



# CAPITAL REGION PUBLIC HEALTH NEWSLETTER

Issue #3

Hello Everyone,

I hope that you all had a relaxing summer. Now that the summer is officially over, the pace of work life is picking up. Work in full swing often generates time sensitive news which outpaces our quarterly newsletter's distribution schedule and our occasional monthly updates. Therefore, we are going to eliminate the monthly updates and join the world of social media! To keep up with time sensitive public health grants, news and meeting schedules, please like us on [Facebook](#), follow us on [Google+](#) and [LinkedIn](#).

The PHIP data staff has been very busy this summer. In June we completed the [2016 Community Health Needs Assessment](#). This 329-page document is the most comprehensive source of public health data available for the 6 counties of the Capital Region. See the article and links below for more information on this go to resource or connect with our staff to participate in one of the task forces working on the health priorities that were selected based on review of this data by over 300 community stakeholders.

This quarter we are also releasing our first [quarterly disparities report](#). The report provides a thorough analysis of a health issue, which is Obesity and Diabetes this quarter, through the lens of sub-populations in the region such as race, gender, age, and SES. See the article and accompanying report below to learn more about where the disproportionate burden of obesity and diabetes are in the region. It was disturbing to find Diabetes over 50% more prevalent for Black non-Hispanics than White non-Hispanics while hospitalizations and emergency department visits were 4 and 5 times higher respectively!

*Stay in touch,*

Kevin Jobin-Davis  
Executive Director, HCDI



# NEW YORK STATE HEALTH INITIATIVES

## Population Health Improvement Program (PHIP)

Healthy Capital District Initiative (HCDI) hosted its first Community Health Improvement Plan Conference on Wednesday, August 3, 2016 in Latham, NY. Guest Speakers from Bassett Healthcare (5-2-1-0), Dutchess County Health Department, Broome County Mental Health, and Erie County Health Department highlighted their approach to develop a successful Community Health Improvement Plan (CHIP). To learn how your organization can become active in the implementation of the Community Health Improvement Plan contact the planner assigned to your county. Click [here](#) to see the PowerPoint presentation.

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The next PHIP Advisory Council meeting is scheduled for Thursday, November 10, 2016, 9:00 a.m. – 10:00 a.m. at HCDI. Please join us and share with your networks. Contact Amelia Kelly ([akelly@hcdiny.org](mailto:akelly@hcdiny.org)) to join PHIPAC.

# HEALTH DISPARITY

## The State of Diabetes in the Capital Region



Albany



Columbia



Greene



Rensselaer



Saratoga



Schenectady

Each quarter Healthy Capital District Initiative (HCDI) will publish a report focusing on the equity of a particular health issue in the Capital Region. The topic of our first report is diabetes. The report reviews diabetes-related indicators (e.g. prevalence, hospitalization, ED visits and costs) by health equity which includes: geographic area; age; gender; race/ethnicity; and socioeconomic status. Key points are highlighted with information presented via numerous graphs, charts and maps.

Most importantly, this report is meant as a resource for you, and we want to deliver the information to you in a way that best suits your needs. Was the format of the document easy for you to follow? Do you find the length to be appropriate? Let us know! [newsletter@hcdiny.org](mailto:newsletter@hcdiny.org)

### Did you know?

Black non-Hispanic residents in Columbia County had a 3 times higher diabetes-related emergency department visit rate when compared to White non-Hispanic residents, while Black non-Hispanic residents in Albany County had a 6 times higher rate. All counties had 3-6 times higher rates in Black non-Hispanic residents than White non-Hispanic residents.

Similarly, Black non-Hispanic residents in the Capital Region had 2.5 to over 4 times higher hospitalization rates due to diabetes when compared with White non-Hispanic residents. The disparity was largest in Albany County, where rates were 4.2 times higher in Black non-Hispanic residents.

In Columbia County, mortality due to diabetes was 1.2 times lower in Black non-Hispanic residents than in White non-Hispanic residents. However, in the rest of the Capital Region, mortality rates due to diabetes were 2 to over 7 times higher in Black non-Hispanic residents, with the disparity being the greatest in Greene County, where the mortality rate was 7.5 times higher.

Capital Region residents in urban neighborhoods of Schenectady, Albany, and Rensselaer counties were in the highest risk groups for diabetes-related hospitalizations and emergency department residents.

Capital Region residents in the lowest socioeconomic status group had diabetes-related emergency department visit rates nearly 8 times higher than those in the highest socioeconomic status group.

### Capital Region Prevalence

The Capital Region's 2013-14 rate of *obesity* of 27.8% is higher than Upstate NY (24.6%) and the Prevention Agenda objective (23.2%), with Schenectady (32.8%) and Greene (31.4%) having the highest obesity rates;

The Capital Region had a higher physician-diagnosed *diabetes prevalence* rate (8.7%) compared to Upstate NY (8.2%); Greene (10.2%) and Rensselaer (10.0%) had the highest rates in the Capital Region;

Capital Region residents had lower rates for physician-diagnosed *pre-diabetes* (4.8%) compared to residents of Upstate NY (5.9%). Columbia had the highest pre-diabetes prevalence rate of 6.4%;

Capital Region residents had similar rates of receiving a *diabetes test* or blood sugar test within the last 3 years (58.7%) compared to Upstate NY (59.1%). Greene (54.1%) and Albany (59.1%) counties had the lowest diabetes screening rates in the Capital Region.

## QUARTERLY NEWSLETTER TOPIC

### New Community Health Needs Assessment

The NYS Department of Health has asked local health departments (LHDs), hospitals, and community partners to work together in 2016 to address identified community health priorities tied to the Prevention Agenda. The LHDs and hospitals in Albany, Columbia, Greene, Rensselaer, Saratoga, and Schenectady asked HCDI to prepare a comprehensive CHNA for use in the 2016 assessment and planning cycle. The 2016 Capital Region CHNA was completed July 1, 2016; shared with LHDs, hospitals and community partners; and is available on the [HCDI website](#).

The structure of the Report is based on the 2013-2018 Prevention Agenda Priority Areas and presents the most recent data by county and Zip-code aggregate neighborhoods, comparing numbers and rates against the Capital Region, NYS excluding NYC, and the Prevention Agenda objectives. Data are presented by health equity if available.

**The contents of the 329 page 2016 Capital Region CHNA is as follows:**

*Executive Summary:* methodology; key findings;

*Socio-demographic:* age; race/ethnicity; poverty; income;

*General Health Status:* total mortality; leading causes of death and premature death; Years of Potential Life Lost (YPLL);

*Chronic Disease:* respiratory; diabetes; cardiovascular; cancer; obesity;

*Environmental:* lead poisoning/screening; injury; crime; built environment;

*Maternal and Child Health:* prenatal care; birth outcomes; teen pregnancy;

*Infectious Disease:* HIV/AIDS; STDs; vaccine-preventable diseases;

*Mental Health/Substance Abuse:* mental health indicators; alcohol abuse; drug abuse; opiate abuse;

*Appendices*

*Neighborhood-level (Zip code aggregates) data:* sociodemographic; mortality; birth-related; Prevention Quality Indicators (PQI); ED visit, and hospitalization-based indicators; County-specific Assets and Resources;

*Results from the 6 County Capital Region Community Health Survey* (Siena College administered).

The 2016 Capital Region CHNA can be a useful resource document for present and future assessment and planning activities. It is useful for the development of the local Community Health Improvement Plans and Community Service Plans. It identifies key public health issues in the region and counties, as well as high risk populations and neighborhoods. It can also be used for providing baseline data for monitoring and evaluating interventions.

The [HCDI website also contains the 2013 Capital District CHNA](#), which covered the counties of Albany, Rensselaer and Schenectady.

# Resources You Can Use

## Health Data and Links on the HCDI Website

In addition to the 2016 Capital Region Community Health Needs Assessment, there is a wealth of other health data and link on the HCDI Website. HCDI is working to provide its partners with useful Capital Region health information either by topical reports, dashboards, or links to useful health information sites. Here are examples of the health data available through the HCDI website.

### Reports

#### *2016 Capital Region Health Prioritization Meeting Presentations*

Four Capital Region Public Health Prioritization Workgroups (Albany /Rensselaer; Columbia/Greene; Schenectady and Saratoga) were formed to review data analyses prepared by HCDI and to select the top public health priorities. PowerPoint data presentations were given at the meetings to provide summarized available data on the leading problems in each of the Workgroup's service areas. Key health indicators were included in the data presentations for each of the five Prevention Agenda Priority Areas: Prevent Chronic Diseases, Promote a Healthy and Safe Environment, Promote Healthy Women, Infants, and Children, Promote Mental Health and Prevent Substance Abuse, and Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections. Ninety (90) health indicators across the five Prevention Agenda Priority Areas were presented. Available data on prevalence, emergency department visits, hospitalizations, mortality and trends were included for each of the 90 indicators. Equity data for gender, age, race/ethnicity, and neighborhood groupings were presented as available. The PowerPoint data presentations are listed by Prioritization Workgroup and Prevention Agenda Priority Area, and are presently available to Capital Region partners on the HCDI website homepage (<http://hcdiny.org/>).

#### *County and Neighborhood Sociodemographic Data*

[The Sociodemographic data](#) were extracted from the Bureau of Census's 5-Year 2009-2013 American Community Survey for age; race/ethnicity; poverty level; educational attainment; language; disability; and uninsured. These data were available at the county and Zip code levels and were aggregated into sub-county "neighborhoods" that were previously identified by HCDI's Capital Region Partners. County-specific sociodemographic PowerPoint summaries were developed as well

as multiple Zip code and “neighborhood” tables for each of the Capital Region counties

#### *Public Health Indicator Matrix for the Capital Region Counties*

[The Public Health Indicator Matrix](#) presents a list of over 150 commonly used public health indicators for New York State, New York State excluding NYC, the Capital Region, and each of the six Capital Region counties. The indicators are listed by the Prevention Agenda Priority Areas. The Public Health Indicator Matrix contains both rates (age-adjusted, or age specific) as well as the population at risk, and identifies if the counties fall into the 3<sup>rd</sup> or 4<sup>th</sup> risk quartile for all NYS counties

#### *eBRFSS Chart Books*

[The New York State Expanded Behavioral Risk Factor Surveillance System](#) 2013-2014 (2014 eBRFSS) was designed to supplement the Center for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), which is conducted annually in New York State. The purpose of the 2014 eBRFSS was to produce local information on key public health issues. Data for the project were collected from April 15, 2013 to May 10, 2014. The 2014 eBRFSS reached both households with landline telephones and households which only had cell phones. Like the annual BRFSS, New York State's 2014 eBRFSS was designed to be representative of the non-institutionalized adult household population, aged 18 years and older. The Chart Books for the Capital Region and the 6 individual counties are available on the HCDI website.

### **Dashboards**

#### *Community Dashboard*

[The Community Dashboard](#) contains over 130 health and socioeconomic indicators for each Capital District County (Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady) and, where available, by Zip code. The indicators are grouped into topic areas including: Health, Economic, Education, Environment, Public Safety, Social Environment and Transportation. Many of these indicators are available by age, gender and race/ethnicity.

#### *Healthy People 2020 Tracker Dashboard*

[Healthy People](#) provides a framework for prevention for communities in the US. Healthy People 2020 is a comprehensive set of key disease prevention and health promotion objectives. The Healthy People 2020 Tracker allows county comparisons of selected indicators against the national objectives

#### *NYS Prevention Agenda Tracking Indicator Dashboard*

[The NYS Prevention Agenda](#) 2013-2018 is a blueprint for state and local action to improve the health of New Yorkers in five priority areas: Chronic Diseases; Healthy and Safe Environment; Healthy Women, Infants, and Adolescents; Mental Health and Substance Abuse; HIV, Sexually Transmitted Diseases, Vaccine Preventable Diseases and Healthcare-Associated Infections. The Prevention Agenda Dashboard

presents the most current Preventive Agenda tracking indicator data at the state and county levels. It serves as a key source for monitoring progress that communities have made in meeting Preventive Agenda 2018 objectives.

#### *DSRIP Dashboards*

[The Delivery System Reform Incentive Reform Payment \(DSRIP\) Program](#) is a key component of the \$8B New York State Medicaid Waiver that provides funding to fundamentally restructure and improve quality in the safety net health care system to focus on primary and preventive care and reduce avoidable hospital use. The DSRIP Dashboards were developed by NYSDOH and Salient HHS. They will allow access to customizable analytic views of Medicaid Utilization data for development and monitoring of DSRIP initiatives. The Dashboards will offer the public a better understanding of the types of services provided by Medicaid, as well as where and by whom those services are provided.

#### **Data Links (NYSDOH)**

The HCDI website has links to useful community assessment, planning and implementation data sources, both from NYSDOH and elsewhere, making it easier for “one-stop data shopping”.

#### *NYSDOH Community Health Indicator Reports (CHIRS and CHAI)*

[This site](#) links to the Community Health Indicator Reports (CHIRS) and the County Health Assessment Indicators (CHAI). The site contains over 300 health-related indicators. State and county data are available for the majority of these indicators. From this site, nearly 20,000 tables, maps and trend graphs of health-related indicators are available for community health assessment and planning. The CHIRS allows one access to an indicator for all counties in NYS by health topic areas. The CHAI provides access to individual county profiles of these health topics, with direct links to county trend data.

#### *NYSDOH County Health Indicators by Race/Ethnicity (CHIRE)*

[CHIRE](#) provides selected health indicators by race/ethnicity for New York State and counties. Data related to births, deaths and hospitalizations are presented.

#### *NYSDOH County/ZIP code Perinatal Data Profile*

[Vital statistics data](#) for a three-year period are used to create ZIP code-based tables of commonly requested perinatal data. Tables for individual counties are provided.

#### *Leading Causes of Death in New York State*

[This site](#) presents the five leading causes of death in New York State in the past 10 years by age, gender, race, ethnicity region, and county. Statistics on the leading causes of premature death among New York residents is also provided.

#### *Asthma Surveillance Data*

[Asthma surveillance data](#) includes lifetime and current asthma prevalence by selected socio-demographic groups for the U.S. and NYS. In addition, hospital



discharge and emergency department (ED) visit data from the Statewide Planning and Research Cooperative System (SPARCS) are also available at the state, county and ZIP code level. Data on county-specific asthma death rates, both crude and age-adjusted, are also available by region within NYS as well.

#### *Cancer Registry/Cancer Statistics*

[Cancer indicators are provided](#) for both incidence and mortality by county, New York State and New York City. Site (body) of the cancer is available by the above geographic areas and by males and females.

#### *Communicable Disease Statistics*

[Reports](#) of the number of cases and rates for the over 50 reportable communicable diseases in New York State. These data are available New York State, New York State excluding NYC, New York City and at the county level.

#### *Health Data NY/Open Data*

[Health Data NY](#) is an open data site devoted to state data accompanied by targeted public health messaging, expansive metadata and customized visualizations. Health Data NY not only provides raw data, but allows users to analyze and download valuable health data in a variety of formats; review comprehensive metadata; create visualizations of data; and share data and visualizations through popular social media tools like Twitter and Facebook.

#### *Report on Managed Care Plans Performance in New York State*

[These reports](#) provide information on health plan performance with respect to primary and preventive health care, access to health care, behavioral health and enrollee satisfaction. Data are provided for commercial and government-sponsored managed care providers. Enrollment reports show the level of consumer participation in various types of managed care plans.

#### *Vital Statistics (births, pregnancies, deaths)*

[This site](#) provides annual reports containing data tables and charts, presenting information extracted from birth, death, and fetal death certificates. Data such as pregnancies and births by age, race/ethnicity, educational attainment and birthweight as well as deaths by selected causes, race and age are included. Data are presented for New York State by county.

#### **Data Links (Other)**

##### *County Health Rankings-Mobilizing Action Toward Community Health*

[This site](#) was developed jointly by Robert Wood Johnson Foundation, the CDC, and the University of Wisconsin Population Health Institute. It compares the overall health of a county with the health of other counties in the state. Ranking also includes factors that contribute to health such as health behaviors, quality of health care, and social and economic factors.

### *CDC's-Community Health Status Indicators (CHSI)*

[The CHSI site](#) produces county profiles for indicators of health outcomes (mortality and morbidity) health care access, health behaviors, social factors, and physical environment. A key feature of CHSI is the ability to compare the indicators of a selected county with demographically similar “peer counties” nationally. Indicators are also compared to the HP 2020 targets.

### *Kids Well-being Indicator Clearinghouse (KWIC)*

[KWIC](#) provides NYS and county level data for a series of indicators organized by 6 life areas to monitor children’s health, education, and well-being. The website provides the user with mapping and graphing capabilities as well as a data query. Data are gathered from NYS agencies including health, education, social service, labor, and criminal justice.

### *U.S. Census Bureau – American Fact Finder*

[The Census Bureau](#), through American Fact Finder, provides access to data from the Decennial Census, American Community Survey, Annual Population Estimates Program, and other economic and business-related surveys. The Fact Finder data system allows a user to search for data by topic, geography (state, county, city, town and ZIP code), race/ethnic groups and industrial codes.

## **UPCOMING EVENTS AND RESOURCES**

New York State Department of Health Medical Grand Rounds hosted by the Commissioner.

### **From A to Zika: An Update on Zika Virus for Primary Care Providers**

*Thursday, September 29, 2016, 6-8 p.m.*

This presentation will inform clinicians on current evidence about transmission, best practices for laboratory testing and evaluation, potential health effects, and prevention of Zika virus infection.

Stony Brook Medicine – Health Science Center, Level 2, Lecture Hall 2 101 Nicolls Road, Stony Brook NY 11794. Click [here](#) to register.

### **SAMHSA**

Every September, SAMHSA sponsors Recovery Month to increase awareness and understanding of mental and substance use disorders and celebrate the people who recover.

[Click here](#) to print your SAMHSA Recovery Month materials.

# Professional Development Opportunities

## **Stanford Chronic Disease Self-Management Program (CDSMP) 4-day Peer Leader Training**

*October 24-27, 2016 | 9:00am - 4:30pm*

QTAC-NY Program Offices, Albany NY

## **Stanford Diabetes Self-Management Program (DSMP) Peer Leader Cross-Training**

*October 28, 2016 | 9:00 a.m. - 4:30 p.m.*

QTAC-NY Program Offices, Albany NY

To register for trainings click [here](#)

## Grants

### **Community Action Grants Program**

American Association of University Women announces funds to support community-based projects and provide start-up funds for new projects that address the particular needs of the community and develop girls' sense of efficacy through leadership or advocacy opportunities. Applications for AAUW Community Action Grants are open August 1, 2016 – January 15, 2017. Click [here](#) to learn more.

### **Community Education Grant**

Brown Rudnick Charitable Foundation Corp. announces funds to support educational programs that seek to improve inner-city education within eligible cities. Letters of Support are required. There is no application deadline. Click [here](#) to learn more.

### **Aging in Place Programs**

Griswold Cares Foundation announces funds for programs that enhance the quality of life for low-income seniors and adults with disabilities who choose to age in place by providing services such as home delivered meals, transportation, friendly visitors, home chores and repairs, hospice, and respite and caregiver support. The application deadline is October 17, 2016. Click [here](#) to learn more.

### **Baseball Tomorrow Fund**

Major League Baseball Community - Major League Baseball Players Association announces funds to support new programs, expand or improve an existing program, undertake a new collaborative effort, or obtain facilities or equipment necessary for youth baseball or softball programs. The application deadline is October 1, 2016. Click [here](#) to learn more.

### **Media, Water Quality, and Animal Welfare Grants**

Park Foundation announces funds to support animal welfare, quality media, and the protection of the environment. The application deadline is September 30, 2016. Click [here](#) to learn more.

## **Meet Our New Team Members**



### **Caroline Troue, MPH**

Caroline Troue is a Public Health Planner serving Columbia and Greene Counties. Caroline holds a Bachelor of Arts degree in Anthropology from the State University of New York at Oneonta and a Master of Public Health from the University at Albany School of Public Health. Caroline is passionate about the health and wellness of her community and she actively participates and attends local community service events. Caroline has previous experience in breast cancer support and education, and in strategic planning for Greene County Public Health Department. Additionally, she is an experienced lifeguard and swim coach. In her spare time, Caroline enjoys traveling with family and friends, spending time at the local farmer's market, and catching up on her guilty pleasure, reality TV.



## Christine Barry

Christine is a Public Health Intern working with Healthy Capital District Initiative on asthma and diabetes self-management practice guidelines. Christine graduated from the University at Buffalo with a Bachelor of Science in Psychology and a minor in Studio Art. She is currently pursuing her Master of Public Health in Health Policy and Management from the University at Albany School of Public Health. Christine has a strong interest in addressing disparities in health care access and oral health, and the treatment of chronic conditions. In her free time, Christine enjoys drawing and painting, and trying new food recipes.