthma and Smoking:
  - Schenectady County Public Health Services, Ellis, and other community organizations applied for and received a grant from New York State Health Foundation to support a "Schenectady Asthma Support Collaborative" (SASC). A required local cash match was provided by The Schenectady Foundation, the GE Foundation, and MVP Healthcare. Services of a collaborative model combining care management, patient education, and in-home nursing services began in late 2014, with the grant period ending in December 2015.
  - SASC created a seamless three-tiered care model (centralized care coordination, home visits/assessments, and asthma education). Over the course of the project, 68 patients consented to participate in care coordination. While 57 (84%) of these remained engaged after two months, only 13 (19%) completed both the home visits and asthma education components. The project's final report concluded that cultural dynamics ("fatalism") and structural barriers (issues of trust) may have prevented individuals from accessing optimal care.
  - Although the project clearly demonstrated the challenges of engaging patients, the clinical aspects of the three-tiered model remain valid. The design of the Schenectady model was used to inform development of asthma projects across the six-county service area of the regional DSRIP partnership, the Alliance for Better Health.
  - Ellis, the Schenectady City School District (SCSD), and Price Chopper Pharmacy participated in the "School-based Asthma Management Program," which enrolls a small but increasing number of the 1,150 diagnosed asthmatic students in SCSD. The program administers albuterol treatments, enabling students to return to class 98.7% of the time. In addition to the in-school component, nearly a third of the students and their parents completed outpatient Asthma Self-Management Training sessions through Ellis Asthma Care.
  - The Ellis Asthma Education program found that "graduates" achieve a 60-70% reduction in Emergency Department visits over 12 months post-discharge.
  - A Care Manager from the Ellis-sponsored Health Home completed a two-day asthma training course.

Impact Metrics

Schenectady's asthma ED visit rate is worse than NYS excl. NYC but improved by 24% since the 2016 CHNA.

Schenectady County's asthma hospitalization rate is better than NYS excl. NYC but got 52.2% worse since the 2016 CHNA.

- Ellis continued its strong asthma education program, and continued to collaborate with the Capital District Tobacco Free Communities. Informal "suasion" within the community encouraged various smoke-free initiatives; a newly-constructed affordable housing project on Albany Street in Schenectady is smoke-free from the start, and the entire Union College campus was smoke-free as of January 1, 2017. Since August 2016, the legal age for the sale of tobacco products in Schenectady County is set by local law at 21.

- Inappropriate Emergency Department Utilization:
  - Ellis led creation of two region-wide health innovations collaborations – a Medicare MSSP ACO ("Innovative Health Alliance of New York" (IHANY)) and a Medicaid DSRIP PPS ("Alliance for Better Health" (AFBH)) – both with goals of reducing inappropriate hospital utilization.
  - Both collaborations were approved for inauguration in 2015 – the ACO on January 1 and the PPS on April 1.
  - IHANY adopted the goal of reducing inappropriate hospital Emergency Department utilization as part of a comprehensive program intending to reduce costs and produce shared savings. AFBHC is required by the State to reduce inappropriate hospital utilization (both Emergency Department and inpatient) by 25% over a five year period. IHANY was successful in reducing Emergency Department use by its attributed patients during its first year of operations.

- Adolescent (Teen) Pregnancy:
  - Ellis, the Schenectady City School District, Planned Parenthood Mohawk Hudson, the Alliance for Positive Health (formerly the AIDS Council), and the Schenectady Teen and Adult Coalition (STAC) worked to consider causes and solutions to the consistently high rates of adolescent pregnancy in certain neighborhoods.
  - The project engaged adolescents/teenagers in focus group and multiple meetings. A gap in health education at local schools was identified. After most health education teachers had been laid off due to budget cuts, students are receiving no health education classes between 6th grade and 10th grade. Planned Parenthood arranged student health education assemblies in 2016 and 2018, and is seeking to reintroduce middle school health classes.
  - The Schenectady Foundation's "Call to Action for Schenectady's Youth" grant program is providing funding for the "Cradle Project," a multimedia project that is focusing a lens on Schenectady's high rate of teenage pregnancy – the highest in the Capital Region – and its toll on the community. Dozens of local youth are involved in writing original music and dialog, performing and producing "Cradle," a documentary film about teen pregnancy. The film debuted on Saturday, July 13, 2019, at Proctors Theatre in Schenectady. The Cradle Project will also include music videos and forums about sexual health and professional development.

Impact Metrics

Schenectady's teen (15-17) pregnancy rate is much worse than NYS excl. NYC (21.5 vs. 9.9) but improved by 27.9% since the 2016 CHNA.

- Arthritis and Disability:
  - As this need was not categorized among the top priorities in the development of the CHNA, resources were devoted to other higher priority projects.

- Dental Health:
  - In 2015, Ellis received the final payment of a $250,000 "Member Item" grant from then-State Senator Hugh T. Farley which was used to acquire equipment for the pediatric dental program. Ellis Dental Care now provides expanded services to low-income patients; including the new facilities for pediatric dental surgery and a program for parents and families of pediatric dental patients.
  - During 2016, the Ellis Dental Health Center applied for and received designation as a National Health Service Corps (NHSC) practice site.

- Falls:
  - The 2013 CHNA identified particularly high falls mortality in the community, and a high number of falls in one neighborhood. Data analysis and "drilling down" identified a large senior housing facility in this neighborhood as the falls "hot spot."
  - Ellis staff met with administrators at the facility on several occasions. Union College students were engaged to assist the facility staff to track indicators and trends.
  - Having identified the issue at one senior housing facility, ambulance call data were obtained from the local ambulance company in an effort to analyze the prevalence of falls at other senior facilities.
  - Schenectady County Public Health Services and Schenectady County Senior and Long Term Care Services partnered to offer Tai Chi for arthritis classes in the community to help prevent falls in older adults.
  - As part of the work of the Schenectady Coalition for a Healthy Community, the Schenectady County League of Women Voters (LWV) undertook lead activities for a "Falls Prevention Work Group." The Work Group met regularly and engaged experts from the State Department of Health, senior citizen organizations, rehabilitation facilities, and local government agencies. The LWV became unable to lead the group as of early 2017, and the group ceased to meet.

Impact Metrics

Schenectady County's rate of hospitalizations due to falls for people 65 and older is now well below NYS excl. NYC (88.7 vs. 189.9) and has substantially improved (by 49.3%) since the 2016 CHNA.

- Food Insecurity:
  - The focus on Food Insecurity came from a 2013 UMatter Schenectady survey finding that the majority of residents in three Schenectady neighborhoods (Hamilton Hill, Eastern Avenue, and Central State) had run out of food at least once in the past year. Interestingly, this finding correlated with the prevalence of severe obesity (BMI >35) which is more than double for people who run out of food every month or nearly every month than for those who never run out of food.
  - A partnership including Schenectady Community Action Program, City Mission of Schenectady, Ellis Hospital, and The Schenectady Foundation obtained a grant from the Robert Wood Johnson Foundation to support a "Community Coach" from the University of Wisconsin Population Health Institute. The "Coach" convened a series of telephone conferences and an on-site visit to help focus community resources and thinking.

Impact Metrics

Schenectady's percentage of low-income population with low food access is worse than NYS excl. NYC, but has improved by 40.6% since the 2016 CHNA.

  - As a result of the coaching, the partnership developed a community plan including asset mapping and a root cause analysis, and developed collaboration with the Schenectady County Food Providers Group. No clear, single, cause was found, although there was some evidence that some service gaps (e.g., few food pantries are open on weekends) and inefficiencies in the distribution system may be contributors.
  - During 2015, Ellis, SCPHS, and their partners worked with two grants (a Robert Wood Johnson Foundation Roadmaps to Health Action Award and Partnerships to Improve Community Health) to improve access to healthy foods. These efforts resulted in development of a Schenectady Food Resource map (http://sicmfood.com/), an online tool accessible from portable devices such as smartphones, which shows the locations of such resources as soup kitchens, food pantries, and stores which accept electronic benefit cards. The resource map has also been developed into a mobile phone application, called "Food 4 Schdy." The app allows users to view the resource map using their smartphone's location and get directions to the resources.
  - The PICH grant also supports policy, systems, and environmental improvements at food pantries within the county to increase access to healthy foods. This grant supported the opening of a new food pantry in the 12308 ZIP code (Northside neighborhood), which is an underserved area of the county.
  - As part of the PICH grant, a community wide food plan was developed with goals, strategies and evidence based activities to address food insecurity in the community.
  - Physicians at the Ellis Family Health Center continue to promote fresh fruit and vegetable consumption among patients.

- Neighborhood Safety:
  - Ellis and the City of Schenectady participated on several initiatives to stabilize the Northside/Goose Hill neighborhood where the Nott Street campus is located. These include a "Walk to Work" initiative and a program to promote home ownership ("Home Ownership Made Easy" (HOME)). In addition, construction at the Nott Street campus included new sidewalks and improved street lighting, both issues of neighborhood safety which had been identified in the CHNA.
  - Ellis was invited by the New York State Health Foundation to apply for a community-wide "Healthy Neighborhoods Fund" grant. The application was submitted but not funded.

- Programs for Youth and Adolescents:
  - In December 2014, The Schenectady Foundation hosted a conference entitled "Bridges to Youths" to better understand the needs of Schenectady's youth.
  - The conference led to the "Call to Action for Schenectady's Youth." Since its launch, The Schenectady Foundation has so far invested $770,000 in eight programs with the potential to bring powerful and positive change to Schenectady's youth. Call to Action for Youth is a three-year, $2 million community-wide effort to empower children and teens that face significant barriers to success. Grants include support of scholarships, job training, and sports programs for youth.

- Community and Coalition Building:
  - Ellis and SCPHS continue to lead and participate in numerous community coalitions. These include the Schenectady Coalition for a Healthy Community, the Schenectady Strategic Alliance for Health, and the Healthy Capital District Initiative.

  - In addition, during 2014 Ellis undertook two major business initiatives promoting broad coalitions of healthcare providers. A Medicare Shared Savings Program Accountable Care Organization (MSSP ACO) partnered three hospital systems, an FQHC, and several community medical practices. A New York State Medicaid Delivery System Reform Incentive Payment program Performing Provider System (DSRIP PPS) partnered the same three hospital systems, two FQHCs, and two large community medical practices, along with more than 50 community agencies. Both were approved by their respective regulators to start operations in 2015.
  - The MSSP ACO (Innovative Health Alliance of New York, or IHANY) was approved to start operations on January 1, 2015, and the DSRIP PPS (Alliance for Better Health, or AFBH) to begin on April 1, 2015. Each was established as a separate limited liability company (LLC) and each undertook to adopt an Operating Agreement and seat a Board of Directors. The DSRIP PPS received scheduled funding from the New York State Department of Health under a five-year agreement. The MSSP ACO was funded by capital contributions from the two Members of the LLC (Ellis Hospital and St. Peter's Health Partners), and has not achieved "shared savings." In 2017, Ellis withdrew as an equity partner of the MSSP ACO, but remains a clinical partner. In fall 2017, the federal Centers for Medicare and Medicaid Services (CMS) approved renewal of IHANY's MSSP ACO agreement for another three years.

- Community Health Improvement:
  - Ellis continued programs of community and patient education and support.

- Health Professions Education:
  - Ellis, the only hospital in the region to sponsor both physician education and nursing education, continued to provide a broad variety of health professions education programs including the Belanger School of Nursing, the Family Medicine Residency, the General Dental Residency, Grand Rounds and other continuing professional education programs. Ellis also serves as a training and preceptorship site for numerous community-based health professions education programs. Unreimbursed costs of health professions education are reported on IRS form 990, Schedule H.

- Subsidized and Free Health Services:
  - Ellis continued to participate in government insurance programs including Medicare and Medicaid, while providing reduced rates and charity care for self-pay patients, as detailed in IRS form 990, Schedule H. Medicare, Medicaid, and Financial Assistance (Charity Care) covered about two-thirds of inpatient discharges during 2019.

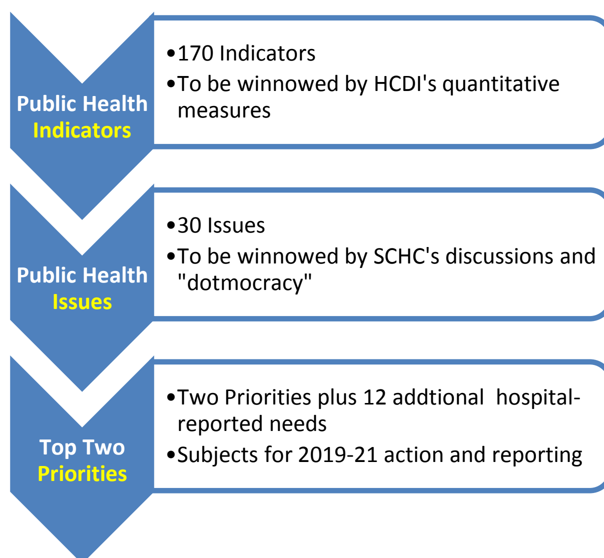
E. Community Health Improvement Plan / Community Service Plan / Implementation Strategy

1. Identification of Top Two Priorities – Process, Criteria, and Community Engagement

Summary of Prioritization Process

Prioritization of the identified community health needs – including selection of the top two Prevention Agenda priorities – was a five-part process engaging multiple participants, numerous data sources, and both sequential and concurrent methodologies.

The intent of the process was to comply with all applicable State and federal requirements governing the Community Health Improvement Plan (CHIP) of Schenectady County Public Health Services (SCPHS), the Community Service Plans (CSP) of Ellis Hospital and Sunnyview Rehabilitation Hospital, and the Implementation Strategy of Ellis Hospital regarding the prioritization of community health needs, including description of community and expert engagement, documentation of methodology, and communication of results. (The federal Implementation Strategy for Sunnyview Rehabilitation Hospital is being separately filed using the format of its parent organization.)



- As described in greater detail below, the process began with the ongoing tracking of 170 "Public Health Indicators" by expert staff at the Healthy Capital District Initiative (HCDI).

- HCDI experts used a quantitative tool to winnow the 170 "Indicators" down to 30 scored and priority-ranked "Public Health Issues." Each "Issue" is comprised of one or more (usually several) "Indicators." The quantitative ranking methodology described in detail below assigns points for relative significance within five measurement dimensions. The 30 "Issues" derived for Schenectady are shown in Figure E1.

- In consultation with representatives of not-for-profit hospitals, public health departments, not-for-profit insurers, and community-based organizations comprising the "Prevention Agenda Work Group" (PAWG), HCDI and a local leadership group (see "Leader Choice" column in Figure E1) in each county selected 12 to 15 of these "Issues" for in-depth discussion by that county's local Prioritization Work Group, which, for Schenectady, was the Schenectady Coalition for a Healthy Community (SCHC). Although great deference was given to the quantitative ranking, additional consideration was given to practical aspects of successful intervention. For example, although "assault" ranks high (#3) on the quantitative listing for Schenectady, the leadership

group noted that health care organizations can have limited impact on solving what may be either a very broad social concern, or a limited law enforcement concern.

- The 13 "Issues" selected for Schenectady were then explored in depth by SCHC participants during two focused meetings in March 2019. The process consisted of detailed data presentations by HCDI experts followed by open discussion at the first meeting, with "pitches" made by community members and representatives having an interest in a specific topic followed by an iterative voting process at the second meeting. As described and illustrated below (see also Figures E1, E2, and E3), this process resulted in selection of the top two Prevention Agenda Priorities for inclusion in the New York State CHIP and CSP. In accordance with federal requirements for the Implementation Strategy, Ellis Hospital reports herein on all of the originally identified community health needs.

Figure E1: Quantitative Rankings and Community Voting for Schenectady Health Issues

Health Issue	Score	Rank	Leader Choice	1st Vote	2nd Vote
Mental Health	3.20	1	X	39c	31c
Kidney Disease	2.90	2	X	0	
Assault	2.70	3		2	
Stroke	2.50	4	X	9	
Lyme Disease	2.50	4	X	0	
Asthma	2.40	6	X	4	
Suicide	2.40	6	X	39c	31c
Diabetes	2.17	8	X	4	
Drug Use	2.13	9	X	17c	10c
Sexually Transmitted Disease	2.07	10	X	4	
Maternal and Infant	1.93	11	X	1	
Alcohol Use	1.80	12	X	17c	10c
Prenatal Care	1.75	13	X	1	
Smoking	1.70	14	X	29c	28c
Congestive Heart Failure	1.70	14	X	9c	
Coronary Heart Disease	1.67	16	X	9c	
COPD/CLRD	1.60	17	X	29c	28c
Breast Cancer	1.38	18			
Unintended Pregnancy	1.38	19	X	4	
Obesity	1.34	20	X	18	11
Childhood Lead Poisoning	1.31	21			
Newborn Drug	1.25	22	X	1	
HIV/AIDS	1.20	23	X	4	
Well Child Visits	0.67	24			
Food	0.33	25			
Housing	0.33	25			
Colorectal Cancer	0.28	27			
Falls	-0.20	28			
Immunization	-0.39	29			
Breastfeeding	-0.67	30			

Note: "C" means combined with other issue(s) of same number of responses.

- Parallel to, but entirely independent from, this selection and prioritization process, the Sienna Survey community telephone survey described below directly engaged a sample of consumers by asking them to identify the relative priorities of a number of public health issues. The results of the survey independently confirm the selection of the top two priorities.

- As something of a check on the process, the draft Capital Region Community Health Needs Assessment document was publicly posted on the websites of multiple participating

organizations with a request for public comments. None of the comments received identified substantive issues with the ranking process or results.

Engagement of Community Organizations Serving and Representing the Interests of Medically Underserved, Low Income, and Minority Populations; also Engagement of Local Public Health Department

The Schenectady Coalition for a Healthy Community (SCHC) engaged in a multistage process for identifying and prioritizing Schenectady's community health needs. This started with a regional process led by HCDI, and concluded with final priority selection by members of the broadly representative Schenectady community organization.

Engaging the community in the health needs assessment process was a priority of HCDI and its Schenectady County stakeholders. Broad community engagement began with participation in the community health survey. The survey offered multiple choice questions to learn about residents' health needs and priorities, health behaviors, barriers to care, and social determinants of health. Demographic information collected by the survey allowed review of information by age, gender, race/ethnicity and income. The Schenectady Coalition for a Healthy Community (SCHC) includes community voices through representatives from community based organizations that serve low-income residents, the homeless, and other vulnerable populations; federally qualified health centers; advocacy groups; employers; public health departments; providers; and health insurers. In moving from "needs" to "priorities," participants were encouraged to share data of their own and to advocate for the needs of their constituents.

Selection of the top health priorities was facilitated by a new "Public Health Issue Prioritization" tool created by HCDI, based on feedback from the prior (2016-2018) Prioritization Cycle. In the fall of 2018, HCDI staff reviewed approximately 170 "Public Health Indicators" across the five Prevention Agenda priority areas and incorporated the key indicators into 30 "Public Health Issues." Public Health Issues were identified by reviewing the present New York State Department of Health Prevention Agenda Focus Areas, as well as Public Health Issues incorporated in the last Prioritization Process in 2016. The 30 Public Health Issues were ranked for each of the six counties in the Capital Region. The ranking tool utilized a quantitative method, based on previous prioritization efforts (e.g. Hanlon Method), to assist the county selection process from 30 Public Health Issues to a shorter list of health issues for participating partners to examine and final selections.

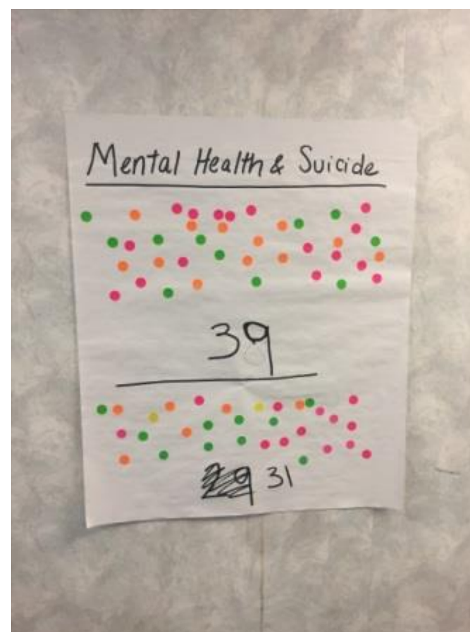
Each Health Issue was valued based on between one and four comparison measures which were scored on five dimensions. When an Issue had more than one measure, the measures' scores were averaged. In general, the quantitative rankings were built by first establishing a point of comparison or a baseline measurement instrument, and then assigning a point value to Schenectady's amount of deviation from the point, or its position on the continuum. The point assignment process was:

Dimension	Point Assignment
Size (percent or rate) relative to NYS excluding NYC	Between +5 and -5 based on % variance from NYS excl. NYC rate; with an extra point if one of the worst five counties for that indicator
Impact on quality of life ("seriousness")	Between +5 and +1 based on table of "seriousness" ranging from "mortality" as most serious to "health behavior" as least serious

Trends from 2013-2015 or a comparable timeframe	Between +5 and -5 based on % variance from 2016 CHNA data
Disparity (Index of Disparity using race/ethnicity)	Between +4 and +2 depending on "Index of Disparity" score (which can range between 75+ and 25)
Absolute number of individuals affected	Between +5 and +1 based on the quintile ranking of the absolute number of individuals affected

The results of the raw quantitative ranking for Schenectady are shown in Figure E1 on page 51. Derivation of the rankings for Schenectady County is shown in detail on the HCDI website (http://hcdiny.org) by selecting "Explore by County" and locating "Public Health Issue Prioritization Methodology Review" in the section titled "County Data and Resources."

The "Index of Disparity" (ID) is a method for summarizing disparities among groups within a population that can be applied across health indicators, and across different populations. The Index of Disparity indicates how different the population sub-group rates are from one another, no matter if they are higher or lower than the total population rate. As the difference between the sub-group rates increase, the ID increases. By definition, the Index of Disparity is the average of the absolute difference between rates for specific groups within a population and the overall population rate, divided by the rate for the overall population, expressed as a percentage. More information is available here: http://www.hcdiny.org/content/sites/hcdi/equity_reports/Index_of_Disparity_Equity_Report-Narrative.pdf



A regional Prevention Agenda Work Group, with participation from the local Public Health Departments of Albany, Columbia, Greene, Rensselaer, Saratoga and Schenectady counties, St. Peter's Health Partners, Ellis Hospital, Albany Medical Center, Saratoga Hospital, and Columbia Memorial Hospital, met in the winter of 2018 to review the Ranking Methodology and provide oversight and guidance in the prioritization process. Using the quantitative rankings provided by the tool, as well as consideration of the availability of quality data, adequacy of current efforts, organizational capacity, upstream vs. downstream factors, and potential for evidence-based interventions, Prevention Agenda Work Group participants selected 12 to 15 Public Health Issues in each county for more comprehensive review by the local Prevention Agenda Prioritization Work Groups; which, in Schenectady, was the SCHC.

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. Prior to the presentation, the full data set reviewed by the Prevention Agenda Work Group was made available to Capital Region partners on the HCDI website (http://hcdiny.org/). Presentations can be found by selecting "Explore by County" and opening the "2019 Prevention Agenda Prioritization Presentation" under the "County Data and Resources" section.

Figure E2: First Round of Schenectady Priority Votes

Topic	Number of Votes
Asthma	4
Smoking	29
Diabetes	4
Obesity	18
Kidney Disease	0
Cardiovascular Disease (coronary heart disease, congestive heart failure and stroke)	9
Assault	2
Sexually Transmitted Infections	4
Perinatal and Infant Health	1
Prenatal Care	1
Unintended Pregnancy	4
Mental Health and Suicide	39
Substance Use and Alcohol Use	17

Figure E3: Second (Final) Round of Schenectady Priority Votes

Topic	Number of Votes
Smoking	28
Obesity	11
Mental Health and Suicide	31
Substance Use and Alcohol Use	10

After the presentation of each set of health indicators, a discussion was held to answer any questions, and for individuals to share their experiences with the health condition in the population. Participants were encouraged to consider the importance of the condition in the community based on three qualitative dimensions: what the data and organizational experiences suggested; if there was community awareness and concern about the condition; and the opportunity to prevent or reduce the burden of this health issue on the community. Participants were provided with a Prioritization Tracking Tool to record their own comments and measure their thoughts on the local experience, community value, and potential opportunity regarding each health indicator.

Upon completion of the data summaries, SCHC members were given an opportunity to advocate for the priorities they believed were most meritorious and the group voted (using a "dot-mocracy" process which permitted "bullet voting;" participants were given "dots" – three in the first round and two in the second round – and could cast single votes for each of three or two Issues, all three or two votes for a single Issue, or some combination – see voting examples on page 53 and results in Figure E1 (columns "1st Vote" and "2nd Vote") on page 51, and Figures E2 and E3 above on this page) on the top two Prevention Agenda categories. Mental health, behavioral health, and chronic disease categories received the greatest amount of votes by far, because they impacted 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 Schenectady Coalition for a Healthy Community (SCHC) was led in this exercise by Schenectady County Public Health Services, Ellis Hospital, Sunnyview Rehabilitation Hospital, and Hometown Health Centers (the local FQHC). SCHC itself is an informal coalition of community service organizations created following the State-mandated consolidation of Schenectady's hospitals, which has met regularly for the past ten years to share information on community health issues. Meetings were held on February 14, 2019, March 7, 2019, and March 14, 2019 at which HCDI presented data for the heath indicators selected by the Prevention Agenda Work Group, and facilitated discussions. The PowerPoint data presentations used during these meetings were made available to the SCHC members and the general public on the HCDI website (http://www.hcdiny.org/). SCHC members chose their priorities at the last

meeting. Community-representing organizations actively participating (see Appendix A for attendees at the February, March, June, and/or July meetings) in the Schenectady Coalition's selection process were:

- Alliance for Better Health (DSRIP PPS)
- Bethesda House (homeless services)
- Capital District Center for Independence, Inc
- Capital Roots (community gardens and nutrition services)
- Capital Region Chamber
- Capital Region Tobacco Free Communities
- CDPHP Health Plan (non-profit Managed Care Organization)
- Centro Civico
- Ellis Asthma Care
- Ellis Department of Psychiatry
- Ellis Family Health Center
- Ellis Medicine Board of Trustees
- Ellis Pediatric Health Center
- Ellis Primary Care
- Healthy Capital Region Initiative
- Hometown Health Centers (FQHC)
- Independent Living Center of Hudson Valley
- Mohawk Valley Physicians (MVP) Health Plan (non-profit Managed Care Organization)
- New Choices Recovery Center (addiction prevention and treatment services)
- Planned Parenthood - Mohawk Hudson
- Schenectady City Mission, Empower Health
- Schenectady Community Action Program
- Schenectady County Office of Community Service (local government MH/SUD services)
- Schenectady County Public Health Services
- Schenectady County Public Library
- Schenectady Inner City Ministry
- St. Peters Health Partners
- Sunnyview Rehabilitation Hospital

In the Schenectady County Prevention Agenda Prioritization Meetings, input was received from the community on a number of health issues. Asthma, respiratory diseases and tobacco use were seen by members of the Schenectady Coalition for a Healthy Community as important health topics in the community where disparities also exist. There was extended discussion about the issue of electronic cigarette use among youth and how this will impact combustible tobacco use rates in the future. Capital District Tobacco-Free Communities shared projects they would like to work on in Schenectady County that impact these issues, while Ellis Medicine's tobacco cessation program spoke about the resources they have available to assist the community.

The topics of mental health and suicide were discussed by the group at length. The community thought that the data underrepresented the issue because of lack of formal diagnosis for many with poor mental health. Participants expressed the view that suicide data is also not captured correctly or consistently all of the time. Alcohol and substance abuse were also discussed. Heroin and fentanyl use continues to concern the community and public health organizations. There are many groups working on addressing the issue of substance use and they were able to speak about their work.

Engagement of Consumers through Community Telephone Survey

The Healthy Capital District Initiative (HCDI) conducted its third Community Health Survey of residents in the Capital District from December 9 – 18, 2018. The aim of the survey was to continue to learn more about behavioral health/lifestyle practices, health care utilization and needs, challenges to practicing healthy behaviors and accessing care as well as other social determinants of health. The Siena College Research Institute (SCRI) was contracted to collect the data for this Community Health Survey. A random sampling design was applied to recruit a representative sample of residents of the Capital District (including the counties of Albany, Columbia, Greene, Rensselaer, Saratoga, and Schenectady) and augmented by an oversample of lower income individuals (defined as yearly household income of no more than $50,000).

The sample from each county was statistically weighted to the proportionate share of the population of the entire region making the overall margin of error including the design effects of weighting +/- 3.4 percentage points across the sample of 1204 residents at the 95% confidence level. Additionally separate weighted estimates were prepared for: 1) Albany, Rensselaer (n=529), 2) Columbia, Greene (n=258) 3) Saratoga (n=226), 4) Schenectady (n=191 at MOE +/- 8.9%), and 5) lower income respondents across the six counties (n=724).

The data collection instrument was developed by HCDI in collaboration with the Prevention Agenda Workgroup and Siena College. The behavioral questions were asked in reference to a 12-month period to improve consistency in response. The questionnaire was pilot tested before adopted for use. Trained interviewers at Siena College administered the questionnaire to ensure fidelity of the data. Participants who were 18 years of age or older and eligible to take part in the study were interviewed on their cellphones or landlines. The questionnaire took approximately 15 minutes to complete and a response rate of 8.2% was obtained. Up to seven attempts were made before participants were classified as non-response. The participants were not compensated to take part in the survey. Additionally, 301 surveys were completed online.

When asked to rank the seriousness of public health issues "in your community," Schenectady residents surveyed chose mental health, substance use, and tobacco use as most significant. The top five topics listed as "very serious" by overall percentage were:

#1 – Drug abuse including opioid addiction – 39%
#2 – Mental illness including suicide – 36%
#3 – Alcohol abuse – 34%
#4 – Tobacco use and related illness – 33%
#5 – Unsafe sexual activity including teen pregnancy and STDs – 31%

Although the survey responses of Schenectady residents generally mirrored those of the overall Capital Region, there were a number of notable variances from the region or within the county. These included:

- Very-low-income Schenectady residents report poor health at a very high rate. Countywide, only 4% of respondents report "poor" health; regionwide, 11% of very-low-income (less than $25,000/year) report "poor" health; but in Schenectady, 20% of very-low-income residents report "poor" health.

- Younger Schenectadians in particular are more likely to be in good physical health than in good mental health. More than half (53%) of respondents under age 55 report no days when their physical health was "not good," while only about a third (34%) of this age category report no days with their mental health "not good."

- Low-income, low-education Schenectady residents report very high rates of tobacco use. Regionwide, 20% of low-income (under $50,000) residents smoke or use tobacco every day, while that share is fifty percent higher in Schenectady County, at 30%. Within Schenectady County, 18% of the total population smokes or uses tobacco every day, doubling to 36% for people with a high school degree or less.

- Food insecurity remains a problem for very low-income Schenectady residents. More than half (52%) of very-low-income respondents report not having enough money to buy food at least once in the past 12 months, fifty percent higher than the regionwide response of 36%.

- It appears that, in Schenectady at least, money does buy happiness. About a third (31%) of very-low-income residents report feeling "overwhelmed or stressed" all seven days of the week, while only 2% of respondents with incomes of $50,000 or over report that much stress. Conversely, a nearly identical share (34%) of higher-income residents report never feeling "overwhelmed or stressed out."

Engagement of Community Organizations and Consumers through Written Comments Received on 2013 and 2016 CHNAs and Implementation Strategies

As required, the hospitals posted the 2013 and 2016 CHNAs and Implementation Strategies on their public websites. (See, for example, http://www.ellismedicine.org/pages/community-report.aspx). In addition, the Implementation Strategies were included in the IRS forms 990 Schedule H also posted on the hospitals' websites. Ellis, for example, solicited public comment via a "contact us" form on its website (https://www.ellismedicine.org/pages/contact.aspx), through its Facebook presence (https://www.facebook.com/EllisMedicineNY) and on Twitter (https://twitter.com/ellismedicine) with all accounts actively monitored by staff from the Communications and Marketing office. The hospitals also solicited public comments through the regular meetings of the Schenectady Coalition for a Healthy Community (SCHC).

No written comments were received regarding the 2013 and 2016 CHNAs and Implementation Strategies. Verbal comments were received, however, during meetings of SCHC and were used to modify and make mid-course corrections to the overall identification, evaluation, and prioritization of health needs. The most significant comments related to priority modifications so as to be able to take advantage of opportunities which occurred between adoption of the 2013 and 2016 documents. This particularly involved elevation of the priority of Food Insecurity (initially listed as Tier B) as several funding opportunities became available. Greater knowledge of the impact of Food Insecurity on the overall well-being of individuals and families in Schenectady then led to it inclusion as a component in the Obesity/Diabetes initiative for 2016.

Given this experience, the partners undertook a collaborative regional effort to more aggressively encourage written comments on the 2019 regional CHNA early in its development process. HCDI provided a link to the near-final draft and an accompanying on-line questionnaire, while all of the

regional hospitals and public health departments (including Ellis, Sunnyview, and SCPHS) prominently posted the link on questionnaire on their public websites during May and June 2019. This posting throughout the entire six-county region resulted in 30 written comments. The written comments indicate that commenters found the draft CHNA easy to understand (67% = easy or very easy vs. 3% difficult) and generally informative (33% = extremely informative, 53% = informative, 13% = somewhat informative). Some commenters identified apparent errors and made suggestions for improvement which were incorporated in the final regional CHNA.

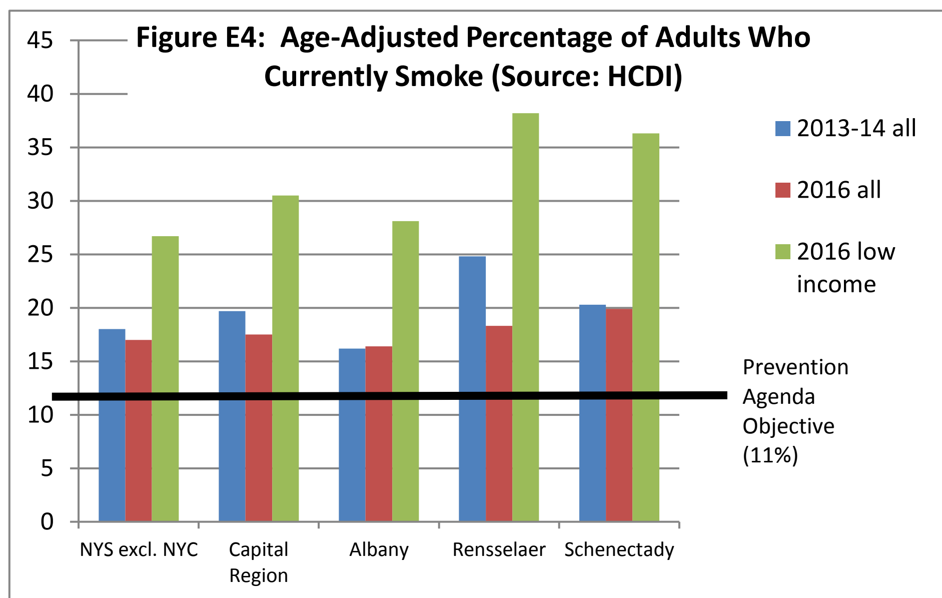
Resulting Selection of Top Two Prevention Agenda Priorities

The final selected top two Prevention Agenda Priorities and Focus Areas are:

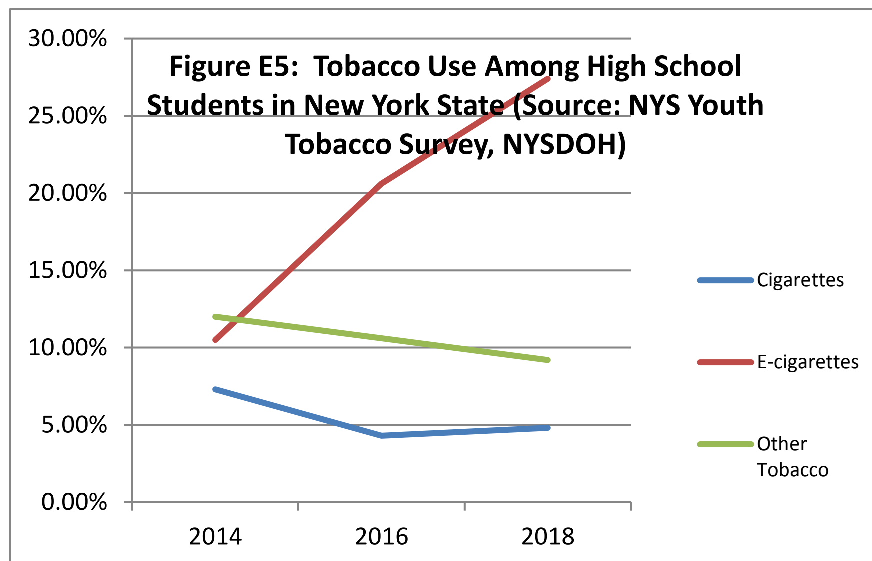
1. **Priority Area: Prevent Chronic Diseases**
   - **Focus Area: Tobacco Prevention**

As described in substantial detail above, the Prevention Agenda Focus Area of "Tobacco Prevention," within the Priority Area of "Prevent Chronic Disease" was selected as one of the top two priorities for Schenectady County and its hospitals during the 2019-2021 CHIP/CSP cycle.

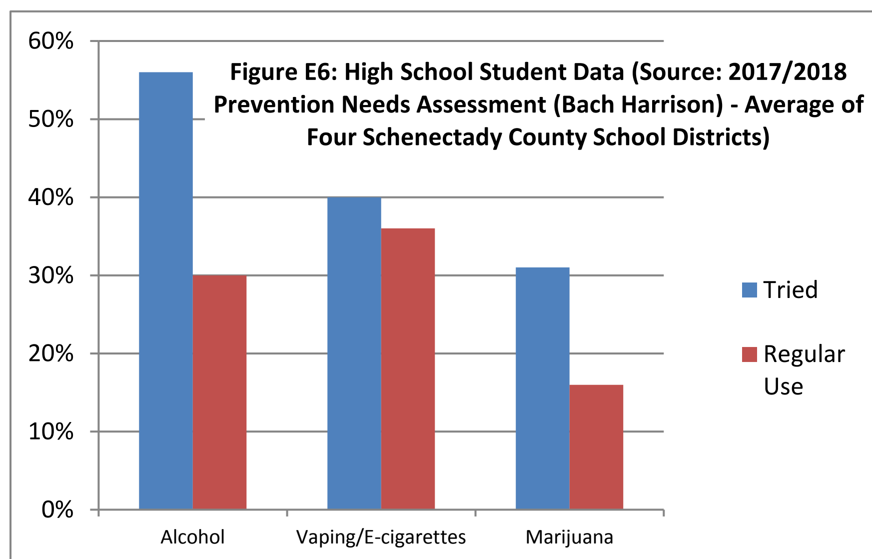
Tobacco and smoking received the second highest number of votes in both the first and second rounds of the SCHC's "dotmocracy" selection process, was identified as the fourth most serious health issue in the community by the telephone survey of community residents, and was scored as the 14th most serious health issue in Schenectady using HCDI's quantitative methodology.



In part, the prioritization discussion reflected broad public health data and historical trends. The 2013 "UMatter Schenectady" community survey, which served as a comprehensive basis for community input into the 2013-2015 CHIP/CSP, found that 37.1% of the City of Schenectady residents surveyed were current smokers. Although that survey intentionally oversampled residents of lower-income neighborhoods, county-wide data also show relatively high rates of smoking throughout Schenectady County. Figure E4 shows Schenectady to have the highest or second-highest smoking rates of the core Capital Region counties (Albany, Schenectady, and Rensselaer), with the entire region exceeding both the NYS excl. NYC benchmark as well as the Prevention Agenda objective.



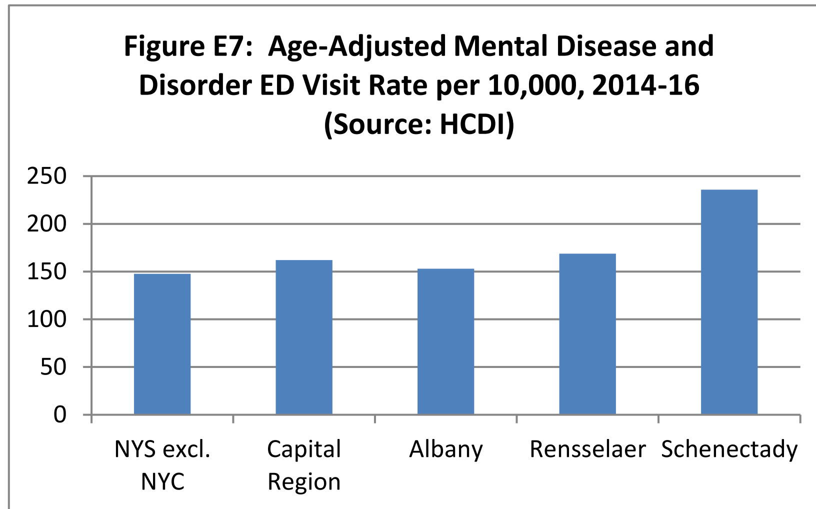
Discussion during the March 14, 2019 SCHC meeting, however, added significant information and a new focus on youth tobacco/nicotine use. Figure E5 shows tobacco use among high school students in New York State, from the New York State Department of Health's "Youth Tobacco Survey." Although the statewide data demonstrate reduced youth use of cigarettes and other tobacco products over the 2014-2018 measurement period, this is more than offset by a dramatic (155%) increase in use of e-cigarettes, resulting in a net increase in nicotine exposure by high school students.

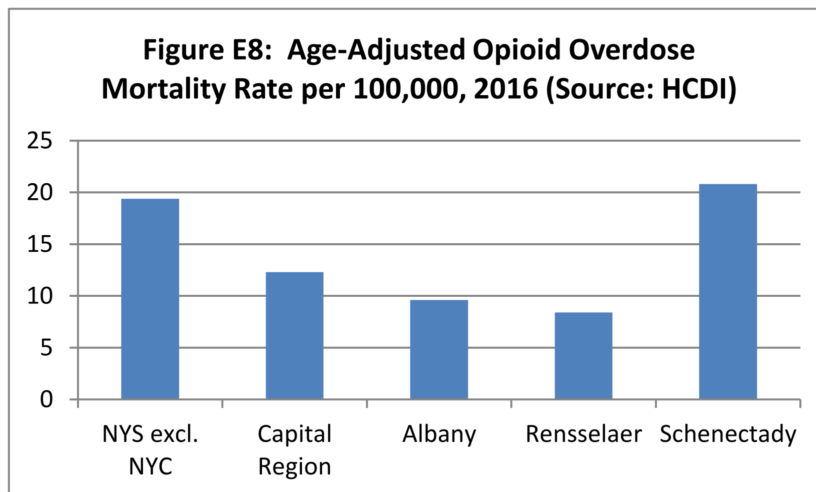


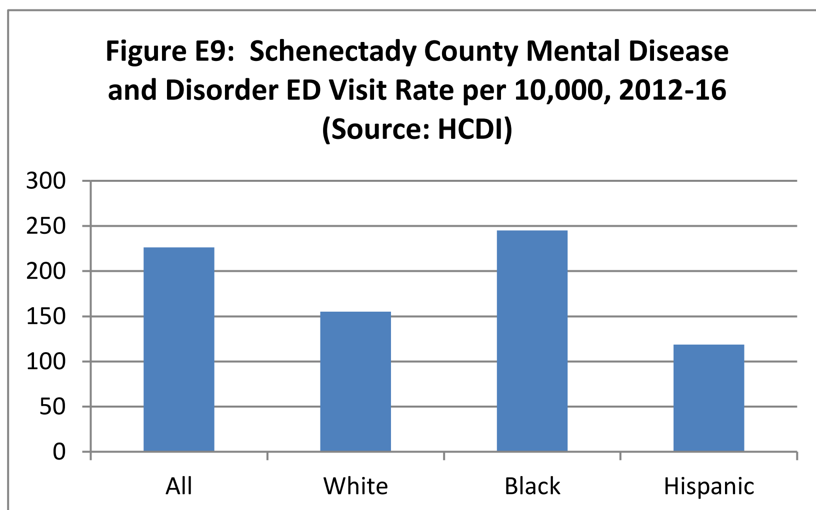
During the formal opportunity for priority-specific "pitches," a community advocate provided Schenectady-specific data (Figure E6) taken from surveys of high school students in the Schenectady City, Duanesburg, Niskayuna, and Scotia-Glenville School Districts showing that local high school students <u>try</u> alcohol, vaping/e-cigarettes, and marijuana in varying degrees; but only about half of those who try alcohol and marijuana become regular users (alcohol: 56% try, 30% use; marijuana: 31% try, 16% use). Nearly <u>all</u> of the Schenectady area high school students who try vaping/e-cigarettes, however, become regular users (40% try, 36% use).

2. **<u>Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders</u>**
    - **<u>Focus Area: Mental and Substance Use Disorders Prevention</u>**

Mental Health issues have topped Schenectady County priorities since the first CHIP/CSP for the 2013-2016 planning cycle. The county has long been characterized by high measures of need, especially within lower-income and minority communities, contrasted with limited clinical capacity.







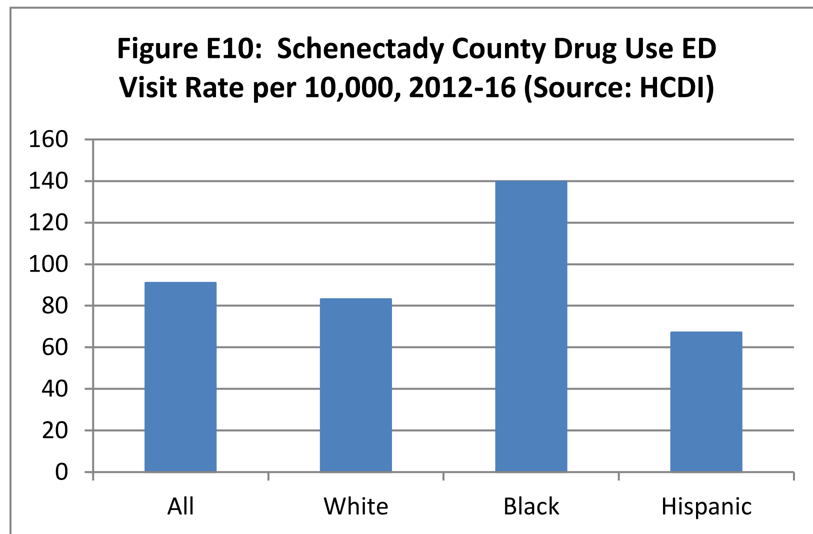
In the 2019 prioritization exercise, "Mental Health" received the highest number of votes in both the first and second rounds of "dotmocracy" prioritization, "Mental Health" and "Drug Abuse" received the second and first priority rankings, respectively, in the telephone survey of community residents, and "Mental Health" scored the number one highest need ranking in HCDI's quantitative need methodology ("Suicide" was 6th and "Drug Use" ranked 9th).

The 2013 "UMatter Schenectady" community survey found that while nearly a quarter (24.9%) of survey respondents had been diagnosed with depression, almost a third (32.1%) of those diagnosed were not currently taking medication or receiving treatment. This suggested that eight percent of the City's population had been diagnosed with a mental illness, but were not being treated.

The 2014 Community Needs Assessment of Medicaid patients undertaken for the DSRIP program found that 16 of the top 21 chronic conditions resulting in Emergency Department visits by Medicaid patients in the ten-county combined service area of the two Capital Region DSRIP PPSs were for Mental Health or Substance Use diagnoses. (See Figure B-51 of the document as referenced on page 24.)

The 2016 CHIP/CSP again ranked "Promote Mental Health and Prevent Substance Abuse" as one of Schenectady's top two Prevention Agenda priorities. Data from that report showed Schenectady County as ranking worst among all the Capital District counties for rates of: 1) mental disease and disorder

emergency department visits, 2) suicide mortality by males, and 3) opiate poisoning emergency department visits.



As shown in Figures E7 and E8, Schenectady's mental disease and disorder ED visit rate and opioid overdose mortality rate remain the worst in the core Capital Region counties. In the latter case, Schenectady is the only tri-county jurisdiction where the local rate exceeds the NYS excl. NYC benchmark.

Figures E9 and E10 show that Schenectady's Black community is disproportionately impacted by mental disease and drug use issues. For measures of both mental disease and disorder ED visits and drug use ED visits, there are clear disparities, with rates for Black Schenectady residents higher than for White residents, with rates for Hispanic residents coming in lowest. The ED opioid overdose rate for Schenectady's Hamilton Hill neighborhood, the only "minority-majority" neighborhood in the County, is the highest in the entire Capitol Region.

2. Goals, Objectives, Intervention Strategies, and Process Measures

Priority Area: Prevent Chronic Diseases

Focus Area: Tobacco Prevention

NY State Prevention Agenda Goals	Statewide Objectives	Local Intervention Strategies	Local Process Measures
3.1 Prevent initiation of tobacco use	3.1.3 Decrease the prevalence of vaping product use by high school students	• Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies, and reshape social norms	• Number of nicotine prevention workgroup meetings held • Number of attendees • Number of educational campaigns used in schools
3.2 Promote tobacco	3.2.8 Increase the utilization of smoking	• Promote Medicaid and other health plan	• Number of participants in

use cessation	cessation benefits (counseling and/or medications) among smokers who are enrolled in any Medicaid program	coverage for tobacco dependence counseling and medications	"The Butt Stops Here" program who are enrolled in Medicaid • Number of participants in "The Butt Stops Here" program with any other insurance coverage

Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders

Focus Area: Mental and Substance Use Disorders Prevention

NY State Prevention Agenda Goals	Statewide Objectives	Local Intervention Strategies	Local Process Measures
2.2 Prevent opioid and other substance misuse and deaths	2.2.2 Increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD) by 20% to 43.1 per 1,000 population (Baseline: 35.9 per 1,000) 2.2.4 Reduce all ED visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate by 5% to 53.2 per 100,000 population	• Increase availability of/access to medication-assisted treatment (MAT) including Buprenorphine	• Number of Buprenorphine trainings held in Schenectady County • Number of providers trained • Number of people receiving MAT in the Schenectady County Jail • Number of SUD treatment promotional materials distributed
		• Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers,	• Number of Naloxone trainings held in Schenectady County

		pharmacists, and consumers	• Number of people trained
		• Establish additional permanent safe disposal sites for prescription drugs and organized take-back days	• Number of workgroup meetings held • Number of attendees • Number of new permanent safe disposal sites established
		• Integrate trauma informed approaches in training staff and implementing program and policy	• Number of Trauma Informed Work Groups held and number of workshops held • Number of attendees

3. Work Plan (see also Appendix B)

a. Hospital Actions and Impact

1. **Priority Area: Prevent Chronic Diseases**
   a. **Focus Area: Tobacco Prevention**

Ellis Hospital will continue to support the growth and promotion of "The Butt Stops Here" evidence-based smoking cessation patient education program. This is currently provided through the hospital's Respiratory Therapy Department. The program was offered 11 times in 2019 with a total of 58 registrants, and 20 successfully completing the program. The completion rate seems low, but is reported to be similar to that of other "behavior change" programs.

Ellis will promote appropriate patient referral to this program from the Ellis Medical Group's (EMG) primary care practices, and will accept and encourage referrals from non-affiliated practices. Ellis will continue to include completion of this program as both a benefit and incentive component of its employee health insurance plan.

Ellis also plans to revise and update its tobacco use policies as they apply to employees, patients, and visitors. This will include a complete replacement of current "no smoking" signs and other messaging

with comprehensive regulatory-compliant signage consistent with current standards and in a format consistent with signs at Sunnyview and other large campuses.

Finally, Ellis will utilize its new system-wide Cerner Millennium Electronic Health Records (EHR) system to collect data related to the countywide tobacco prevention goals and objectives and will work with SCPHS to report annually.

Ellis will participate in, and lend expert assistance to, the SCHC Nicotine Prevention Work Group. The group will decide what work to focus on around vaping prevention and will then implement activities on policies and education for schools and for the county and its institutions to both prevent initiation and reduce the use of nicotine.

Ellis supports and will work toward the Statewide Prevention Agenda Objectives of: 1) Decrease the prevalence of vaping product use by high school students (3.1.3) and 2) Increase the utilization of smoking cessation benefits (counseling and/or medications) among smokers who are enrolled in any Medicaid program (3.2.8). Ellis recognizes and will work to address the disparity that a greater proportion of low income residents in Schenectady County use tobacco.

2. Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders

a. Focus Area: Mental and Substance Use Disorders Prevention

Ellis Hospital will continue to support the growth and promotion of several opioid and other substance use harm reduction and treatment initiatives operated through the hospital's emergency department (ED), the Ellis Medical Group (EMG) primary care practices, and the outpatient retail pharmacy.

Ellis currently offers real-time on-line Naloxone training to friends and families of overdose patients while they are in the ED waiting room. Upon completion of the training, these potential caregivers may receive free (if uninsured or on Medicaid) or low-cost (if commercially insured) Naloxone kits, typically even before the patient is discharged from the ED.

As part of a DSRIP-funded collaboration with community agencies licensed to provide substance use treatment and recovery services, certified recovery peer advocates (CRPA) are stationed in the Ellis Emergency Department during high-risk times. CRPAs work with overdose patients and their friends/families to promote harm reduction and community support activities upon discharge, and also to engage patients with detoxification providers.

Ellis also offers Medication Assisted Treatment (MAT) programs both in the ED and through certain primary care practices. Suboxone or Buprenorphine treatment may be started in the ED and then seamlessly transitioned to a primary care practice.

Ellis will continue to provide dissemination of materials that are related to the goals and interventions selected, and will continue to co-host and provide meeting space for the Schenectady Coalition for a Healthy Community as well as to provide meeting space for the Trauma Informed Community Work Group and the Schenectady County Public Health Services' Naloxone monthly trainings.

As a teaching hospital, Ellis will continue to collaborate with SCPHS in educating both hospital-employed and community clinical providers at all levels. In 2019, three Buprenorphine trainings were held in Schenectady: 12 providers were trained on January 7, 24 providers were trained on February 7, and 29

providers were trained on May 31. The Ellis Hospital Social Work Department hosted an "academic detailing" event for care coordination and implementation of MAT on January 7.

Ellis supports and will work toward the Statewide Prevention Agenda Objectives of: 1) Increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD) by 20% to 43.1 per 1,000 population from the baseline of 35.9 per 1,000 (2.2.2) and 2) Reduce all emergency department visits (including outpatients and admitted patients) involving any opioid overdose by 5% to the age-adjusted rate of 53.2 per 100,000 population (2.2.4). Ellis recognizes and will work to address the disparity that substance use disorders disproportionately affect the low income population in Schenectady.

Priority Areas 3 through 14 (arranged by original CHNA priority tier)

Tier	Community Health Need	Prevention Agenda Priority	Summary of Ellis Hospital Implementation Strategy including Action, Program, Resources, Collaboration, and Evaluation
A	Asthma	no	Ellis will continue to lead and participate in a number of initiatives intended to reduce the occurrence of asthma; these include DSRIP project 3.d.i. (Asthma Home-Based Self-Management), the Schenectady Healthy Neighborhoods program (with SCPHS), policies regarding tobacco-use reduction (with the Capital District Tobacco-Free Communities and SCPHS), and specific employer- and community-based smoking reduction programs (with "The Butt Stops Here" program). Ellis and SCPHS pioneered a three-pronged asthma care model based on 1) care coordination, 2) environmental assessment, and 3) asthma education. Although originating as a grant-funded pilot in Schenectady, this model informed development of the region-wide DSRIP asthma project. When the project was operational, eligible patients who presented at the Ellis Emergency Department with symptoms of asthma which could have been effectively managed in the community were offered the opportunity to enroll in a care management program through the Health Home. Care managers with expertise in asthma helped to ensure that the patients received appropriate care in the community and had adequate access to medications such as controller and rescue inhalers. Patients then received a home visit from a SCPHS public health nurse (PHN) who assessed the home environment, identifying such asthma triggers as pet dander and mold. To the extent that triggers could be remediated, referrals were made (e.g., Schenectady Municipal Housing Authority for water intrusion issues). Patients were also enrolled in the Ellis Asthma Education program where Respiratory Therapists who are Certified Asthma Educators provided a formal multi-session education program emphasizing self-management through avoidance of triggers and proper use of medications. Overall, patients who completed the full self-management course experienced a 60-70% reduction in asthma-related Emergency Department visits. For a time during 2017 and 2018, Ellis and SCPHS worked with the State Department of Health's Medicaid contractor CMA Consulting in development of additional enhancements to community-based asthma management; including "data mining" of Medicaid pharmacy claims to ensure that patients refill inhaler prescriptions and potential deployment of "smart inhalers" which could provide care managers with real-time reports whenever a patient uses a rescue inhaler, helping to predict the need for interventions before an

Tier	Community Health Need	Prevention Agenda Priority	Summary of Ellis Hospital Implementation Strategy including Action, Program, Resources, Collaboration, and Evaluation
			emergency department visit. Resources expended by Ellis include the care management and Asthma Education services. Metrics include measures of community, rather than ED or inpatient, management of asthma, as well as measures of reduced tobacco use and smoking.
A	Adolescent Pregnancy	Healthy Women et al Action Plan, Goals 1.2 and 2.1	Schenectady has the highest adolescent pregnancy rate in the region, although it no longer exceeds the Prevention Agenda objective. It also has the highest rates for all race/ethnicity categories (Black, White, and Hispanic). This is largely driven by the rate in the Hamilton Hill (ZIP code 12307) neighborhood which is three times the Rest of State rate. Ellis will continue to offer high quality maternity care for high-risk adolescent pregnancies, both as a direct provider of care through the Family Health Center and as the county's only maternity hospital; Bellevue Woman's Center. Bellevue partners with other maternity providers including Hometown Health and Planned Parenthood Mohawk Hudson to offer seamless care from initial pre-natal care to birth and then follow-up. The Ellis Family Health Center and the Ellis Pediatric Care Center are located in the same building, allowing warm handoffs from the mother's pre-natal care to the baby's well care. In addition to direct clinical care for pregnant Medicaid beneficiaries and their babies, the Health Home provides care management and coordinates with the Schenectady County Public Health Service's home visiting program. Resources expended by Ellis include the net unreimbursed cost of the various maternity care services; metrics include maternity outcomes data.
A	Diabetes, Obesity, and Food Insecurity	Chronic Disease Action Plan, Focus Areas 1 and 2	In late 2018 the Ellis Diabetes Prevention Program (DPP) was awarded full recognition from the federal Centers for Disease Control (CDC). Started in October 2016, the Ellis DPP was the first in the community in a number of years, initially using grant funds sub-allocated from Schenectady County Public Health Service. The DPP is a lifestyle change program designed to prevent diabetes. It runs 16 consecutive weeks and then monthly maintenance sessions continue for the remainder of a year. CDC-recognized programs are able to apply for reimbursement through Medicare. Ellis Medicine will pursue Medicare reimbursement for DPP services once a sufficient volume of Medicare-covered participants is achieved. In addition to the DPP, Ellis also offers Diabetes Self-Management Education (DSME) programs for individuals already diagnosed with diabetes. They receive referrals from Ellis practices, and also from community based organizations and other medical providers in the community. Over the years, the "conversion rate" – the number of patients who follow through on their referral and attend at least one class – increased from 26% to 58%. This could be due to a number of factors including providers explaining the program better to their patients at the time of referral and referrals getting scheduled faster. The increased conversion rate means that more patients are learning effective management skills for their diabetes. Resources expended will include the unreimbursed cost of operating the DPP until a sufficient volume of Medicare beneficiaries is achieved, metrics may include numbers of referrals and participants in both DPP and DSME courses.
B	Arthritis and Disability	no	Arthritis as a contributor to disability was identified as a Community Health Need by the 2013 UMatter Survey which found that just under a

Tier	Community Health Need	Prevention Agenda Priority	Summary of Ellis Hospital Implementation Strategy including Action, Program, Resources, Collaboration, and Evaluation
			third (29%) of the Schenectady residents surveyed report having arthritis, and most (68%) of these are limited in their usual activities because of joint pain. There is limited access to rheumatology specialists in Schenectady; there are however a number of specialists in the greater Capital Region. Ellis will continue to support patients with arthritis through its primary care practices, and will collaborate with other providers to encourage access to specialists. Resources expended may include uncompensated primary care services; metrics may include changes in clinical outcomes.
B	Dental Health	Healthy Women et al Action Plan, Goal 3.3	Ellis and Hometown Health (the local FQHC) operate the only significant dental facilities in Schenectady which accept Medicaid patients. For the important pediatric population, Ellis provides the only pediatric dental surgery program for Medicaid, while Hometown provides an in-school pediatric dental program. Ellis will continue to operate the Dental Health Center at the McClellan Street Health Center, which was designated a National Health Service Corps (NHSC) practice site in 2016. The resources expended reflect the net cost (if any) of operating the Dental Health Center after payor reimbursement. Metrics may include any overall impact on dental health, particularly among children. The Dental Health Center also serves as the practice site for the Ellis General Dental Residency; other metrics may relate to resident completion rates.
B	Falls	Healthy and Safe Environment Action Plan, Goal 1.1	Data from prior years showed falls among the elderly to be a major problem in Schenectady – the 2013 and 2016 CHNAs reported the overall falls hospitalization rate among the elderly to be higher than the NYS excl. NYC average, with the rate in the Woodlawn neighborhood twice the State rate. By the time of the 2019 CHNA (using 2016 data), however, the rate of hospitalizations due to falls for persons 65 and older in Schenectady dropped to the lowest in the Capital Region and ED visits, while still the highest in the region, were only slightly above the NYS excl. NYC rate. Careful evaluation of this phenomenon following the 2013 UMatter Survey traced many of the falls to a large senior housing facility, but was not successful in further evaluation; for example, is there something specific to that facility or are the falls numbers high simply because the population is large, or are rates of falls similarly high in other senior housing complexes? Since it is not clear that any particular intervention resulted in the improvements in the measure, Ellis will continue to work with other stakeholders including Mohawk Ambulance Service (paramedics can identify falls hazards in homes when responding to calls), Sunnyview Rehabilitation Hospital (which provides rehabilitation services for patients following falls), and various senior housing projects. Resources expended by Ellis may include staff time for data collection and evaluation; measurement may involve possible new metrics tied to falls and specific environmental elements such as identified senior housing locations.
B	Neighborhood Safety	Healthy and Safe Environment Action Plan, Focus Area 1	As one of the largest employers in the community and with a significant physical presence in the Schenectady Northside (Goose Hill) neighborhood, Ellis will continue to cooperate with the City of Schenectady, the Goose Hill Neighborhood Association, and other major neighbors including Union College and the Golub Corporation in projects

Tier	Community Health Need	Prevention Agenda Priority	Summary of Ellis Hospital Implementation Strategy including Action, Program, Resources, Collaboration, and Evaluation
			and activities to enhance the safety of the community. This will continue to include participation in the Mayor's "Northside Walk to Work Initiative" and support of other City projects and grant applications. Ellis will continue to enhance the safety of its immediate environment; during 2015 this included a new sidewalk the length of the Rosa Road side of the Nott Street campus, which was continued in 2016 as Sunnyview Rehabilitation Hospital installed a new sidewalk along the adjacent Rosa Road side of its property. Ellis also enhances neighborhood safety through the use of its own security force, now including a highly trained security dog used to defuse difficult situations. Collaborative efforts may be measured by meeting attendance, staff participation in City projects, and, potentially, an increased number of employees living in the neighborhood.
B	Programs for Youth and Adolescents	Healthy Women et al Action Plan, Focus Area 3	Ellis will serve as a resource to support community-based programs including those through schools, local governments, and neighborhood organizations. This may include offering meeting space, organizational expertise such as public relations, and/or clinical guidance (e.g., mental health, pediatrics). Collaborative efforts may be measured by attendance at meetings or development of new programs.
C	Community and Coalition Building	no	Ellis will continue to actively participate in community and regional coalitions including the Schenectady Coalition for a Healthy Community (SCHC), the Healthy Capital District Initiative (HCDI), the Alliance for Better Health DSRIP PPS, and *ad hoc* partnerships as may be created to pursue specific community goals. Hospital resources used include staff time for support and participation, in-kind support such as use of meeting rooms, and organization dues. These are reported on IRS 990 Schedule H.
C	Community Health Improvement	no	Ellis will continue the hospital's various Community Health Improvement and Community Benefit Operations as are reported on IRS 990 Schedule H. These include health fairs, community support groups, and community donations. In addition, Ellis will participate in community projects as organized by the DSRIP PPS (Alliance for Better Health) and Schenectady County Public Health Services (SCPHS). The costs of staff support for these services are reported on IRS 990 Schedule H.
C	Health Professions Education	no	Ellis will continue as a teaching hospital, with two Residencies (Family Medicine and General Dental), medical student training through arrangements with Albany Medical College and other medical schools, clinical preceptorships for mid-levels and other licensed/certified clinician training through arrangements with local academic institutions, nursing education leading to the RN degree through the Belanger School of Nursing, and clinical Grand Rounds and other CME programs open to community providers. Hospital resources used include the net costs of operating the formal education programs, plus the professional staff time when serving as preceptors. These are reported on IRS 990 Schedule H.
C	Subsidized and Free Health Services	no	Ellis will continue to participate in the Medicare and Medicaid programs and to provide subsidized and free health care services to underserved, low-income, and uninsured populations, offering a formal program of Financial Assistance consistent with the requirements of federal and State law. In addition, Ellis employs Certified Application Counselors and

Tier	Community Health Need	Prevention Agenda Priority	Summary of Ellis Hospital Implementation Strategy including Action, Program, Resources, Collaboration, and Evaluation
			provides no-charge office space to federally-designated Health Insurance Navigators, in order to assist patients and community members to enroll through the Exchange. Hospital resources used include net losses from serving Medicare and Medicaid patients, the cost of Financial Assistance, and bad debts incurred by uninsured patients. These are reported on IRS 990 Schedule H.

b. Hospital Resources to be Committed

As a financially-stressed not-for-profit community hospital, Ellis has little ability to divert its limited fiscal resources from critical patient care needs to non-clinical community programs. Given the demographics of the community it serves, Ellis already devotes substantial resources to delivering unreimbursed clinical care to patients who are uninsured or are covered by government programs such as Medicare and Medicaid which typically reimburse at less than the cost of delivering care. According to the most recently available (2017) form 990 Schedule H filed with the Internal Revenue Service, in that year Ellis lost $27.4 million caring for Medicare and Medicaid patients, provided $4.1 million in Financial Assistance (free care) to uninsured patients, and accumulated $12.5 million in bad debt (patients who did not pay their bills).

Ellis affirmatively seeks out grant funding for community service programs, often in partnership with local government and community organizations, and seeks to maximize the value of reimbursable services in providing community services. The hospital also volunteers the utilization of fixed resources for community purposes, such as making conference rooms and auditoriums available at no charge to community groups and using its EHR to gather community-oriented patient care data.

The cost of the “The Butt Stops Here” program, for example, is a covered benefit by both of the local not-for-profit managed care organizations, delivering a valuable service to their insured customers while simultaneously enabling Ellis to cover costs. Similarly, both the Naloxone and Suboxone/Buprenorphine treatment programs are typically covered by Medicaid and commercial insurance. The fact that Ellis may be paid for delivering these clinical services does not diminish their value to the community.

Ellis also devotes direct resources in providing paid time to employed physicians and other clinicians to attend education programs, in providing staff to administer community programs, and in using Foundation funds to support community programs.

c. Local Health Department Actions and Impact

1. **Priority Area: Prevent Chronic Diseases**
    a. Focus Area: Tobacco Prevention

Schenectady County Public Health Services (SCPHS) has two programs that address tobacco/nicotine prevention and cessation directly, and these programs will continue in the 2019-2024 cycle. The Healthy Neighborhoods Program provides home visits from a SCPHS public health nurse (PHN) to approximately 400+ households annually. The PHN assesses the home environment, identifies asthma triggers such as smoking, and (when applicable) provides education on tobacco/nicotine prevention and refers

interested clients to "The Butt Stops Here" program, which provides tobacco/nicotine cessation program options. The second program, Healthy Schenectady Families (HSF), is an evidence-based, free and voluntary home visiting program for pregnant women and parents of infants and toddlers, which currently serves over 150 families in Schenectady County. The services, which may continue for three to five years, provide support, nurturing, and education to help parents with the changes and needs of their family that can come along with the birth of a child. HSF provides home visitors in collaboration with Schenectady County Public Health Services and Cornell Cooperative Extension, Schenectady County, and provides both screening for tobacco/nicotine use and tobacco/nicotine prevention education, and then provides appropriate referrals and/or education.

To further address nicotine/tobacco use in our county, SCPHS also co-hosts with Ellis Hospital, the Schenectady Coalition for a Healthy Community, in which SCPHS works closely with the Tobacco Free Communities on policy and prevention work, and will continue to promote this work this cycle utilizing their evidence-based Reality Check program which is geared towards preventing youth from starting to use any nicotine products, and is a program that is integrated in the high schools in our county. In addition, SCPHS has a newly formed partnership with the Cancer Prevention in Action group (funding and programming support for this group is provided by the CDC), and has received a commitment from them to support the Tobacco Prevention policy work that SCPHS is currently involved with, as well as support future related endeavors. SCPHS has also committed to both support and promote the work currently being done by both New Choices Prevention and Hometown Health Centers, which are providing education on tobacco/nicotine prevention as well as prevention and education programs on vaping specifically, in both the middle and high schools in Schenectady County.

2. Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders

a. Focus Area: Mental and Substance Use Disorders Prevention

SCPHS is a registered provider of Naloxone and has a registered Naloxone trainer. SCPHS will continue to hold monthly Naloxone trainings, which provides training and Naloxone kits for approximately 100 community members annually. In addition, SCPHS is committed to continuing to ensure that each of the Schenectady County departments has at least one person trained in the administration of Naloxone and that there is a kit available in each department.

In addition, to address our county's high opioid burden, SCPHS is the recipient of an Opioid Crisis Funding Grant. The approved work plan for this grant, which commenced on September 1, 2019 (and is expected to be funded for three years), includes evidence-based programs for both treatment and prevention of Substance Use Disorders (SUD) and Mental Health (MH) Disorders. Twenty percent of the SCPHS Public Health Systems Administrator's time is dedicated to spearheading the work detailed in the work plan as well as promoting the current SUD and MH prevention and treatment work; both happening as a result of the grant funding, as well as the work that has been ongoing to address SUD and MH. SCPHS is committed to ongoing promotion of buprenorphine trainings and support for the doctors receiving that training. To enhance this work, SCPHS will be attending trainings and/or conferences and then developing/sharing best practices for Office Based Addiction Treatment, for development of MAT protocols in the ED, and to develop a Training Needs Assessment for local prevention and response efforts.

SCPHS will be working closely with Ellis Hospital and first responders to develop Certified Recovery Peer Advocate (CRPA) protocols to directly connect individuals/friends/family who have experienced an overdose to a CRPA. In addition, SCPHS has a close partnership with Schenectady County Office of

Community Services, and is working closely with the County jail to provide MAT to inmates. To further support the work in the correctional setting, SCPHS will be working towards developing best practice protocols to integrate peer-support during incarceration and to develop a protocol for coordination with CRPAs for inmates upon release from Schenectady County Corrections.

SCHPHS will also be working closely with Ellis hospital to develop safe disposal guidelines and education, and will promote and share the materials developed or sourced. To address Mental Health, SCPHS will continue hosting their Trauma Informed Community Work Group, in which over 20 community-based organizations are represented.

SCPHS will also develop (and co-host) a Co-Occurring Disorders Awareness (CODA) Prevention Work Group, in which the following topics will be addressed: Increased awareness and understanding of co-occurring disorders for youth, increased early intervention for mental health challenges and substance misuse leading to a decline in incidence of youth mental health crises, drug misuse, addiction and overdose, increase the likelihood that those already impacted by co-occurring disorders will seek help and support, and this group will encourage youth to positively impact their peers/communities by building connections to each other and being a link to resources.

d. Local Health Department Resources to be Committed

Health Educators and Public Health Systems Administrator will provide ongoing support by either hosting and/or co-hosting work groups and/or coalitions that are directly related to the goals and interventions selected, as cited in Section E.2.

Health Educators and Public Health Systems Administrator will provide ongoing support by providing (or sourcing) training to support goals and interventions selected, as cited in Section E.2.

SCPHS will promote and share relevant materials and resources that address goals and interventions selected, as cited in Section E.2.

SCPHS via their Healthy Neighborhoods Program and Healthy Schenectady Families program, will provide referrals to programs that address the goals and interventions selected (as cited in Section E.2) when applicable to the community members the programs serve.

SCPHS will collect data (as available) that is related to the goals and interventions selected, as cited in Section E.2.

e. Roles and Resources of Others

Sunnyview Rehabilitation Hospital will continue their ongoing support and partnership, and as appropriate will refer their clients to: smoking cessation programs, MAT programs, utilization of CRPAs when needed, and disseminate materials that are related to the goals and interventions selected. Sunnyview will also inform Ellis and SCPHS if they notice a significant increase or decrease in referrals to programs.

Referrals (as appropriate) will be made by partners to insurance companies (Managed Care Organizations) that offer Medicaid coverage for nicotine cessation programs and services- i.e., MVP, CDPHP, and Fidelis Care.

New Choices Recovery Center will continue their COTI program to increase referrals to MAT programs, to increase naloxone kits in the community, and to engage schools in SUD prevention and Nicotine Prevention education programs.

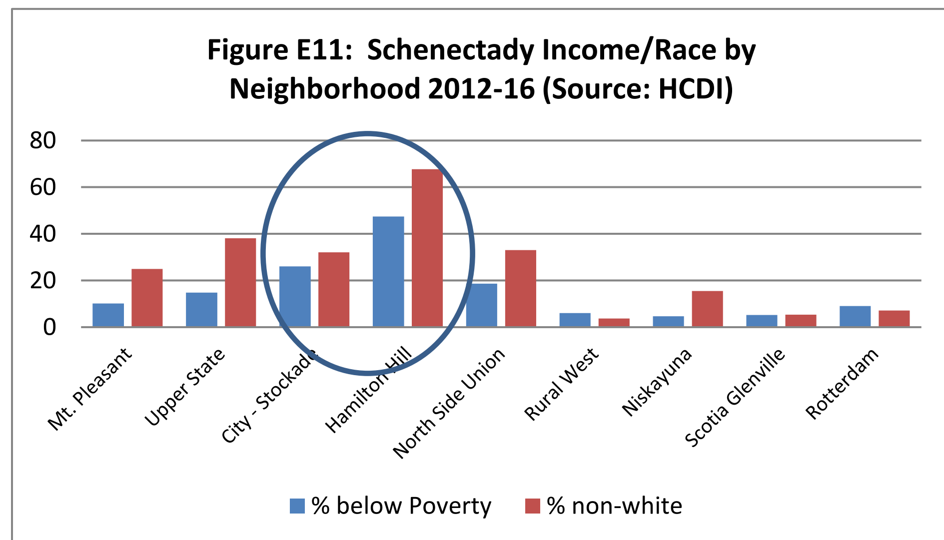
Schenectady County Office of Community Services will provide data on the number of clients in Schenectady County Jail engaged in MAT Services and will also continue to co-host the Trauma Informed Community Work Group.

Hometown Health Center will promote and share any material related to the selected goals and interventions. Hometown Health Center will continue to grow and strengthen their MAT program and referrals to nicotine cessation programs. Hometown Health Center will also provide screening at their school-based clinics to learn more about the need for prevention education on SUD, MH, and Nicotine Cessation, and will work with their providers to ensure that this education (and/or referrals to programs) is provided.

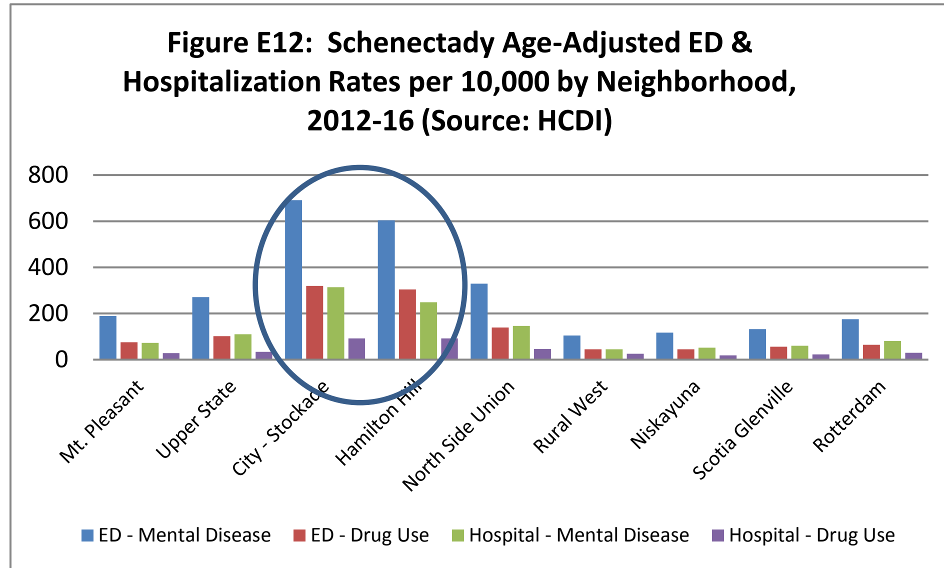
Capital District Tobacco Free Communities and Cancer Prevention in Action will work on policies and education for our schools and for our county to both prevent initiation of nicotine use and to provide policies that reduce the use of nicotine. They both will continue to attend and support The Schenectady Coalition for a Healthy Community.

f. How to Address a Disparity

In Schenectady County, chronic illness, mental health disorder, smoking, and substance use disorder all disproportionately affect our low income community members. (See Figures E11 – E13)

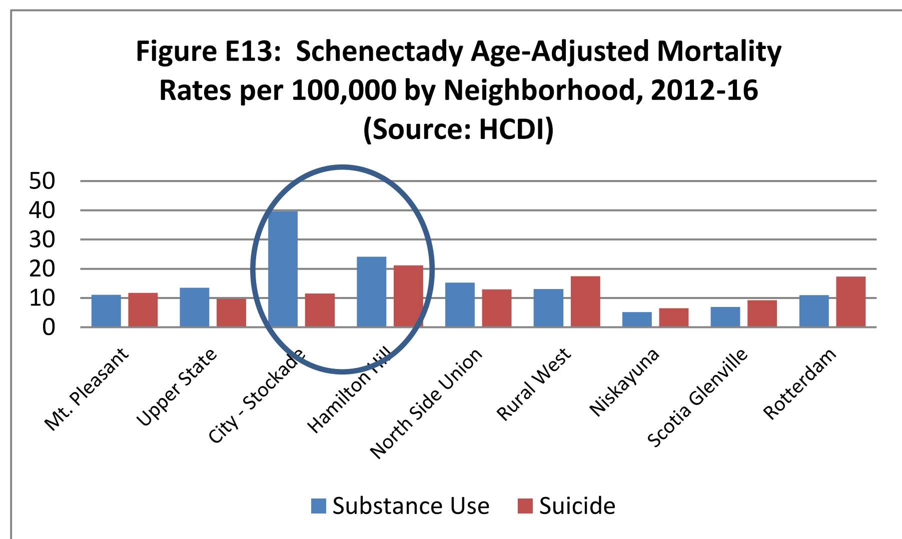


While SCPHS and Ellis will continue to work diligently on addressing these disparities, the objective that we have selected to focus our efforts for the 2019-2024 cycle is to increase the utilization of smoking cessation benefits among smokers who are enrolled in any Medicaid program. While nicotine use has declined among the U.S. population as a whole, the low-income population continues to have the highest rates of use, and smoking is “the leading cause of preventable morbidity, mortality, and health expense in the U.S.” *(Current cigarette smoking among adults - United States,*



2011. Centers for Disease Control and Prevention (CDC). MMWR Morb Mortal Wkly Rep. 2012 Nov 9; 61(44):889-94.). To address this objective, we have selected the intervention, "promote Medicaid and other health plan coverage for tobacco dependence counseling and medications."

Ellis Hospital and Hometown Health Centers have committed to sharing the data of their clients that are attending tobacco cessation programs and/or of those referred to a program. Hometown Health Centers has also committed to providing prevention education and Capital District Tobacco-Free Communities materials in their school based clinics, and New Choices has committed to promote nicotine cessation programs and education within their settings, as well as at the schools they are integrated in. SCPHS and Sunnyview Rehabilitation Hospital will work diligently to promote and refer to nicotine cessation programs for the Medicaid population that each serve, and provide education when appropriate.



4. Process to Maintain Partner Engagement, Progress Tracking, and Mid-Course Corrections

Engagement of local partners over the next three years will be accomplished through the regular meetings and activities of the Schenectady Coalition for a Health Community (SCHC) and its work groups, particularly those focused on the two selected Priority/Focus areas.

SCHC meets at least quarterly, and more often when pursuing a specific project. See Appendix A (page 76) for information about meetings in fall 2018 and through 2019. Each meeting agenda includes

reports from work groups assigned to study and implement a particular project or objective. Agendas are distributed prior to the meetings, and copies of presentations and/or notes are provided at or following each meeting.

Two designated Work Groups will monitor the two selected Priority/Focus areas and formally report at each quarterly SCHC meeting. For the 2019-2021 implementation cycle, in the interest of efficiency and effectiveness, the SCHC membership agreed to designate existing community groups as the Work Groups, rather than create new, single-purpose entities. The existing Capital District Tobacco-Free Communities organization agreed to function as the Work Group for the "Tobacco Prevention" Focus Area. There are a number of existing groups working within the "Mental and Substance Use Disorders Prevention" space including: Trauma-Informed Community Work Group, Substance Use Disorder Prevention Coalition, Suicide Prevention Coalition, Dual Recovery Task Force, Schenectady County Heroin and Opiate Task Force, and Ellis Emergency Department Certified Peer Recovery Advocates and Substance Use Disorder Work Group. The capacity and level of interest of each organization remain under discussion.

This process of actively including a broad variety of different public health issues into the regular activities of SCHC will maintain interest among the many partner organizations, and will help to maintain engagement.

The work groups may also engage jointly with their equivalents in the other five Capital Region counties. With significant overlap in the identified Community Health Needs, all six of the counties will be implementing strategies which will likely benefit from collaborative approaches. Similarities in the 2019-2021 CHIP/CSP priorities include: 1) all counties chose "Prevent Chronic Disease" and "Promote Well-Being and Prevent Mental and Substance Use Disorders" for their top two overarching Priority Areas, 2) all counties chose some aspect of substance use disorder within their Focus Areas, and 3) the counties chose some aspect of tobacco cessation, obesity prevention, or both as another Priority Area. HCDI regularly convenes a "Prevention Agenda Work Group" with representation from all County Public Health Departments and hospital systems. The Work Group met quarterly during 2019.

Tracking of progress to enable mid-course corrections will be built upon these regular work group meetings and quarterly reports to the full Coalition. In addition, staff from Schenectady County Public Health Services and Schenectady County Office of Community Services, HCDI, and the hospitals will track local metrics as they are available to measure progress for each of the goals and outcomes. These reports will serve as the basis for any recommendations of mid-course corrections.

5. Dissemination of CHNA and Executive Summary

The Executive Summary of this Community Health Needs Assessment and Improvement Strategy and Community Service Plan will be disseminated to the public, and the full two-volume document, including 353-page multi-county regional Community Health Needs Assessment (described as Volume Two), will be made widely available to the public.

Electronic copies of the Executive Summary will be affirmatively distributed to all members of the Schenectady Coalition for a Healthy Community, who will be encouraged to further redistribute the information to their component organizations, if any, and to their staffs, volunteers, and program participants. Copies will also be affirmatively distributed to local elected officials and to federal and State elected officials representing the Schenectady area.

The entire document, including the Community Health Needs Assessment, will be posted on the websites of Schenectady County Public Health Services, Ellis Hospital, and Sunnyview Rehabilitation Hospital. As required, the previous (2013 and 2016) CHNAs and Implementation Strategies will remained posted on the hospital websites. Website information is as follows:

- Schenectady County Public Health Services – http://www.schenectadycounty.com/
- Ellis Hospital - http://www.ellismedicine.org/pages/community-report.aspx
- Sunnyview Rehabilitation Hospital - https://www.nehealth.com/About_Us/Community_Health_Needs_Assessment/Sunnyview_-_Community_Health/

Paper copies will be available for inspection by the public at the main offices of Schenectady County Public Health Services, Ellis Hospital, and Sunnyview Rehabilitation Hospital, and at the Schenectady County Public Library. These entities may be contacted by writing or calling the addresses and telephone numbers shown on the Cover Page (page 4) of this document.

An electronic copy of the Community Health Needs Assessment, along with substantial background materials and copies of summary presentations, is available on the website of the Healthy Capital District Initiative (HCDI). This website provides detailed regional comparisons for each of the counties in the Capital Region:

- Healthy Capital District Initiative - http://www.hcdiny.org/

The local news media will be advised of the availability of these documents.

Appendix A - Community Meetings of the Schenectady Coalition for a Healthy Community (SCHC)

- **May 24, 2018**

Topics:

- Potentially establishing a Law Enforcement Assisted Diversion (LEAD) program in Schenectady
- Hometown Health Centers affiliation discussions
- Carver Community Center reestablishment committee
- Community Media Services video production discussion
- Discuss possibility of UMatter2 survey for 2019 Community Health Needs Assessment

Attendees: Schenectady County Public Health Services, Catholic Charities, Schenectady City School District, Bethesda House, Capital District Physicians Health Plan, Healthy Capital District Initiative, Schenectady Inner City Ministry, Schenectady Community Action Program, Ellis Hospital, New Choices Recovery Center, Miracle on Craig Street, LEAD National Support Bureau, Hometown Health Centers, Capital District Tobacco Free Communities, Boys and Girls Club of Schenectady, Ellis Medical Group, Schenectady County Office of Community Services, Schenectady Inner City Ministry, Schenectady County Public Library, The Schenectady Foundation, Schenectady City Mission, Community Media Services

- **June 26, 2018**

Topic – Mission, Vision, and Goals for Trauma-informed Community Work Group

Attendees: Ellis Hospital, Schenectady County Public Health Services, Capital District Child Care Coordination Council, Prevent Child Abuse, Schenectady Community Action Program, Healthy Capital District Initiative, Schenectady County Office of Community Services, Alliance for Better Health, Ellis Medical Group

- **July 19, 2018**

Topics:

- Schenectady Suicide Prevention Coalition
- Regional and County-Specific Mental Health Equity Report
- Trauma-informed Community Work Group report out
- 2019 CHNA report and next steps
- DSRIP Innovation Funds report

Attendees: Healthy Capital District Initiative, Cancer Peer Education Program, New Choices Recovery Center, The Schenectady Foundation, Ellis Hospital, Capital District Child Care Coordinating Council, Boys and Girls Club of Schenectady, University at Albany School of Public Health, Schenectady County Office of Senior and Long-term Care, Schenectady Community Action Program, Bethesda House, Capital District Tobacco Free Communities, Catholic Charities, Schenectady City Mission, Conifer Park, The Community Builders, Prevent Child Abuse, Schenectady County Public Health Services, Schenectady County Office of Community Services, Catholic Charities, Capital District Physicians Health Plan

- **July 31, 2018**

Topic – Initiate Trauma Informed Care Organizational Self-Assessment Tool (TICOSAT) survey

Attendees: Ellis Hospital, Healthy Capital District Initiative, Schenectady County Public Health Services, Schenectady Community Action Program, Bethesda House, Schenectady County Office of Community Services, YWCA of Northeastern New York

- **August 28, 2018**

Topics:

- Trauma Informed Work Group – Common definition of terms
- Trauma Informed Work Group – Time line for TICOSAT survey

Attendees: Northern Rivers, Northeast Parent and Child Society, Victims Advocacy Service of Planned Parenthood Mohawk Hudson, YWCA of Northeastern New York, Schenectady County Office of Community Services, Ellis Hospital, Schenectady Community Action Program, Schenectady County Public Health Services, Healthy Capital District Initiative, Bethesda House, Centro Civico

- **October 18, 2018**

Topics:

- Capital Region Health Connections Health Home – new Health Home replacing Care Central
- Cancer Peer Education Walking Program at Mohawk Harbor
- Special Victims Task Force
- Trauma informed Community Work Group report out
- Opioid Grant activities report

Attendees: Ellis Hospital, Cancer Peer Education, Capital Region Health Connections, The Legal Project, Schenectady County Public Health Services, Empower Health, Catholic Charities, Capital District Center for Independence, Schenectady Inner City Ministry, Schenectady Works, Scotia-Glenville Substance Abuse Task Force, New York State Division of Criminal Justice Services, Healthy Capital District Initiative, Victims Advocacy Service of Planned Parenthood Mohawk Hudson, St. Peter's Health Partners, In Our Own Voices

- **October 30, 2018**

Topics:

- Trauma Informed Work Group – TICOSAT update
- Trauma Informed Work Group – Trauma Sensitive Schools presentation
- Trauma Informed Work Group – Introduction to Adverse Childhood Experiences (ACEs) for health care professionals course

Attendees: Centro Civico, Schenectady County Public Health Services, SAFE Inc., Ellis Hospital, Schenectady City School District, Schenectady County Office of Community Services, Victims Advocacy Service of Planned Parenthood Mohawk Hudson, The Legal Project, Empower Health, Bethesda House, concerned citizen

- **January 17, 2019**

Topics:

- Ellis Diabetes Prevention Program (DPP) CDC Full Recognition
- Schenectady County Disaster Preparedness Program
- "Asset Limited, Income Constrained, Employed" (ALICE) Project\
- Trauma Informed Community Work Group Report
- Mayor McCarthy's Health Care Education Initiative
- Community Health Needs Assessment Planning Report

Attendees: Ellis Medicine, Conifer Park, Planned Parenthood Mohawk-Hudson, Capital Roots, Tri-County Catholic Charities, City of Schenectady Mayor's Office, Schenectady County Public Health Services, Bethesda House, United Way of the Greater Capital Region, Boys and Girls Clubs of Schenectady, The Food Pantries for the Capital District, SAFE Inc., New York State Division of Criminal Justice Services, Capital District Physicians Health Plan, Capital Region Health Connections Health Home, Schenectady City School District, Schenectady County Office of Community Services, Katal Center, St. Peter's Health Partners Creating Healthy Schools Project, Healthy Capital District Initiative, Sunnyview Rehabilitation Hospital, Capital District Tobacco-Free Communities, Centro Civico

- **January 25, 2019**

Topics:

- Trauma-Informed Work Group – Developing a Purpose-Driven Culture Workshop
- Trauma-Informed Work Group – Survivor Speak Planning

Attendees: Victims Advocacy Service of Planned Parenthood Mohawk-Hudson, Our Wellness Collective, Schenectady County Office of Community Service, Schenectady Community Action Program, New Choices Recovery Center, Centro Civico, Ellis Medicine, 845 Commons Residence, SAFE Inc., Schenectady County Public Health Services, Healthy Capital District Initiative, concerned citizen, Capital District YMCA, Northeast Parent and Child Society, St. Mary's Healthcare Amsterdam

- **February 14, 2019**

Topics:

- CHNA Partner Kick-off – brief discussion of CHNA laws and process
- List and Summary Description of Top-Ranked Community Health Needs
    - Sources and structure of public health data, including Prevention Agenda framework
    - HCDI Rankings process
    - Data summary for each Top Ranked need
- Group Discussion Questions
    - Is there anything on the list which is not a community health need?
    - Is there a community health need which is not on the list?
    - What are the top community health need priorities?
- Next Steps
    - Refinement of needs listing and data
    - Data presentation to community forum
    - Prioritization exercise

Attendees: (CHNA Partners by Invitation) - Schenectady County Public Health Services, Healthy Capital District Initiative, Hometown Health Centers (FQHC), Ellis Medicine, Sunnyview Rehabilitation Hospital

- **February 22, 2019**

Topics:

- Trauma-Informed Work Group – Employee Wellness and Employee Assistance Programs

Attendees: Ellis Medicine, Victims Advocacy Service of Planned Parenthood Mohawk-Hudson, St. Mary's Healthcare Amsterdam, Bethesda House, Schenectady County Public Health Services, Schenectady Community Action Program, 845 Commons Residence, Centro Civico, SAFE Inc., Capital District YMCA, New York State Police

- **March 7, 2019**

Topics – Day One of CHNA/CHIP Prioritization Exercise:

- Welcome and Introductions – Lisa Ayers
- Background on the CHNA/CHIP Process – Dave Smingler
- Introduction to the Prevention Agenda and the Ranking Methodology – Kevin Jobin-Davis
- Structured Review (approx. 10 minutes each) of each Public Health Issue (X 14 Issues – see over)
    - Current and Historical Data – Mike Medvesky
        - Ranking
        - Number
        - Rate
        - Trend
        - Disparity
        - Comments
    - Group Discussion – Kevin Jobin-Davis
        - Does anything especially stand out about this Issue? Do you have newer data or recent experience suggesting different results?
        - How important is the Issue to the community? (unimportant/neutral/important)

Conclusion and Preparation for Day Two – Natalie Prehoda, Jordyn Wartts

Attendees: Healthy Capital District Initiative, Ellis Medicine Board of Trustees, Schenectady County Public Health Service, Ellis Medicine, Alliance for Better Health, Capital Region Chamber of Commerce, New Choices Recovery Center, Planned Parenthood Mohawk-Hudson, Schenectady Community Action Program, Capital District Physicians Health Plan, Capital District Tobacco Free Communities, St. Peters Health Partners, Sunnyview Rehabilitation Hospital, Hometown Health Centers, Schenectady County Public Library, Schenectady County Office of Community Services, Centro Civico

- **March 14, 2019**

Topics – Day Two of CHNA/CHIP Prioritization Exercise:

- Welcome and Introductions – Lisa Ayers

- Report of Siena Survey Results – John Lake
- Review of Process and Goals – Natalie and Dave
- Structured Discussion (approx. 10 minutes each) of each Public Health Issue (X 14 Issues – see over) – Mike, John, Natalie, and Dave
    - Very Brief Data Summary
    - Evidence-based Opportunities/Solutions
    - Currently Available Services/Solutions
    - “Pitches” from Issue Advocates
    - Open Discussion – Surprises, Unknowns, Missing Info, Connections
- “Dot-mocracy” Prioritization Exercise – Natalie and Dave
    - Group selection – dots for top three priorities
    - Open Discussion of Results
    - Potential iterative group selection – combinations, permutations, deletions
- Closing Discussion and Thank You – Lisa Ayers

Attendees: Schenectady County Public Health Service, Ellis Medicine, Capital District Physicians Health Plan, St. Peters Health Partners, Capital Roots, New Choices Recovery Center, Schenectady Community Action Program, Independent Living Centers of the Hudson Valley, Schenectady Inner City Ministry, Planned Parenthood Mohawk-Hudson, Capital Region Chamber of Commerce, Schenectady County Office of Community Service, Capital District Center for Independence, Alliance for Better Health, Capital District Tobacco Free Communities, Bethesda House, Schenectady City Mission, Schenectady County Public Library, Sunnyview Rehabilitation Hospital, Hometown Health Centers, Healthy Capital District Initiative

- **March 22, 2019**

Topics:

Trauma-Informed Work Group general discussion

Attendees: Schenectady County Office of Community Service, Schenectady Community Action Program, St. Mary’s Healthcare Amsterdam, 845 Commons Residence, Victims Advocacy Service of Planned Parenthood Mohawk-Hudson, Capital District YMCA, Ellis Medicine, St. Peters Health Partners (St. Peters Addiction Recovery Center), Schenectady County Public Health Service, Centro Civico, Safe Inc., concerned citizen

- **April 18, 2019**

Topics:

- PAX Good Behavior Game – school-based health promotion
- Vale Urban Farm – healthy nutrition in a low-income urban neighborhood
- CHNA/CHIP Report and next steps
    - Review of NYSDOH Prevention Agenda-endorsed interventions
    - Discuss implementation via existing groups/committees
        - Chronic Disease – Tobacco-Free Communities
        - Wellness – Trauma-informed Community Work Group, Substance Use Disorder Prevention Coalition, et al
    - Implementation/Action Steps
- Partner Updates

Attendees: Schenectady County Public Health Service, New Choices Recovery Center, Hometown Health Centers, Capital Roots, Cancer Prevention in Action, Vale Urban Farm, Healthy Capital District Initiative, Bethesda House, Familial Hypercholesterolemia Foundation, Capital Region Chamber of Commerce, St. Peters Health Partners, Harris Brand Recruiting, Cancer Prevention in Action, Sunnyview Rehabilitation Hospital, Schenectady County Office of Community Service, Ellis Medicine, Capital District Physicians Health Plan, Capital District Tobacco Free Communities, SUNY Schenectady Community College, Schenectady County Public Library

- **April 26, 2019**

Topics:

Trauma-Informed Work Group general discussion

Attendees: New Choices Recovery Center, Bethesda House, Schenectady Community Action Program, Victims Advocacy Service of Planned Parenthood-Mohawk Hudson, SUNY Schenectady Community College, Schenectady County Office of Community Service, St. Mary's Healthcare Amsterdam, Centro Civico Project Needle Smart, Healthy Capital District Initiative, Murray and Zuckerman Inc., Ellis Medicine, Schenectady County Public Health Service

- **May 24, 2019**

Topics:

Trauma-Informed Work Group – presentation on "Getting Ahead in a Just Getting By World"

Attendees: Schenectady County Public Health Service, Ellis Medicine, Healthy Capital District Initiative, Schenectady County Office of Community Service, YWCA, SUNY Schenectady Community College, New Choices Recovery Center, Victims Advocacy Service of Planned Parenthood Mohawk-Hudson, Safe Inc. of Schenectady, Boys and Girls Clubs, Schenectady Community Action Program, Empire State College, Centro Civico

- **June 10, 2019**

Topics:

Schenectady CHNA/CHIP/CSP Planning Meeting

Attendees: Healthy Capital District Initiative, Schenectady County Public Health Service, Ellis Hospital, St. Peter's Health Partners, MVP Healthcare

- **June 28, 2019**

Topics:

- Trauma-Informed Work Group – NYS Trauma-Informed Network
- Trauma-Informed Work Group – Brainstorm Actionable Items for the Year

Attendees: New Choices Recovery Center, SUNY Schenectady Community College, Healthy Capital District Initiative, Victims Advocacy Service of Planned Parenthood Mohawk-Hudson, Schenectady County Public Health Service, Schenectady County Office of Community Service, Schenectady Police Department, St. Mary's Healthcare Amsterdam, Schenectady Community Action Program, Bethesda House, health services consultant

- **July 18, 2019**

Topics:

- "Cancer Prevention in Action" program for Schenectady, Montgomery, and Fulton Counties
- Trauma Informed Community Work Group report
- Community Health Improvement Plan (CHIP) preparation exercise – break into two groups for discussion and selection of specific interventions, including partner roles and resources
    - Focus Area #1: Tobacco Prevention
    - Focus Area #2: Mental and Substance Use Disorders Prevention
- Partner updates

Attendees: Ellis Medicine, Schenectady County Public Health Service, Hometown Health Centers, Healthy Capital District Initiative, Cancer Prevention in Action, Empower Health – Schenectady City Mission, Capital District Physicians Health Plan, New Choices Recovery Center, Capital District Tobacco

Free Communities, St. Peters Health Partners, Schenectady County Office of Community Service, Capital Roots, MVP Healthcare, Schenectady Inner City Ministry, Sunnyview Rehabilitation Hospital

Schenectady County — Schenectady County Public Health Services, Ellis Medicine, St. Peters Health Partners Sunnyview Rehabilitation Hospital

2019 Workplan

Planning Report Liaison Natalie Prehoda
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Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.1 Prevent initiation of tobacco use	Decrease the prevalence of vaping product use by high school students by 5% by 2021.		3.1.2 Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms.	**Output:** • Number of nicotine prevention workgroup meetings held • Number of attendees • Number of educational campaigns used in schools **Intermediate:** • Number of students participating in anti-vaping educational campaigns	The nicotine prevention workgroup will be new for 2020, no meetings occurred in 2019. New Choices Prevention worked in all of the school districts in Schenectady County in 2019 engaging them in programming and education around tobacco use prevention, including vaping.	New Choices Prevention and the Capital District Tobacco-Free Communities will colead the nicotine prevention workgroup. The group will decide what work to focus on around vaping prevention and them implement activities. Additional community based organizations, Ellis Medicine and SCPHS will be engaged in the group as it determines its plan. The Capital District Tobacco-Free Communities and Cancer Prevention in Action will work on policies and education for schools and for the county to both prevent initiation of nicotine use and to provide policies that reduce the use of nicotine.	Interventions planned in 2020 will continue into 2021 along with workgroup meetings.	Local governmental unit	SCPHS via their Healthy Neighborhoods Program and Healthy Schenectady Families program, will provide referrals to programs that address the goals and interventions when applicable to the community members the programs serve. SCPHS will collect data that is related to the goals and objectives and work with Ellis Hospital to report annually.
		Goal 3.2 Promote tobacco use cessation	Increase the utilization of smoking cessation benefits (counseling and/or medications) by 5% among smokers who are enrolled in any Medicaid program by 2021.	A greater proportion of low income residents in Schenectady County use tobacco.	3.2.4 Promote Medicaid and other health plan coverage benefits for tobacco dependence counseling and medications.	**Output:** • Number of Butt Stops Here programs started in Schenectady County **Intermediate:** • Number of participants in the Butt Stops Here program who are enrolled in Medicaid • Number of participants in the Butt Stops Here program with any other insurance coverage	Ellis Medicine currently offers The Butt Stops Here Program. The program was offered 11 times in 2019 with a total of 58 registrants, and 20 completing the program. This completion rate is not unlike other programs in the area. Behavior change is difficult and even more so when addiction is a factor.	Ellis Medicine will continue to offer The Butt Stops Here program and SCPHS and community based organizations will promote the program.	Ellis Medicine will continue to offer The Butt Stops Here program and SCPHS and community based organizations will promote the program.	Hospital	Ellis Hospital will continue their support, growth, and promotion of The Butt Stops Here and referrals to this program from other Ellis practices. Ellis Hospital will collect data related to the goals and objectives and work with SCPHS to report annually.
										Hospital	Sunnyview Rehab Hospital will continue their ongoing support and partnership, and as appropriate will refer their clients to smoking cessation programs (including The Butt Stops Here)
										Community-based organizations	New Choices Prevention will continue to engage schools in nicotine prevention education programs. They will also provide support for the nicotine prevention workgroup.
										Health Insurance Plans	MVP Healthcare, CDPHP and Fidelis Care will continue to offer coverage for nicotine cessation programs and services including medication.
										Federally qualified health care center	Hometown Health Center will continue to provide referrals to nicotine cessation programs and share any related materials within their practice.
										Hospital	St. Mary's Hospital Cancer Prevention in Action Program will work with the Capital District Tobacco-Free Communities on policies and education for schools and for the county to both prevent initiation of nicotine use and to provide policies that reduce the use of nicotine.
										Hospital	The Capital District Tobacco Free Communities (Part of St. Peter's Health Partners Community Health Programs) will work on policies and education for schools and for the county to both prevent initiation of nicotine use and to provide policies that reduce the use of nicotine.

Schenectady County | Schenectady County Public Health Services, Ellis Medicine, St. Peters Health Partners Sunnyview Rehabilitation Hospital

2019 Workplan

Planning Report Liaison Natalie Prehoda
E-mail: natalie.prehoda@schenectadycounty.com

Priority	Focus Area	Goal	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	Increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD) by 5% by 2021.	Substance use disorders disproportionately affect the low income population in Schenectady	2.2.1 Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine	**Output:** • Number of Buprenorphine trainings held in Schenectady County • Number of providers trained • Number of SUD treatment promotional materials distributed **Intermediate:** • Number of people receiving MAT in the Schenectady County Jail	3 Buprenorphine trainings were held in Schenectady in 2019. 12 providers were trained on January 7th. 24 providers were trained on February 7th. 29 providers were trained on May 31st. Events where SUD treatment promotional materials and education were distributed include: Academic detailing for care coordination and/or implementation of MAT on January 7th, 3 locations (Schenectady County Office of Community Services, Hometown Health Center, and Ellis Hospital Social Work Departments); Opioid Crisis Panel Discussion on January 7th, 80 plus participants; Office Based Addiction Treatment at Hometown Health Center (FQHC) on May 30th, 15 trained; Pain Management While Reducing the Risk for OUD on May 31st, 80 plus participants.	SCPHS is the recipient of an Opioid Crisis Funding Grant. The approved work plan for this grant, which commenced on 9/1/19 (and is expected to be funded for 3 years), includes evidence-based programs for both treatment and prevention of Substance Use Disorders (SUD) and Mental Health (MH) Disorders. There will be ongoing promotion of buprenorphine trainings and support for the doctors receiving that training. SCPHS will be attending trainings and/or conferences and then developing/sharing best practices for Office Based Addiction Treatment, for development of MAT protocols in the ED, and to develop Training Needs Assessment for local prevention and response efforts. In addition, SCPHS has a close partnership with Schenectady County Office of Community Services, and is working closely with the county jail to provide MAT to inmates. To further support the work in the correctional setting, SCPHS will be working towards developing best practice protocols to integrate peer-support during incarceration and to develop a protocol for coordination with Certified Recovery Peer Advocate for inmates upon release from Schenectady County Corrections.	SCPHS is the recipient of an Opioid Crisis Funding Grant. The approved work plan for this grant, which commenced on 9/1/19 (and is expected to be funded for 3 years), includes evidence-based programs for both treatment and prevention of Substance Use Disorders (SUD) and Mental Health (MH) Disorders. There will be ongoing promotion of buprenorphine trainings and support for the doctors receiving that training. SCPHS will be attending trainings and/or conferences and then developing/sharing best practices for Office Based Addiction Treatment, for development of MAT protocols in the ED, and to develop Training Needs Assessment for local prevention and response efforts. In addition, SCPHS has a close partnership with Schenectady County Office of Community Services, and is working closely with the county jail to provide MAT to inmates. To further support the work in the correctional setting, SCPHS will be working towards developing best practice protocols to integrate peer-support during incarceration and to develop a protocol for coordination with Certified Recovery Peer Advocate for inmates upon release from Schenectady County Corrections.	Local health department	Provide staff and ongoing support for workgroups and/or coalitions that are directly related to the goals and objectives. SCPHS will promote and share relevant materials and resources that address the goals and objectives selected. SCPHS will collect data that is related to the goals and objectives and work with Ellis Hospital to report annually.
			Reduce all emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate by 5% by 2021.		2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers	**Output:** • Number of Naloxone trainings held in Schenectady County • Number of double sided palm cards distributed - that have COTI Project and Project Safe Point information **Intermediate:** • Number of people who completed naloxone administration training by Schenectady County Public Health Services	In 2019, 12 Naloxone trainings were held in the community and over 100 people were trained.	Schenectady County Public Health Services will continue to hold monthly Naloxone trainings in 2020 and community partners will promote the trainings	Schenectady County Public Health Services will continue to hold monthly Naloxone trainings in 2021 and community partners will promote the trainings	Hospital	Ellis Hospital will continue their support, growth, and promotion of their MAT programs, utilization of CRPAs in the ED, the dissemination of materials that are related to the goals and interventions selected, and continue to co-host the Coalition for a Healthy Community as well as provide meeting space for the Trauma Informed Community Work Group and the Naloxone monthly trainings
					2.2.5 Establish additional safe disposal sites for prescription drugs and organized take-back days	**Output:** • Number of workgroup meetings held • Number of attendees **Intermediate:** • Number of new safe disposal sites established	The Schenectady Coalition for a Healthy Community members have had discussions about the implementation of this project and the group is interested in starting it in 2020.	An existing SUD workgroup in Schenectady will be selected as the lead on this project and members from the Schenectady Coalition for a Healthy Community will be invited to attend the meetings and support the implementation of the intervention.	The established workgroup will continue work into 2021.	Hospital	Sunnyview Rehab Hospital will continue their ongoing support and partnership, and as appropriate will refer their clients to MAT programs, utilization of CRPAs when needed, and disseminate materials that are related to the goals and interventions selected. Sunnyview will also inform Ellis and SCPHS if they notice a significant increase or decrease in referrals to programs
					2.2.6 Integrate trauma informed approaches in training staff and implementing program and policy	**Output:** • Number of Trauma Informed Work Groups held • Number of attendees **Intermediate:** • Number of people who complete Trauma-Informed trainings	Schenectady County Public Health Services and the Office of Community Services co-lead a trauma-informed community group that has representation from over 20 community organizations. The group met a total of 9 times in 2019, with an average attendance of 20. The group provided 3 trainings in 2019: Workplace Wellness: Developing a Purpose Driven Culture Workshop, 25 attendees; Secondary & Vicarious Trauma Training, 13 attendees; and Getting Ahead- In Just a Getting By World, 15 attendees.	SCPHS and The Office of Community Services will continue to lead the Trauma-Informed Community Workgroup. Trainings will be held specific to integrating trauma informed approaches into SUD care and these will be shared widely with the community.	SCPHS and The Office of Community Services will continue to lead the Trauma-Informed Community Workgroup. Trainings will be held specific to integrating trauma informed approaches into SUD care and these will be shared widely with the community.	Community-based organizations	New Choices Recovery Center will continue their COTI program to increase referrals to MAT programs and increase naloxone kits in the community
										Local governmental unit	The Office of Community Services will provide data on the number of clients in Schenectady County Jail engaged in MAT Services and will also continue to co-host the Trauma Informed Community Work Group
										Federally Qualified Health Center	Hometown Health Center will continue to grow and strengthen their MAT program and promote and share any materials related to the selected goals and objectives.