Schenectady Coalition for a Healthy Community

2013 Community Health Needs Assessment and Community Action Plan

A Consolidated, Multi-Year, Multi-Agency, Community-wide Plan for Action to Improve the Health of People in Schenectady, New York

Also submitted in fulfillment of federal and State government requirements by

- Schenectady County Public Health Services: New York State Department of Health Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) (2014-2017)
- Ellis Hospital (d/b/a Ellis Medicine): Community Health Needs Assessment (CHNA) and Implementation Strategy as required to be filed with the Internal Revenue Service by the Patient Protection and Affordable Care Act of 2010 (2013-2015)

Filed November 15, 2013
Schenectady Coalition for a Healthy Community

- American Cancer Society of Northeastern New York
- Asthma Coalition of the Capital Region
- Bethesda House
- Bigelow Corners Partnership
- BOCES Capit
- Boys and Girls Clubs of Schenectady
- Capital District Center for Independence
- Capital District Child Care Coordinating Council
- Capital District Physicians Health Plan
- Capital District Tobacco Free Coalition
- Capital District Transportation Authority
- Catholic Charities
- City Mission of Schenectady
- City of Schenectady
- Community Fathers, Inc.
- Cornell Cooperative Extension of Schenectady County
- Ellis Medicine
- Fidelis Care
- Girls, Inc.
- Guyanese American Association of Schenectady
- Habitat for Humanity of Schenectady County, Inc.
- Healthy Capital District Initiative
- Hometown Health Center
- League of Women Voters of Schenectady County
- Mohawk Ambulance Service
- MVP Health Care
- Northeast Parent and Child Society
- Optimum Health Chiropractic
- Parsons Child and Family Center
- Planned Parenthood Mohawk Hudson
- Price Chopper
- Rainbow Access Initiative
- Rehabilitation Support Services, Inc.
- SAFE, Inc.
- Schenectady ARC
- Schenectady City School District
- Schenectady Community Action Program
- Schenectady County Community College
- Schenectady County Department of Social Services
- Schenectady County Department of Probation
- Schenectady County Human Rights Commission
- Schenectady County Office of Community Services
- Schenectady County Public Health Services
- Schenectady County Senior and Long Term Care Services
- Schenectady Day Nursery
- Schenectady Free Health Clinic
- Schenectady Inner City Ministry
- Schenectady Municipal Housing Authority
- Schenectady Stand Up Guys
- Schenectady United Neighborhoods
- Seton Health Center for Smoking Cessation
- Sunnyview Rehabilitation Hospital
- The Albany Damien Center
- The Chamber of Schenectady County
- The Schenectady Foundation
- Union College
- Union Graduate College
- United Way
- University at Albany, School of Public Health
- Visiting Nurse Service of Schenectady and Saratoga Counties, Inc.
- YMCA of the Capital District
- YWCA

The principal authors of this document are David Pratt, MD, MPH, Medical Consultant to Schenectady County Public Health Services, and Erin Buckenmeyer, MPH, Epidemiologist at Ellis Medicine, assisted by Isaac Michaels, MPH candidate at University at Albany School of Public Health.
## Table of Contents

Executive Summary 3

I. Introduction
   1. Community-wide Assessment Project 5
   2. Description of the Community 8
   3. Mission and Vision 13

II. Community Health Assessment
   1. Overview and Methodology 15
   2. Significant Community Health Needs
      a. Category A
         i. Asthma and Smoking 16
         ii. Diabetes and Obesity 17
         iii. Emergency Department Inappropriate Utilization 19
         iv. Mental Health and Substance Abuse 20
         v. Adolescent Pregnancy 22
      b. Category B
         i. Arthritis and Disability 23
         ii. Dental Health 24
         iii. Falls 25
         iv. Food Security 25
         v. Neighborhood Safety 26
         vi. Programs for Youth and Adolescents 28
      c. Category C
         i. Community and Coalition Building 28
         ii. Community Health Improvement 29
         iii. Health Professions Education 29
         iv. Subsidized and Free Health Services 30

III. Community Health Improvement Plan/Community Service Plan
   1. Overview and Methodology 31
   2. Community Action Plan Priorities 31
      a. Reduce Smoking and Asthma as Dual Causes of Respiratory Illness 32
      b. Intervene in Diabetes and Obesity in the Greater Community and with Special Focus in the West Indian Population 34
      c. Improve Emergency Services Delivery Assuring the Right Care in the Right Place 36
      d. Develop a Community Approach to the Structure and Delivery of Mental Health Services 37
      e. Support and Evaluate Current Efforts to Reduce Adolescent Pregnancies 38
      f. Interdisciplinary Priority 39
   3. Crosswalks to Legal Requirements
      a. Hospital Community Service Plan – NYSDOH 39
      b. Hospital Implementation Strategy – Internal Revenue Service 45
IV. Communications, Dissemination, and Implementation Strategy

V. Appendices

1. Data Sources
   a. U Matter Community Survey Description 57
   b. Schenectady County Public Health Services REACH MAPP & CAP Description 60
   c. HCDI Community Health Profile Description 62

2. Community Involvement
   a. Schenectady Coalition for a Healthy Community Membership List 63
   b. Lists of Meetings and Participants 64

3. Full Community Action Plan Grid and Materials 70

4. HCDI 2013 Community Health Profile (Volume 2)
Executive Summary

Development of this assessment and plan has been a unique undertaking for the Schenectady healthcare and human services community. This document, a consolidated, multi-year, multi-agency, community-wide plan for action to improve the health of people in Schenectady, New York is the result of the combined efforts of 62 organizations. The Schenectady Coalition for a Healthy Community, informed by multiple credible data sources including a door-to-door survey of community residents, developed this assessment and plan to serve the people of the City and County of Schenectady.

In addition to setting the community’s priorities, action plans, and evaluation metrics for the next three years, this document fulfills certain legal requirements of the Schenectady County Public Health Services (SCPHS) and of Ellis Hospital (d/b/a Ellis Medicine). It will be made publicly available on the hospital and public health department websites, and filed with the federal and State governments. This transparency insures public accountability regarding implementation.

Three of the top priorities identified in Schenectady are consistent with the three Prevention Agenda priorities of the other Capital Region counties; Albany and Rensselaer. This consistency will enable consideration of a Region-wide approach to implementation strategies.

Central to this assessment and plan, the “UMatter Schenectady” survey consisted of more than 280 questions and was administered to over 2,000 residents of the City of Schenectady between February and May 2013 by Community Health Workers and volunteer college students. In addition to the survey results, this plan was informed by secondary data from such sources as the U.S. Census and the New York State Department of Health, and from specialized data sources including a recent federally-funded study of diabetes in Schenectady’s West Indian population.

All told, between November 2012 and October 2013 the Coalition held 28 meetings of healthcare experts, representatives of community interests, and community residents; utilizing government-recommended group-voting techniques to compile a list of 20 significant community health needs, and to prioritize five of these as most requiring community-wide corrective action over the next three years. The five highest needs are:

<table>
<thead>
<tr>
<th>Significant Community Health Need</th>
<th>Critical Indicator Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma &amp; Smoking (Prevention Agenda Item)</td>
<td>A third of surveyed City residents smoke; disparity of asthma hospitalization rate among pediatric population</td>
</tr>
<tr>
<td>Diabetes &amp; Obesity (Prevention Agenda Item)</td>
<td>Highest rates of child and adult obesity in the Region; disparity of high rate of diabetes in West Indian population</td>
</tr>
<tr>
<td>Emergency Department Inappropriate Utilization</td>
<td>Half of Regional ED visits may be preventable; highest utilization among lowest income population</td>
</tr>
<tr>
<td>Mental Health &amp; Substance Abuse (Prevention Agenda Item)</td>
<td>Double the State rate for newborn drug-related hospitalization; opportunity for more coordination</td>
</tr>
<tr>
<td>Adolescent Pregnancy</td>
<td>Highest rate in the Region; Black, non-Hispanic and Hispanic females age 15-17 disproportionately impacted compared to White, non-Hispanic females</td>
</tr>
</tbody>
</table>
Designing measurable, realistic, collaborative action plans for the identified community needs is the end goal of the work described. In the narrative that follows each of the top five needs is addressed and the actions to be taken described. A sixth, “interdisciplinary priority,” pulls together the others.

- The smoking and asthma plan recognizes the interaction of cigarette smoke and indoor air quality. Smoke free environments reduce wheezing in children and adults. Smoking and asthma efforts will be synergistic.

- A recent CDC Racial and Ethnic Approaches to Community Health (REACH) grant earned by the Schenectady County Public Health Services resulted in the development of a plan to address type 2 diabetes in the West Indian population. This is outlined in the REACH CAP (see Appendix 1.b.). Simultaneously addressing obesity further reduces the risk of type 2 diabetes.

- Ellis Medicine, CDPHP, and Mohawk Ambulance all have intervention activities that deal with the overuse of the Emergency Department. Recognizing that there are strong incentives for ED overuse, intervention efforts support the strategy to focus on reducing preventable ED visits.

- Six years ago when a tragic cluster of suicides among teenage girls developed in the city, mental health professionals and civic leaders developed an intervention taskforce. Their efforts were successful in interrupting the outbreak of suicides. The taskforce ceased to function when the suicides stopped. Priority four identifies a need to once again address mental health issues. The former taskforce has agreed to repurpose itself and start working to improve a “system” of services to reduce fragmentation.

- Adolescent pregnancy is widely known to be a complex, often intractable, social problem with no single best practice intervention. Currently in the city, the schools, health centers and Planned Parenthood have ongoing efforts. The Coalition’s plan is to support and buttress these activities, including an evaluation plan to measure success in reducing adolescent pregnancy rates.

- A sixth “interdisciplinary priority” ties together the community with a formalized information sharing process.

The dynamic nature of health services suggests that as further data are collected and analyzed, new directions and new projects will arise from the five highest need areas. This is a desired and beneficial outcome in itself. The strengths of various Coalition partners will be engaged in the action plans to resolve specific, measurable health improvements within each of the five priority areas.

In compliance with government requirements, this document and annual supplemental documents will be posted on the Ellis Medicine (http://www.ellismedicine.org/pages/community-report.aspx) and the SCPHS (http://www.schenectadycounty.com/FullStory.aspx?m=39&amid=808) websites, as well as on websites of partner organizations. It will also be available for public review in printed form at the offices of Ellis Medicine, the Schenectady County Public Health Services, and the coalition partners. The CHNA Implementation Strategy will be attached to and filed with the Ellis Hospital IRS form 990 schedule H.
I. Introduction

1. Community-wide Assessment Project

This document, the planning which went into it, and results expected from it, represent a unique undertaking for the Schenectady community, including the Schenectady County Public Health Services (SCPHS), Ellis Medicine (Ellis) (the trade name for Ellis Hospital), and the community members of the Schenectady Coalition for a Healthy Community (Schenectady Coalition). Although various local entities have engaged in health planning exercises over the course of many years, for the first time this plan is an integrated effort of the entire community, with broad community-wide responsibility for implementation.

As a consolidated document, or Community Action Plan, this is being submitted by various partner organizations in fulfillment of federal and State health planning requirements. It will serve as the Community Health Assessment/Community Health Improvement Plan for 2014-2017 submitted to the New York State Department of Health (NYSDOH) by SCPHS. It will also serve as the Community Service Plan for 2013-2015 submitted to NYSDOH by Ellis Hospital, and as the Community Health Needs Assessment/Implementation Strategy submitted to the Internal Revenue Service in accordance with provisions of the Patient Protection and Affordable Care Act of 2010 by Ellis Hospital.

Most important, however, it is intended to guide the entire Schenectady community to a coordinated, efficient, and effective resolution of the community’s identified health needs, with a particular focus on the needs of underserved populations and neighborhoods.

The idea behind the Plan was conceived in 2012 as a logical extension of the work of the “Medical Home Group,” an informal alliance of community organizations which had been created in 2008 to guide the response to consolidation of the County’s three hospitals. The details of the Plan stem from a series of meetings in the spring and summer of 2013 involving SCPHS, Ellis, and, most importantly, the Schenectady Coalition. The Coalition is made up of representatives of 62 community organizations and groups (see Appendix 2.a.).

The mission of the Schenectady Coalition was to develop a plan that accurately reflects the major health issues facing the community, to design goals and objectives to materially improve target indicators over the triennium, and to then work collaboratively and independently to implement that plan. The vision is to have Schenectady become a healthier, safer community for all its citizens enabled by community involvement at each step along the way.

The Plan was developed to serve as a living health blueprint for the coming years. One may think of it as a construction project with many groups of skilled craftspeople working in coordination to create the final structure. The Plan started with the integration of objective data taken from four sources: 1) a large (2,229 respondent) community survey conducted door-to-door by Community Health Workers and student volunteers throughout all ten City of Schenectady neighborhoods during spring 2013 (the “UMatter Schenectady” survey), 2) the Healthy Capital District Initiative’s 2013 Community Health Profile, 3) a focused MAPP (Mobilizing for Action Through Planning and Partnership) process used by...
SCPHS and its associated detailed Community Action Plan (CAP) developed by the County to address diabetes in the West Indian immigrant population, and 4) certain focused primary data sources including neighborhood crime statistics compiled by the Schenectady Police Department and ambulance call data provided by Mohawk Ambulance Service:

1) “UMatter Schenectady” was a carefully designed, face-to-face city-wide survey of health concerns funded by The Schenectady Foundation and the Carllian Foundation with direct assistance from SCPHS (which provided the services of its medical consultant to provide survey analysis and participate in writing of this document), Schenectady Community Action Program (SCAP) (which recruited and coordinated Community Health Workers), several local colleges and universities (which provided student volunteers and faculty assistance), and Ellis Medicine (which administered the survey-taking and provided the services of its epidemiologist). Other local organizations facilitated data collection, including the Schenectady Municipal Housing Authority (which allowed use of its facilities) and the Mayor of the City of Schenectady, who personally accompanied the door-to-door surveyors on several occasions. The survey was designed by team of epidemiologists from Ellis and the University at Albany’s School of Public Health, working in consultation with a subcommittee of the Schenectady Coalition. Inspired by neighborhood-based health needs surveys conducted in Chicago for over a decade, the Schenectady project completed 2,229 surveys which, depending on branching from certain responses, covered as many as 283 questions. The sampling frames were designed to oversample the least affluent and most underserved neighborhoods and ZIP codes to assure that we heard the voices of those often missed in phone surveys. Responses were captured on iPads and directly loaded to a “cloud-based” database using the internet at the point of survey. Further data analysis was conducted using SPSS, a software package for statistical analysis marketed by IBM and widely used for academic and business purposes.

2) The Healthy Capital District Initiative’s 2013 Community Health Profile (published June 2013) is a report compiled from secondary data from the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), and the New York Statewide Planning and Research Cooperative Planning System (SPARCS), displayed to show comparisons among the Capital Region counties and between the region and State/national benchmarks. It also includes results from a survey of residents in the three Capital Region counties conducted largely through the local hospitals and healthcare providers. (See Appendix 4)

3) Schenectady County Public Health Services’ Community Action Plan (CAP) is based on a focused MAPP process and surveys conducted as part of a CDC REACH (Racial and Ethnic Approaches to Community Health) grant to SCPHS addressing type 2 diabetes among Guyanese immigrants to the County.

The process of moving from raw data to determination first of what constitute Significant Community Health Needs, then to assigning the priority level of each, and finally to designing Implementation Strategies within the Action Plan has involved a multi-tiered, multi-participant, sequential journey. Figure 1 shows the process we used to move from the raw data to the Plan’s implementation targets.
Initially, the collected data were independently reviewed with care by three expert reviewers: the hospital’s epidemiologist (who previously served with SCPHS and participated in the REACH grant activities), a professor of epidemiology, and the SCPHS medical consultant (who is a physician with a Master’s degree in Public Health and the former County Commissioner of Public Health). The three reviewers looked at each of the sources. The common themes in the data were sought and each was assessed to be certain that sources agreed on trends.

Figure 1: Schenectady Community Health Plan Process Map

Once the major themes were culled from the data a presentation was made to the whole Schenectady Coalition. Next the data, with refinements, were taken to the Coalition’s Subcommittee on Priorities. Using the Hanlon Method (see: http://www.naccho.org/topics/information/CHAIP/upload/Final-Issue-Prioritization-Resource-Sheet.pdf) of priority ranking as recommended by NYSDOH and the CDC the top priorities were identified.

Then, a small independent group of community health leaders including the County’s Director of Public Health and the Ellis CEO utilized a modified PEARL (propriety, economic feasibility, acceptability, resource availability, legality) criteria (a component of the Hanlon Method) process to further refine relative ranking of the significance of the identified Community Health Needs. The subset of PEARL criteria consisted of:
Economics: Does it make economic sense to address the problem?

Acceptability: Will a solution be acceptable to the community?

Resources: Are the resources available to address the problem?

The results of this combined ranking process were then returned to the full Schenectady Coalition group, which used a Multi-Voting Methodology to make the final determination of priority, resulting in a grouping of the five highest ranking areas which were then presented to the Subcommittee on Action Planning for target setting.

NYSDOH regulations require that each county select at least two health needs priorities from among a list of Prevention Agenda priority areas. It was a fortuitous but not predetermined result of the selection process that four of the five highest ranking areas selected by the community also constitute NYSDOH priorities.

Health disparities were addressed in several ways. There are half a dozen city ZIP codes and neighborhood areas known to have high unemployment and persistent poverty. Traditional surveys often under-sample these areas because of lack of phone landlines and the perception of safety concerns. In an effort to correct for these issues, community surveyors entered these areas several times to guarantee over-sampling. This allowed us to create a sharper picture of the health concerns shared by people living in difficult situations. Our data shows we were successful in collecting surveys from these areas. In the analysis we looked specifically for racial, geographic, and gender differences for many of our topics. The identified disparities were considered by the subcommittees.

All data collection has limitations since it is based on the assumption that the data collected faithfully represents the universe of all subjects under review. Samples never perfectly reflect the entire population for several of the following reasons: lack of interest in participation, fear of surveyors (immigration status), reluctance to give personal information, travel out of town when the data was collected, misunderstanding of the questions (even though this concern was addressed in the surveyors’ training and guidance), and language or literacy limitations (bi-lingual surveyors included Spanish and Arabic speakers). There may be potentially important confounding in use of the UMatter survey data as it appears to have been significant skewed toward the lowest income groups (see section V.1.a.).

2. Description of the Community

Schenectady County

Schenectady County (population: 155,124) 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 (population: 66,078). 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 that make up New York’s Capital Region.
Schenectady County Public Health Service (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 Medicine (the trade name for Ellis Hospital), and a single federally qualified health center (FQHC) – Hometown Health Center. There is also a specialty hospital (Sunnyview Rehabilitation Hospital) which is a member of an Albany-based system.

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, but the County’s poverty rate is below that of the State (see Figure 2 below). For example, the median household income for the City, at $37,436, is only about two-thirds that of the County as a whole ($55,587), which is below that of the State ($56,951). The poverty rate in the City (22.6%) is nearly double that of the County as a whole (12.0%). State Health Department data 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, hospitalizations for conditions related to diabetes range from 604/100,000 in the City’s Hamilton Hill neighborhood to 62/100,000 in the nearby suburb of Niskayuna.

<table>
<thead>
<tr>
<th></th>
<th>Schenectady County</th>
<th>City of Schenectady</th>
<th>New York State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons 65 years and over</td>
<td>15.1% (2012)</td>
<td>11.4% (2010)</td>
<td>14.1% (2012)</td>
</tr>
<tr>
<td>White alone</td>
<td>80.9% (2012)</td>
<td>61.4% (2010)</td>
<td>71.2% (2012)</td>
</tr>
<tr>
<td>Black or African American alone</td>
<td>10.8% (2012)</td>
<td>20.2% (2010)</td>
<td>17.5% (2012)</td>
</tr>
<tr>
<td>Bachelor’s degree or higher (age 25+)</td>
<td>28.8% (2007-11)</td>
<td>18.1% (2007-11)</td>
<td>32.5% (2007-11)</td>
</tr>
<tr>
<td>Persons below poverty level</td>
<td>12.0% (2007-11)</td>
<td>22.6% (2007-11)</td>
<td>14.5% (2007-11)</td>
</tr>
</tbody>
</table>

**Figure 2: Schenectady County, City, and State Demographics**
Source: US Census Bureau, State and County QuickFacts, last revised June 27, 2013

A significant minority population in the City of Schenectady is comprised of West Indians of Guyanese 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. Research conducted by physicians at Ellis Medicine has revealed specific health issues regarding the West Indian population. In particular, the unexpected prevalence of diabetes among non-obese Guyanese males has been 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,” *Prev Chronic Dis* 2013; 10:120211) and helped lead to awarding of a federal Racial and Ethnic Approaches to Community Health (REACH) grant to SCPHS in 2010 (see Appendix 1.b.). The initial planning stage of the SCPHS 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.

Overall, however, Schenectady County residents are more likely than the average New York State resident to have health insurance and a primary care provider (see Figure 3 below). Almost all primary medical care and dental care for low-income residents is provided by Hometown Health 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).

<table>
<thead>
<tr>
<th>Adults 18-64 without any health insurance (2010)</th>
<th>Schenectady County</th>
<th>New York State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with regular health care provider (age-adjusted, 2008-09)</td>
<td>11.1%</td>
<td>16.9%</td>
</tr>
<tr>
<td>Adults who visited doctor for routine check-up w/in 1 year (age-adjusted, 2008-09)</td>
<td>89.6%</td>
<td>87.1% (excl. NYC)</td>
</tr>
<tr>
<td>Adult dental visit w/in past year (2008-09)</td>
<td>74.3%</td>
<td>70.9% (excl. NYC)</td>
</tr>
</tbody>
</table>

**Figure 3: Schenectady County and State Health Insurance and Access Measures**
Source: HCDI, 2013 Community Health Profile

**Ellis Medicine**

 Ellis Medicine (the trade name for Ellis Hospital) is a not-for-profit 438-bed community teaching hospital, and is the sole acute care hospital facility located in Schenectady County. In addition to a hospital facility comprising three campuses, Ellis operates two accredited teaching Residencies (Family Medicine and General Dentistry), the Belanger School of Nursing, a skilled nursing facility (the Ellis Residential and Rehabilitation Center), an “emergent care” facility which provides urgent care services 24-hours-a-day, seven-days-a-week, outpatient adult and child/adolescent mental health facilities, and a number of primary- and specialty-care medical practices under the name Ellis Medicine Group (EMG). Most facilities are located in Schenectady County, although some are located in immediately adjoining portions of Albany and Saratoga Counties.

Ellis was founded in 1885 as the Schenectady Free Dispensary. The current configuration of the hospital was established in 2008 when New York State’s hospital closure commission – the Commission on Health Care Facilities in the Twenty-First Century, or “Berger Commission” – effectively required consolidation of Schenectady’s three hospitals into one. Ellis, the remaining institution, retained the physical facilities of the other two hospitals, resulting in one hospital facility with three Schenectady campuses within less than three miles of each other, operated under one New York State hospital operating certificate: Ellis Hospital (Nott Street, Schenectady), the central site for inpatient physical and mental health services, and emergency services; Ellis Health Center (the former St. Clare’s Hospital, McClellan Street, Schenectady), the site for outpatient services including primary care, dental care, outpatient laboratory and imaging services, patient navigation, and a second emergency department; and Bellevue Woman’s Center (the former Bellevue Woman’s Hospital, Troy-Schenectady Road, Niskayuna), the site for maternity and specialized care for women and infants.
For the purposes of this document, Ellis 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 (see Figure 4). (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 State 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 outcomes 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, has evolved into the Schenectady Coalition for a Healthy Community; 62 community groups including businesses, local government agencies, healthcare and social services providers and community agencies, faith-based organizations, and advocacy groups whose leaders meet monthly at Ellis. (See listing in Appendix 2.a.) 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” for this document 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.

Ellis has developed, and is developing, direct services and strong partnerships which extend beyond Schenectady County. For example, the Medical Center of Clifton Park (MCCP), which opened in October 2012, provides urgent care services 24/7 to residents of southern Saratoga County adjacent to Schenectady County. The building also houses medical offices (including those of EMG) plus diagnostic technology including diagnostic imaging and laboratory facilities. The New York State Department of Health (NYSDOH) has designated Care Central, a consortium of Ellis, Hometown Health, and the Visiting Nurse Service of Schenectady and Saratoga Counties, as a Medicaid Health Home for Schenectady and adjacent Saratoga County. On a much broader scale, Ellis is among the lead partners in the North-Eastern New York Community-based Care Transitions Project, a 10-county, 10-hospital collaborative which has been approved by the Centers for Medicare and Medicaid Services (CMS) to deliver care transition services in order to reduce re-hospitalization rates among Medicare patients. Ellis expects that the focus on population health in Schenectady which is at the heart of this report and its associated Implementation Plan will expand to additional populations in adjacent communities in the years ahead.

Schenectady County Public Health Services

Schenectady County Public Health Services (SCPHS) was officially organized as a full-service County health department in January 1991. Until that time, there had been a Health Department of the City of Schenectady. 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 Care 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. The largest unit of the department is Prevention and Patient Care Services. The primary focus of this unit has been programs and services for children and families. Included are: maternal and child health services provided by public health nurses through home visiting to high risk mothers and infants, lead poisoning screening, and immunizations and STD and TB services provided in its clinic. In addition, 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. The department provides a WIC program (Special Supplemental Food and Nutrition Education Program for Women, Infants, and Children) subcontracted to Cornell Cooperative Extension, Schenectady County. 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 Physically Handicapped Children’s 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.

3. **Mission and Vision**

**Schenectady County Public Health Services**

In the fall of 2011 SCPHS commenced a strategic planning process to set direction, and make decisions on allocating its resources.

The SCPHS management team, comprised of the administrators of each program unit, the Health Education Coordinator, and the Fiscal Manager, participate in regular planning meetings to develop strategic and tactical plans for the agency. The foundation of the strategic plan is the recognition that Schenectady County Public Health Services is a major positive force for health and health related activities in the County. The Department is well aware and sensitive to the fact that improvement and progress in the health status of its community is realized though basic social and environmental factors and can be accomplished only in collaboration with the community at large. The department is recognized as an enthusiastic collaborator with other community agencies.

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

**Ellis Medicine**

The Board of Trustees of Ellis Medicine (the trade name for Ellis Hospital) made significant changes to the organization’s statement of Mission, Vision, and Values in December 2012.

Foremost was the formal recognition of community wellness as a core Mission of the organization – modifying its Mission Statement to read: “To meet the health and wellness [emphasis added] needs of
our community with excellence.” Previously, the Mission Statement had been “To meet the healthcare needs of our community with excellence.”

In addition to this formal recognition of community wellness as a core Mission, the Trustees made several modifications to the listing of Vision (the framework for goals) and Values (principles, standards, and qualities) which govern the organization. The current statement of Vision now encompasses the provision of “world class health care” by “providing patient centered care,” “collaborating with our physicians,” and “striving for results in the top 10% of available national comparative data bases by 2017.”

Values are separated into Core Values of Integrity, Safety, Compassion, Excellence, and Stewardship; and Aspirational Values of Patient Satisfaction, Clinical Excellence, Physician Loyalty, Hospital Pride, and Innovation.
II. Community Health Assessment

1. Overview and Methodology

The **Community Health Assessment** has been a multi-resource, multi-participant, sequential process which distilled significant primary and secondary health, social, and demographic data into fifteen prioritized **Significant Health Needs** (sections II.2.a. – c.) five of which drive Schenectady's **Community Action Plan** (sections III.2. and III.3.a.). Three of these needs, which include a disparity, (Asthma and Smoking, Diabetes and Obesity, and Mental Health) are also the Capital Region’s (Albany, Rensselaer, and Schenectady Counties) **Prevention Agenda Priorities**, and will drive region-wide improvement initiatives over the life of the NYSDOH Prevention Agenda. All of the significant health needs will be discussed in Ellis Hospital’s IRS-required **Implementation Strategy** (section III.3.b.).

The methodology drew heavily on the requirements and guidance of the **New York State Commissioner of Health’s Prevention Agenda**, and of the applicable regulations of the **Internal Revenue Service** regarding **Community Health Needs Assessments for Charitable Hospitals**. As discussed in some detail in the Introduction (see section I.1. Community-wide Assessment Project) and the Appendices (see sections V.1.a. - c.), the process started with four comprehensive current local data sources, proceeded through expert evaluation of the raw data and presentation to community representatives, broad community consideration of the expert recommendations, more selective community priority ranking (using the Hanlon Method with a second tier application of modified PEARL criteria), and final ranking by the members of the Schenectady Coalition for a Healthy Community using a Multi-Voting Methodology.

The needs are ranked into three categories, within which they are then presented and discussed in alphabetical order. The top-ranked grouping, Category A, consists of five needs which the Schenectady Coalition determined to be most significant. These (see sections II.2.a.i. - v.) drive specific, actionable Community Health Priorities (see sections III.2.a. – e.) which include measurable process and outcomes metrics. The second tier, Category B, consists of six needs which were identified by the assessment process but which the Schenectady Coalition members did not determine to be of the highest priority. Ellis Medicine will engage in some responses to some of these as part of its PPACA-required Implementation Plan (see section III.3.b.), and other community agencies may also respond as part of their own mission. These needs may be addressed in future Community Action Plans. The third tier, Category C, consists of four needs which are currently being addressed by Ellis Medicine and SCPHS. The Schenectady Coalition recommended that Ellis and SCPHS continue to address these needs.

These significant community health needs are described in a format which describes priority ranking and relationship with other planning elements (such as the Prevention Agenda), provides a narrative and graphical discussion of the significance of the need within the Schenectady community, with specific reference to the four initial data sources, and then for Category A discusses the reason(s) why the Schenectady Coalition determined the need to be among the highest local needs priority.
2.a.i. Asthma and Smoking

The UMatter survey revealed very high rates of smoking in the City of Schenectady – of those surveyed, 52.8% have smoked at least 100 cigarettes in their lifetime and 37.1% are current smokers. At the same time, there appears to be motivation to quit – of current smokers, 49.2% have tried to quit within the past year, with the majority of these (65.2%) “going cold turkey.”

The very high rates of smoking appear to be restricted to the City, and it is possible that these are impacted by the low-income skew of the UMatter survey. Nonetheless, while Schenectady County as a whole, at a smoking prevalence rate of 17.4%, falls mid-way between Albany and Rensselaer Counties in the region, and is roughly equivalent to the New York State and national rates, all of these exceed the New York State goal rate of 15.0%.

There is a significant age-related disparity in asthma hospitalization rates in Schenectady County. Although the rate of pediatric asthma exceeds the all-ages rate by 31% Statewide, and 19% in Albany and Rensselaer Counties; the disparity in Schenectady is 54%.

The Schenectady Coalition placed smoking and related asthma in the highest priority
level for three reasons:

- The very high rate of smoking in the City as shown by the UMatter survey.
- The significant opportunity for successful positive interventions as shown by the number of smokers who have tried to quit.
- The capacity within the community to deliver interventions, given the number and capacity of existing smoking-cessation programs.

2.a.ii. Diabetes and Obesity

<table>
<thead>
<tr>
<th>Local Health Needs Priority Category</th>
<th>Highest Tier (A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Prevention Agenda Priority Group</td>
<td>Prevent Chronic Disease</td>
</tr>
<tr>
<td>Schenectady County/Capital Region CHA Priority</td>
<td>Yes</td>
</tr>
<tr>
<td>Community Action Plan/CHIP Status</td>
<td>Yes – Priority</td>
</tr>
<tr>
<td>Hospital Implementation Plan Status</td>
<td>Yes – Obesity and Diabetes</td>
</tr>
</tbody>
</table>

Schenectady serves as an interesting laboratory for the prevention of diabetes and the treatment of people with the disease. The County shows high rates of obesity, particularly among males (38.5%); exceeding the other Capital Region counties as well as the State average. This measure has been getting worse over time, with adult obesity in the County increasing by 37% between 2003 and 2008-09, a higher rate of growth than in the other two counties.

UMatter survey respondents in the City of Schenectady are even more obese, with 45.0% categorized as obese or severely obese and an additional 30.9% overweight, for a total of 75.9% of the City's population above their ideal weight. The median BMI among UMatter respondents was 30.6, which is characterized as “obese.” Additionally, the UMatter survey showed that obesity currently peaks in the relatively young 35-44 year-old age group, suggesting that diseases and disabilities resulting from obesity will increase as this cohort ages.

Although there are many reasons why people become obese, one potential cause is a lack of access to healthy foods. HCDI data show that Schenectady County’s low-income residents have relatively less access to supermarkets than do their counterparts in the rest of the Region and State.
Obesity may lead to diabetes, a serious health concern. Schenectady County measures the highest rate of hospitalizations for short-term complications in the Region, exceeding the Prevention Agenda objective by nearly a third.

Within the City of Schenectady, however, the West Indian population has presented with unexpectedly high rates of diabetes, especially among non-obese males. Pioneering medical studies at Ellis Hospital (see for example: Hosler, Pratt, Sen, Buckenmeyer, Simao, Back, Savadatti, Kahn, Hunt, “High Prevalence of Diabetes Among Indo-Guyanese Adults, Schenectady, New York,” Prev Chronic Dis 2013; 10:120211) have identified potential genetic causes for the disease. Of UMatter respondents, 11.6% have type 2 diabetes and an additional 13.9% have been told that they have pre-diabetes. HCDI data show that the age/sex-adjusted diabetes rate in the City of Schenectady’s Hamilton Hill neighborhood, home of many West Indians, is the highest in the Capital Region, and is twelve times that of the nearly adjacent Town of Niskayuna.

Complications from diabetes can be very significant. According to HCDI, Schenectady County has the region’s highest rate of diabetes prevalence and the highest rate of hospitalizations for short-term complications of diabetes. Within Schenectady’s high-needs 12307 ZIP code area, NYSDOH data show that the rate of all diabetes hospitalizations is 315% of the expected rate, rising to 548% of expected for short-term complications.

The Schenectady Coalition placed diabetes and obesity in the highest priority level for three reasons:

- The high rates of both diabetes and obesity, with particular concern that prevalence among relatively young residents suggests significant health issues, including complications of diabetes such as lower-limb amputations, will arise in the years ahead.
- The potential for community involvement in environmental solutions to the problem of obesity, such as improved access to healthy food and increased opportunities for physical exercise.
- The amount of research already conducted by the medical community and preparation already completed using the SCPHS REACH grant to resolve the special situation of diabetes within the West Indian population.
2.a.iii. Emergency Department Inappropriate Utilization

<table>
<thead>
<tr>
<th>Local Health Needs Priority Category</th>
<th>Highest Tier (A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Prevention Agenda Priority Group</td>
<td>None</td>
</tr>
<tr>
<td>Schenectady County/Capital Region CHA Priority</td>
<td>No</td>
</tr>
<tr>
<td>Community Action Plan/CHIP Status</td>
<td>Yes – Priority</td>
</tr>
<tr>
<td>Hospital Implementation Plan Status</td>
<td>Yes – Inappropriate ED Utilization</td>
</tr>
</tbody>
</table>

Ellis Medicine operates two separate Emergency Departments located within a mile of each other, an artifact of the previous configuration of two separate general hospitals. With a combined utilization approaching 90,000 visits per year, the busiest in the Capital Region, neither facility is large enough to handle the volume by itself. Ellis is currently engaged in a $61 million capital construction project, scheduled for completion in 2015, to expand the size of the Nott Street Emergency Department so that it can accommodate the combined volume. The facility at the McClellan Street facility would then be converted to an urban urgent care center, seeking to provide neighborhood residents with a more efficient alternative when their care needs are not actual emergencies.

HCDI received a HEAL9 grant from NYSDOH to evaluate Emergency Department utilization in the Capital Region. The 2010 final report, based on 2007 and 2008 data, found that nearly half (48%) of all Emergency Department visits in the Capital Region were potentially preventable; they could have been treated in a primary care setting, or could have been avoided if the patient had received timely primary care. The 2007 rate for Schenectady’s hospitals (then Ellis and St. Clare’s) was 41% potentially preventable, slightly better than average, but the highest rate of non-emergent Emergency Department visits (206.5 non-emergent visits per 1,000 population) came from Schenectady’s Hamilton Hill neighborhood. All told, four of the top ten neighborhoods for non-emergent visits were in Schenectady.

The more recent UMatter survey found that 35.1% of the City of Schenectady respondents had visited an Emergency Department with the past year. Utilization is generally related to income, with people whose incomes are less than $10,000 per year two and a half times more likely (42.1%) to have gone to an
Emergency Department than people with incomes over $71,000 (16.0%).

Call data provided by Mohawk Ambulance show that the highest rate of ambulance calls from Schenectady addresses for transport to the Ellis Emergency Department are for difficulty breathing and falls, both reasonably qualifying as emergencies. Other calls would not seem to qualify as emergencies, including: foot pain, anxiety, toothache, and obesity.

Ellis has attempted, with some success, to encourage patients with non-emergent needs to utilize more appropriate settings. Since 2009, Health Services Navigators stationed at the McClellan campus have scheduled primary care appointments as follow-ups to Emergency Department visits, and as a result several hundred patients have established care at the Family Health Center. Onsite Medicaid facilitated enrollers have helped uninsured patients to apply for Medicaid, reducing the share of uninsured patients at the McClellan Emergency Department to about 20% in 2012 from 25% in 2008.

The Schenectady Coalition placed inappropriate Emergency Department utilization in the highest priority level for two reasons:

- Inappropriate utilization is not only inefficient and expensive, but it may result in harm by delaying care needed by patients with a genuine emergency. In addition, utilization of the ED as a patient’s source of primary care is likely to result in gaps in continuity of care.
- Ellis’ emerging realignment of care – expansion of the Nott Street Emergency Department, conversion of the McClellan Street facility to an urban urgent care center, and development of the “emergent care” facility in Saratoga County – provides a window of opportunity for the community to collaborate to maximize efficiency and quality care. Ellis is also evaluating the effectiveness of various population health initiatives, adding non-facility resources such as care management to the mix.

### 2.a.iv. Mental Health and Substance Abuse

<table>
<thead>
<tr>
<th>Local Health Needs Priority Category</th>
<th>Highest Tier (A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Prevention Agenda Priority Group</td>
<td>Promote Mental Health and Prevent Substance Abuse</td>
</tr>
<tr>
<td>Schenectady County/Capital Region CHA Priority</td>
<td>Yes</td>
</tr>
<tr>
<td>Community Action Plan/CHIP Status</td>
<td>Yes – Priority</td>
</tr>
<tr>
<td>Hospital Implementation Plan Status</td>
<td>Yes – Mental Health and Substance Abuse</td>
</tr>
</tbody>
</table>

Mental Health concerns were a significant focus of Ellis’ previous (2010-2012) NYSDOH Community Service Plan as the community was then reacting to an extraordinary, nationally-studied, epidemic of suicides among female, black, teenagers, referred to as the “Schenectady Suicide Cluster.” In response, the community came together to coordinate services between providers and the school system, and to push adolescent preventive services into the school environment. A NYSDOH HEAL18 grant enabled expansion and relocation of the Ellis Child and Adolescent Outpatient Mental Health Services to the McClellan Street campus, where it is co-located with Family and Pediatric Health clinics and (until mid-
2013) with a school district outreach office. The approach was successful. Between 2009 and mid-2013 there have been no additional teenage suicides.

Overall, Schenectady’s self-reported measurement of mental health is actually rather positive. The basic metric of “Adults Reporting 14 or More Days with Poor Mental Health in the Last Month” not only places Schenectady (at 9.6%) in the middle of the Capital Region (Albany is high at 10.4% and Rensselaer is low at 9.2%), but is better than the New York State average (10.9%) and even is better than the Prevention Agenda objective of 10.1%.

Nonetheless, Schenectady’s mental health provider community has expressed significant concerns regarding access to care, particularly during the State’s transition to managed behavioral health services for Medicaid recipients and for uninsured individuals. A potential harbinger of access issues was identified by the UMatter survey’s questions regarding depression. Of the 24.9% of respondents who have been diagnosed with depression, nearly a third (32.1%) of those diagnosed (which represents 8% of all respondents) are not currently taking medication or receiving treatment. (There is some possibility that this response stems from the language of the questions – “have you ever been diagnosed with depression?” and “are you currently being treated?” – but since treatment is typically long term, the issue warrants further investigation.)

Other aspects of depression from the UMatter survey warrant further evaluation. For example, rates of depression vary by neighborhood, with the highest rate (Stockade, 43.8%) nearly three times the lowest (Union Street, 15.2%).

And, in an issue cutting across mental health and women’s services, more than a quarter (26.7%) of women who have been pregnant within the past five years say they suffered from depression following birth. By way of comparison, the CDC estimates that 10% to 15% of all new mothers in the United States have depression.

A troubling item regarding substance abuse is the growing newborn drug-related hospitalization rate. Not only is Schenectady’s rate the highest in the Capital Region and more than double the State average,
but the rate has nearly quadrupled over the past five years. As shown in the graph below, the numbers are disturbing and the trend is unfavorable.

The Schenectady Coalition placed mental health and substance abuse in the highest priority level largely because of concerns about possible future access limitations. In addition, however, Schenectady’s history of highly effective intervention around the suicide cluster suggests that the community could successfully adopt a team approach to dealing with other behavioral health and substance abuse issues such as drug-related infant mortality.

2.a.v. Adolescent Pregnancy

<table>
<thead>
<tr>
<th>Local Health Needs Priority Category</th>
<th>Highest Tier (A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Prevention Agenda Priority Group</td>
<td>Promote Healthy Women, Infants and Children</td>
</tr>
<tr>
<td>Schenectady County/Capital Region CHA Priority</td>
<td>No</td>
</tr>
<tr>
<td>Community Action Plan/CHIP Status</td>
<td>Yes - Priority</td>
</tr>
<tr>
<td>Hospital Implementation Plan Status</td>
<td>Yes – Adolescent Pregnancy</td>
</tr>
</tbody>
</table>

Schenectady County has the highest rate of adolescent pregnancy in the Capital Region, including the highest rate of adolescent pregnancy among Hispanic women and among white women. The Hamilton Hill neighborhood in the City of Schenectady has the highest adolescent pregnancy rate in the entire region which, at 278.0 per 1,000, is ten times the rate in nearly adjacent Niskayuna (27.6/1,000).

Black adolescents in Schenectady are more than three times more likely, and Hispanic adolescents are more than twice as likely, to be pregnant as whites. And, while the rate for white adolescents is considerably less that for non-whites, it is nearly double the rate for whites Statewide and in adjacent Albany County.

The Schenectady medical community has
been remarkably successful in producing good outcomes in spite of the high risk of adolescent pregnancies. The Ellis Health Center, the primary source of care for many of the adolescent mothers, reported (2012) low birth weight infants at 7.3%, better than the national average of 8.1%, preterm (<37 weeks) at 6.0%, better than the national rate of 11.7%, and an overall C-section rate of 21.7%, well better than the national rate of 32.8% and even better than the overall Ellis rate of 28.6%.

The Schenectady Coalition placed adolescent pregnancy in the highest priority level for three reasons:

- There are significant social costs to adolescent pregnancy, extending far beyond immediate medical costs to include a plethora of negative aspects of childhood poverty, limited preparation for education, and eventual juvenile and adult justice system involvement.
- High rates of adolescent pregnancy, particularly in certain sections of the City of Schenectady, have been an issue for many years.
- The success of the medical community in providing high quality medical outcomes suggests that there may be healthcare system opportunities for interventions with this population.

### 2.b.i. Arthritis and Disability

<table>
<thead>
<tr>
<th>Local Health Needs Priority Category</th>
<th>Middle Tier (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Prevention Agenda Priority Group</td>
<td>Prevent Chronic Diseases</td>
</tr>
<tr>
<td>Schenectady County/Capital Region CHA Priority</td>
<td>No</td>
</tr>
<tr>
<td>Community Action Plan/CHIP Status</td>
<td>No</td>
</tr>
<tr>
<td>Hospital Implementation Plan Status</td>
<td>Yes – see Obesity action items</td>
</tr>
</tbody>
</table>

Just under a third (UMatter: 29.0%, HCDI: 29.7%) of Schenectady residents have arthritis. Most of these people (UMatter: 68.3%) are limited in their usual activities because of joint pain. The impact of this functional limitation is apparent when viewed from the perspective of gainful employment: Of the UMatter respondents who are not working, 40.3% cited disability as the reason for their lack of employment; of these disabled persons, 48.0% have been diagnosed with arthritis.

According to HCDI data, overall arthritis prevalence in Schenectady falls in the middle of the three Capital District counties, with Rensselaer highest and Albany lowest. Women are disproportionately affected in Schenectady, however, where their 37.3% rate is not only the highest in the region, but is 76% higher than the rate for men in the County.
Although the Schenectady Coalition did not include Arthritis and associated Disability in the highest tier of priority, the priority goal which involves reducing obesity (see section II.2.a.ii.) may have a beneficial effect on the prevalence of arthritis, as the UMatter survey found a direct correlation between obesity and joint conditions including arthritis.

2.b.ii. Dental Health

<table>
<thead>
<tr>
<th>Local Health Needs Priority Category</th>
<th>Middle Tier (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Prevention Agenda Priority Group</td>
<td>None</td>
</tr>
<tr>
<td>Schenectady County/Capital Region CHA Priority</td>
<td>No</td>
</tr>
<tr>
<td>Community Action Plan/CHIP Status</td>
<td>No</td>
</tr>
<tr>
<td>Hospital Implementation Plan Status</td>
<td>Yes – Dental Health</td>
</tr>
</tbody>
</table>

Although the majority of people in the City (UMatter: 57.2%) and County (HCDI: 73.0%) of Schenectady have seen a dentist within the past year, more than half (54.7%) of the City residents responding to the UMatter survey have foregone needed dental care because of cost.

There is also a regional disparity in pediatric dentistry; according to HCDI, 40% of the low-income third grade children in Schenectady County have untreated tooth decay, double the rate in Albany County.

Dental health concerns in Schenectady are, on the surface, unexpected. Both Hometown Health and the Ellis Health Center have substantial dental clinics which treat the uninsured and persons on Medicaid, in contrast to many communities where few dentists are enrolled as Medicaid providers. In addition, Hometown Health cooperates with SCSD to provide part-time in-school dental clinics. The providers will explore potential options for additional community outreach.
2.b.iii. Falls

<table>
<thead>
<tr>
<th>Local Health Needs Priority Category</th>
<th>Middle Tier (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Prevention Agenda Priority Group</td>
<td>Promote a Healthy and Safe Environment</td>
</tr>
<tr>
<td>Schenectady County/Capital Region CHA Priority</td>
<td>No</td>
</tr>
<tr>
<td>Community Action Plan/CHIP Status</td>
<td>No</td>
</tr>
<tr>
<td>Hospital Implementation Plan Status</td>
<td>Yes – Participation with community partners</td>
</tr>
</tbody>
</table>

HCDI data show that Schenectady County has the highest rate of mortality in the Capital Region due to falls among people 65 and older, nearly 50% higher than Albany and Rensselaer and ten percent above the State average.

Falls from less than six feet are the second most common reason for ambulance calls in the City of Schenectady. When arrayed by neighborhood, the highest rate of ambulance calls for falls is in the Woodlawn neighborhood, which also has the oldest median age of residents among City neighborhoods.

According to HCDI, “falls are the leading cause of injury deaths among older adults and the most common cause of nonfatal injuries and hospital admissions for trauma.”

2.b.iv. Food Security

<table>
<thead>
<tr>
<th>Local Health Needs Priority Category</th>
<th>Middle Tier (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Prevention Agenda Priority Group</td>
<td>Promote a Healthy and Safe Environment</td>
</tr>
<tr>
<td>Schenectady County/Capital Region CHA Priority</td>
<td>No</td>
</tr>
<tr>
<td>Community Action Plan/CHIP Status</td>
<td>No</td>
</tr>
<tr>
<td>Hospital Implementation Plan Status</td>
<td>Yes – see Obesity action items</td>
</tr>
</tbody>
</table>

Although potentially confounded by the UMatter survey’s apparent overrepresentation of low income respondents, four out of ten of those surveyed ran out of food at least once in the past year; and 13.7% run out of food every month or almost every month. There are substantial variations by neighborhood; only 22.4% of Union Street neighborhood residents ran out of food at all in the year, while the majority
of residents of Hamilton Hill (51.4%), Eastern Avenue (51.0%), and Central State Street (50.2%) have run out at least once.

Physical access to supermarkets may have an impact: 50.8% of the residents in the Union Street neighborhood say that their travel time to grocery shopping is less than ten minutes, while it takes 78.2% of Hamilton Hill residents more than ten minutes to travel to a grocery store. HCDI reports that 9.6% of low-income Schenectady County residents have low access to supermarkets; nearly double the rate of the other two counties and four and a half times the Prevention Agenda goal.

Other resources are available. UMatter respondents participate in the Supplemental Nutrition Assistance Program (SNAP) (42.6%), use food pantries (21.8%), and use hot meal sites (4.4%).

For UMatter respondents, there is a direct correlation between food insecurity and obesity; people who are severely obese are more likely to run out of food than people in any other BMI category. This suggests a “double whammy:” people with limited funds for food purchase cheap but non-healthy foods. As with Arthritis and Disability, although the Food Security need was not selected by the Schenectady Coalition for the highest priority status, other efforts to reduce obesity by increasing access to healthy foods may have a beneficial effect.

### 2.b.v. Neighborhood Safety

<table>
<thead>
<tr>
<th>Local Health Needs Priority Category</th>
<th>Middle Tier (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Prevention Agenda Priority Group</td>
<td>Promote a Healthy and Safe Environment</td>
</tr>
<tr>
<td>Schenectady County/Capital Region CHA Priority</td>
<td>No</td>
</tr>
<tr>
<td>Community Action Plan/CHIP Status</td>
<td>No</td>
</tr>
<tr>
<td>Hospital Implementation Plan Status</td>
<td>Yes – Participation with community partners</td>
</tr>
</tbody>
</table>
A third (UMatter: 32.7%) of City of Schenectady residents say that it is unsafe to walk in their neighborhood during the day, this increases to half (50.3%) who say that it is unsafe to take a walk at night. Safety concerns vary by neighborhood; two-thirds (66.7%) of Hamilton Hill residents say their neighborhood is unsafe at night, while that view is shared by only about half as many (34.6%) Union Street neighborhood residents. Although the vast majority of City residents feel safe in their own homes, overall 6.6% do not feel safe at home and this doubles to 12.9% in Hamilton Hill.

These public perceptions are confirmed by crime statistics. HCDI reports that Schenectady County has the highest age- and sex-adjusted homicide mortality rate, the highest age- and sex-adjusted rate of Emergency Department visits for assault, the highest age- and sex-adjusted hospitalization rate for assaults, and the highest rates of firearm-related crimes, property crimes, and violent crimes among the three counties in the Capital Region. “Assault” is the eighth most common reason for ambulance calls in the City of Schenectady.

An interesting result of the UMatter survey was identification of some neighborhood differences between the public perception of crime and the actual crime rates, the latter drawn from Schenectady Police Department data. Although there is some data inconsistency in geographic boundaries – the Police Department tracks eight precincts rather than the ten neighborhoods – comparisons are close. The public is generally pretty good in evaluating the level of crime in their neighborhood, but people feel that some areas are relatively safer than crime statistics show them to be, while overestimating relative crime in others.
2.b.vi. Programs for Youth and Adolescents

<table>
<thead>
<tr>
<th>Local Health Needs Priority Category</th>
<th>Middle Tier (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Prevention Agenda Priority Group</td>
<td>Promote Healthy Women, Infants, and Children</td>
</tr>
<tr>
<td>Schenectady County/Capital Region CHA Priority</td>
<td>No</td>
</tr>
<tr>
<td>Community Action Plan/CHIP Status</td>
<td>No</td>
</tr>
<tr>
<td>Hospital Implementation Plan Status</td>
<td>Yes – Will support community partners</td>
</tr>
</tbody>
</table>

Schenectadians are somewhat ambivalent about the need for additional programs for youth and adolescents. UMatter survey respondents were about equally split on the topic, with 41.0% saying that there currently are a sufficient number of youth programs and 41.5% saying that there are not enough programs. A substantial number (17.5%) say that they don’t know.

Although the survey did not ask the directly affected youth (because of consent issues, the initial survey was restricted to adults age 18 and over) it is interesting that the three age groups in which the majority of the respondents with an opinion felt there are not sufficient programs were: ages 18-24, the group closest to the “adolescent” category; ages 35-44, likely to be parents of adolescents; and ages 75-84, perhaps grandparents. There is a gender gap on this topic; of those with an opinion, the majority of men (53.1%) think there are sufficient programs, while only 47.3% of women agree.

2.c.i. Community and Coalition Building

<table>
<thead>
<tr>
<th>Local Health Needs Priority Category</th>
<th>Bottom Tier (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Prevention Agenda Priority Group</td>
<td>None</td>
</tr>
<tr>
<td>Schenectady County/Capital Region CHA Priority</td>
<td>No</td>
</tr>
<tr>
<td>Community Action Plan/CHIP Status</td>
<td>No</td>
</tr>
<tr>
<td>Hospital Implementation Plan Status</td>
<td>Continue current efforts</td>
</tr>
</tbody>
</table>

Schenectady actively supports community coalitions and collaborative approaches to providing efficient and effective healthcare, safety, and community services. Membership in the Schenectady Coalition for a Healthy Community is open to all organizations serving Schenectady residents, and includes all major health and mental health providers along with local government agencies (see section V.2.a.). Ellis Medicine provides staff support and physical facilities to support the coalition. There are a number of other coalitions within Schenectady, including the Strategic Alliance for Health (SAH), supported by federal grants and staffed by Schenectady Public Health Services. Ellis, SCPHS, Hometown Health, and St. Peter’s Health Partners (the parent corporation of Sunnyview Rehabilitation Hospital) are all members of the Healthy Capital District Initiative (HCDI), which not only provided data for this assessment, but engages in active planning and evaluation of healthcare needs throughout the three-county region. HCDI has begun to provide services in Columbia, Greene, and Saratoga Counties also. The Schenectady Coalition recommends that efforts at collaboration be continued.
2.c.ii. Community Health Improvement

<table>
<thead>
<tr>
<th>Local Health Needs Priority Category</th>
<th>Bottom Tier (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Prevention Agenda Priority Group</td>
<td>None</td>
</tr>
<tr>
<td>Schenectady County/Capital Region CHA Priority</td>
<td>No</td>
</tr>
<tr>
<td>Community Action Plan/CHIP Status</td>
<td>No</td>
</tr>
<tr>
<td>Hospital Implementation Plan Status</td>
<td>Continue current efforts</td>
</tr>
</tbody>
</table>

SCPHS provides a number of public health community programs including Healthy Schenectady Families, the HUD lead abatement grant, Healthy Homes, Children with Special Needs, and Early Intervention. Ellis engages in a number of community health improvement programs and community benefit operations. These include education and patient education programs. Some of these offer broad information to the community as a whole, such as participation in health fairs and health screening events. Others are targeted at people with specific diseases such as cancer support groups and programs for families of children with diabetes. Programs are open to all members of the community. Ellis also actively supports the Schenectady Coalition and the UMatter survey, with a substantial investment in development of the Community Health Needs Assessment. The Schenectady Coalition recommends that this work be continued.

2.c.iii. Health Professions Education

<table>
<thead>
<tr>
<th>Local Health Needs Priority Category</th>
<th>Bottom Tier (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Prevention Agenda Priority Group</td>
<td>None</td>
</tr>
<tr>
<td>Schenectady County/Capital Region CHA Priority</td>
<td>No</td>
</tr>
<tr>
<td>Community Action Plan/CHIP Status</td>
<td>No</td>
</tr>
<tr>
<td>Hospital Implementation Plan Status</td>
<td>Continue current efforts</td>
</tr>
</tbody>
</table>

Ellis is a teaching hospital with substantial involvement in health professions education. The hospital includes two accredited Residencies – Family Medicine and General Dentistry. The former, originally the St. Clare’s Hospital Family Practice Residency, was the first family medicine residency to be established in the northeast. Of the 18 medical residents completing the program in 2012 and 2013, eight have entered practice in the greater Capital Region, with three of those employed at Ellis. Ellis also includes the Belanger School of Nursing, an accredited institution which prepares students to become Registered Nurses (RN). Of the 49 graduates in 2012, 37 joined the nursing staff at Ellis and the others were employed by other organizations. Ellis cooperates with numerous local medical, nursing, and allied professions colleges and training organizations by providing precepted clinical education to their students. Ellis also provides continuing medical education available to all community physicians through regular Grand Rounds and special education programs. The Schenectady Coalition recommends that, particularly in view of projected shortages of medical professionals, this work should be continued.
2.c.iv. Subsidized and Free Health Services

<table>
<thead>
<tr>
<th>Local Health Needs Priority Category</th>
<th>Bottom Tier (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Prevention Agenda Priority Group</td>
<td>None</td>
</tr>
<tr>
<td>Schenectady County/Capital Region CHA Priority</td>
<td>No</td>
</tr>
<tr>
<td>Community Action Plan/CHIP Status</td>
<td>No</td>
</tr>
<tr>
<td>Hospital Implementation Plan Status</td>
<td>Continue current efforts</td>
</tr>
</tbody>
</table>

Ellis provides and supports numerous subsidized and free health services. According to the most recent IRS form 990, schedule H (2011), Ellis provided $10,011,213 in free or reduced price medical care to patients eligible for charity care or on Medicaid. Ellis lost an additional $5,523,468 (the difference between the cost of care and the amount of reimbursement) in providing care to patients on Medicare, and incurred $4,679,800 in bad debt expense as the result of patients who are unable to pay their bills. Ellis also directly supported the Schenectady Free Health Clinic until its closure in 2013. During 2012, the Ellis provided $306,520 in no-charge laboratory services to the Free Clinic. Residents and faculty from the Family Medicine Residency staff a weekly free medical clinic at the Schenectady City Mission, and a seasonal migrant workers’ free clinic in Columbia County. The Schenectady Coalition recommends that, to the extent that Ellis is able to do so in the face of declining reimbursement from Medicare, Medicaid, and commercial payors, these subsidized services should be continued.
III. Community Health Improvement Plan / Community Service Plan

1. Overview and Methodology

This section describes top five Community Action Plan Priorities, with full details on the actual implementation of each included as Appendix 3. This section also provides “crosswalk” grids to the requirements of the State (three Prevention Agenda Items) and federal (all Significant Health Needs) regulations impacting Ellis Medicine. Schenectady County Public Health Services has adopted the entire Community Action Plan herein as their State-required Community Health Improvement Plan.

Figure 1 (page 7) shows, in graphical form, the process that resulted in the top ranking health priorities for Schenectady. A number of tools were used to assure the selected priorities lent themselves to meaningful interventions. The CDC and NYSDOH recommended using the Hanlon method for priority setting, which was done. In addition, participants in the subcommittee tasked with setting goals were encouraged to comment and vote as the process moved forward. This multistep effort reduced 20 initial priorities to five. Using those five priorities, more meetings helped shape focused goals. Community content experts presented to the goal setting subcommittee and offered their thoughts on the issues and interventions. Further, they helped all involved understand the current programs and how the coalition might leverage successful efforts to get even better results.

An unintended positive consequence of the goal setting effort was the subcommittee and the entire coalition became aware of many programs already at work in Schenectady to address identified concerns.

In some instances the subcommittee set goals to validate a reported problem (for example, high rates of post-partum depression and excess ED use) to be certain that resources were committed to proven problems. In other cases (such as adolescent pregnancy prevention) the goals are to help community agencies get even better at what they do.

It is understood that situations change and that as more is learned about a given problem some of the objectives shown below may change or even disappear if pre-empted.

2. Community Action Plan Priorities (See Appendix 3 for details)

In the Executive Summary (pages 3-4) the five plan priorities (and sixth interdisciplinary priority) are shown. Appendix 3 has a table for each objective with the detailed plans including timelines and those responsible for the outcomes. The terms “project period” and “annual” objectives are used. The “project period” objectives cover the entire three year period and represent the outcome measures of the plan. The “annual” objectives are items that will take place in a given project year. Achievement of the annual objectives should support achievement of the project period objectives.
2.a. Priority 1: Smoking and Asthma

The supporting data is described in section II.2a.i. Increased rates of smoking are strongly associated with coronary heart disease, acute asthma, chronic obstructive pulmonary disease, and cancers of the larynx, lung, and kidney.

Asthma in children and adults has been increasing across the U.S. for several decades. While the explanation for this trend is not completely understood; household allergens, air pollution and second hand smoke all play a role in this important problem.

**Smoking and Asthma Interventions**

*Project Period Objectives:*

1) Decrease asthma hospitalization rate by 5/10,000 within pediatric population
   a) There are a number of existing programs in Schenectady that are contributing to improved asthma outcomes (reductions in ED utilization and hospital admissions). Coordinating these programs should amplify this effect, as evidenced by a model reported at the Boston Children’s Hospital.

2) Decrease prevalence of smoking among mental health patients by 5%
   a) Both our smoking cessation and mental health advocates identified this population as particularly vulnerable and impacted by tobacco addiction.

3) Decrease prevalence of smoking among Schenectady city residents by 5%

*Annual/Multi-Year Objectives:*

1) Increase number of asthma patients who participate in a three-tiered care model (care coordination, home visits/assessments, and asthma education) from 0 to 50/year
   a. Increase by 75% SCPHS visits to the homes of pediatric asthma patients to assess and mitigate triggers plus provide parental guidance in the first year of this effort. Special focus will be given to low income neighborhoods with the highest asthma prevalence
   b. Train 3 additional Public Health Nurses in conducting home assessments and asthma management.

2) Increase number of practices prescribing by NIH guidelines by 5/year

3) Increase by 100 the number of municipal housing units that are smoke-free by 2016. Increase by 100 the number of “affordable housing units” that are smoke-free by 2016

4) Increase by 5 the number of tobacco-free outdoor policies for government, non-profit, and private sector organizations that serve the population with the highest tobacco use rates by 2016

5) Decrease tobacco retailers in Schenectady County by 5%
6) Two mental health service provider facilities in Schenectady County will create a tobacco-free environment and integrate practices that support employee and consumer cessation by January 1, 2015

Community Resources participating in these efforts:

Care Central, operated by Ellis Medicine and Visiting Nurse Service, is a program designed to help patients navigate the health system and coordinate their care. Nurse navigators assist patients in dealing with complex illnesses, systems and processes in an effort to ensure they are receiving appropriate care and reducing their use of the ED and hospital admissions.

Schenectady County Public Health Services operates the Healthy Neighborhoods program that works in conjunction with the Asthma Coalition of the Capital Region. This program sends specially trained public health nurses into homes to help families understand environmental asthma triggers. The nurses advise parents on measures that can be used to help children with asthma. Recently CMS has expanded the funding for this kind of home visiting. Additional funding will allow nurses to reach more children.

Schenectady County Public Health Services’ Environmental Health team operates an Adolescent Tobacco Use Prevention program. The activity employs minors to try to purchase tobacco products at local stores. This “sting” operation can result in fines and penalties for store owners. It has discouraged illegal tobacco sales especially near schools and youth centers.

The Capital District Tobacco-Free Coalition has approached the problem using interventions based on policies, systems, and environmental changes. Currently they have legislation pending in the Schenectady County Legislature to prohibit the sale of tobacco in drugstores or grocery stores with pharmacies. They have been successful limiting advertisements and with age restriction enforcement.

Seton Health’s “The Butt Stops Here” program offers smoking cessation programs in Schenectady. They are committed to reaching out to our mental health clinics (see Project Period Objective 2 above). With the help of Seton’s Center for Smoking Cessation and the Tobacco-Free Coalition, mental health facilities in Schenectady will move towards becoming smoke free over the next three years. To promote this effort they will offer cessation programs to mental health employees on site. Smoke free sites with non-smoking mental health professionals set an excellent example for patients. The Seton program works with the NYSDOH Quit Line.

Sunnyview Rehabilitation Hospital will participate by implementing the Quit Line’s “Opt to Quit” program to ensure that smoking cessation services are available to inpatients following discharge, by providing cessation information to outpatients, and by assisting staff with cessation services.

Ellis Medicine offers an Asthma Care program for people with reactive airways disease to better understand the ailment and how they can control their symptoms. The program follows the NHLBI diagnosis and treatment guidelines and has proven that successful participants can have fewer Emergency Room visits if they follow the program. It is very important that their doctors follow the NHLBI guidelines, too.
2.b. Priority 2: Diabetes and Obesity

Section II.2.a.ii. above outlines the community challenges with type 2 diabetes and obesity. Schenectady’s West Indian population has a strikingly high prevalence of diabetes. Extensive plans to address this group are outlined in the SCPHS REACH CAP (Appendix 1.b.). In Schenectady, the high rates of hospitalization for complications is also concerning. These expensive hospital stays are often associated with long term problems and permanent disability from amputations, blindness and kidney failure. Because there is strong scientific evidence that type 2 diabetes can be prevented, attacking this problem is very attractive.

The obesity problem in New York is well established. Schenectady County has the highest rate of adult and child obesity in the region. Long term problems associated with obesity include diabetes, high blood pressure, sleep apnea, gall stones, arthritis, and coronary heart disease. The interaction of obesity and diabetes allows us to get a synergistic benefit by addressing either one.

**Diabetes and Obesity Interventions** (note the synergistic interaction outlined above)

*Project Period Objectives:*

1) Decrease prevalence of obese students/adults by 5%

2) Increase screening among the West Indian population by 10%
   
   a) This objective is directed at West Indians because of the exceptionally high prevalence among this population

3) Decrease rate of diabetes short-term complication hospitalizations among 18+ population by 2/10,000

*Annual/Multi-Year Objectives:*

1) Increase availability of diabetes self-management classes in 5 faith-based (FB) communities/year

2) Increase number of opportunities for physical activity from 0 to 5/year

3) Three medical practices providing primary care will implement a policy to screen all West Indian adults for diabetes, regardless of BMI or age

4) Increase by 10 the number of municipalities and community based organizations in Schenectady County that have adopted food procurement standards and policies based on the Dietary Guidelines for Americans

5) Increase the number of adult individuals from Schenectady County with diabetes who are members of fitness centers, including such centers at rehabilitation hospitals

Community Resources participating in these efforts:
Schenectady County Public Health Services operates three programs that have been instrumental in addressing obesity in children and adults:

The Strategic Alliance for Health (SAH) brings together community partners interested in all aspects of community wellbeing. SAH has offered small grants that have allowed schools and parks to substantially upgrade their play equipment and make it safer. It has also funded “Peaceful Playgrounds,” an innovative program to increase children’s activity and to encourage conflict resolution. All park improvements come with the stipulation that no smoking signs be posted and that the playground be smoke free. SAH also has supported the renovation of school cafeterias. Pleasant surroundings encourage healthy eating. SAH has made eye level fruit baskets available to school cafeterias to encourage children to select fresh fruit as part of a healthy diet. SAH has also made significant environmental improvements to Schenectady city parks and playgrounds by funding new equipment and walking trails.

SCPHS is one of two county health departments in New York State to be funded to assist in the adoption of food procurement standards and policies in community based organizations and municipalities. Changing the food environment and increasing the demand for healthier food products is central to this work.

Healthy Schenectady Families serves the most vulnerable mother-child pairs in the community. Health workers visit mothers-to-be and help them prepare for their baby. Breast feeding (an important obesity intervention) is encouraged and supported. Guidance towards healthy eating and nutritious foods is provided. Finally, future reproductive choices are described to allow birth spacing and a reduction in repeat adolescent pregnancy in some instances.

Cornell Cooperative Extension, Schenectady County sponsors a summer gardening program for children called Roots and Wisdom. This program offers opportunities for children to grow vegetables and learn how to prepare them for meals. Children also operate a vegetable market stand to sell some of their products. Much of it is given to local food pantries.

Cooperative Extension, Public Health, Schenectady ARC, and Ellis Medicine are currently engaged in a program called Health Shares. Medical residents practicing at Ellis’ Family Health Center are “prescribing” free produce to their patients who have chronic conditions. Produce is grown and harvested from the Central Park greenhouse and pick-up sites have been established in convenient locations. Nutrition education is provided to patients, as well as easy recipes. Changes in clinical outcomes (BMI, BP) are being measured.

Sunnyview Rehabilitation Hospital operates the Sunnyview Lifestyle Wellness Center, with memberships available to everyone in the community, and expects to particularly seek to increase memberships among the West Indian community.

Ellis Medicine has a diabetes education program designed to help people with diabetes better understand the disease and how to remain free of complications and hospital admissions. The program reaches out to children and adults. In addition, as of October 2013 a Certified Diabetes Educator (CDE)
has been embedded into the Family Health Center to provide diabetes education to patients and providers at the point of care. Ellis also offers bariatric surgery to those with morbid obesity and serious co-morbidities. Many of their patients have lost significant weight and normalized their blood sugars.

The Schenectady YMCA offers a diabetes prevention program that provides pre-diabetics with a lifestyle coach, Y memberships and 12 sessions of education and coaching. The program is based on a proven NIH model and has had success in the students enrolled so far. The program is expanding and will soon be taught in venues outside the YMCA.

2.c. Priority 3: Inappropriate Utilization of the Emergency Department

The issue of inappropriate utilization of the Emergency Department is described in section II.2.a.iii. Studies done in the local area and nationally have shown that a large proportion of ED visits are not true emergencies. Such visits are expensive to society and at times supplant establishing an enduring primary care relationship. Further, seeking routine care in the ED may delay the care of other patients with serious problems. Experts explain the perverse incentives to obtain care in this manner (no appointment needed, one stop (e.g., all radiology studies done at one time, medications provided). Hence changing this “logical” pattern of behavior is not likely to be easy. Therefore, the focus will be on reducing ED visits that are preventable (e.g., visits for medication reconciliation, falls, dental issues, uncontrolled asthma).

**ED Inappropriate Use Interventions**

*Project Period Objectives:*

1) A 15% reduction in preventable ED visits over 36 months

2) A 15% reduction in inappropriate ambulance transport

3) Decrease rate of mortality due to falls among the 65+ population by 30/100,000

*Annual/Multi-Year Objectives:*

1) Expand the number of self-referrals to Care Central by 10%

   a) Care Central was described above under community resources for asthma. This care coordination group can pick up patients from the ED and guide them to a more appropriate pattern of care.

2) Conduct study of 500 ambulance calls to assess Paramedics’ estimate of overuse of ambulance transport to ED

3) Conduct falls assessments in 100 homes in the Woodlawn Neighborhood

*Community Resources participating in this effort:*
Care Central will play a pivotal role with high use patients. This program has been well received by the community and by patients. The Nurse Navigators are highly competent and empathetic. They will employ quality improvement tools to measure the impact of this program.

The Ellis Emergency Department will support this effort with HIPAA compliant client identification and coaching.

Mohawk Ambulance is prepared to support a point of service intervention with medical control to explore the possibility of alternative use patterns for their client base. CDPHP is also interested in working with Mohawk Ambulance to get their subscribers to the right care at the right time.

Sunnyview Rehabilitation Hospital offers special expertise in developing assessment tools, providing overall consultation on falls assessment, and conducting individual falls assessments and home assessments.

2.d. Priority 4: Mental Health and Substance Abuse

Objective measurements of mental health patterns for Schenectady appear to be similar to our neighboring communities as described in Section II.2.a.iv. One outlier was the frequency of addicted infants born in the City. Subjective measurements from the UMatter survey pointed to a high rate of post partum depression. Mental health advocates, providers, and mental health quality experts identified additional opportunities for improvement and encouraged making this a priority.

In 2008-2009 a tragic cluster of suicides occurred among African American teenage girls in Schenectady. The community rallied around the issue and established a taskforce of civic leaders and mental health professionals to address the crisis. The taskforce was successful and teen suicides ended. Many of the taskforce members still live and work in the community.

**Mental Health and Substance Abuse Interventions**

Project Period Objective:

1) Document with a large sample the rate of newborn drug-related hospitalizations. If the data support the high rate used in this report (187 drug-related hospitalizations/10,000 newborn discharges in 2010) set a reduction target of 36/10,000 newborn discharges or 20%

Annual/Multi-Year Objectives:

1) Hold four meetings/year of the Mental Health Task Force

2) Conclude study of 100 drug-addicted mother/child pairs

3) Conduct study of 100 post-delivery mothers to evaluate the reported high rate of post partum depression
   a) Providers question this rate and requested validation
Community Resources participating in this effort:

The successful Adolescent Suicide Prevention Task Force was led by Darin Samaha, the Director of the Office of Community Services for Schenectady County. As Director he has responsibility for the County mental health and substance abuse programs. He will lead the reactivated a mental health task force similar to the task force that was successful with the suicides.

Ellis Medicine mental health professionals will serve on the Task Force and provide inpatient and outpatient care.

National Alliance on Mental Illness, a family/relative support group, is active in the community and provided very helpful guidance to the community coalition.

Care Central is piloting a Mentor Program. Peers who are living successfully with mental health conditions are acting as advocates and navigators of the mental health system for mental health patients who are part of Care Central. They assist patients with the transition from inpatient care to care in the community and are working to reduce mental health readmissions.

Union College is located in Schenectady. Union has an ambitious “Leaders in Medicine” Program (LIM) for students on a track to matriculate directly to medical school at graduation. These students are required to have projects that serve the health of the community. The LIM students will be offered an opportunity to help assess the post partum depression problem and the infant addiction rates. Students from the School of Public Health are also potential project interns.

2. e. Priority 5: Adolescent Pregnancy

Schenectady has had an elevated adolescent pregnancy rate for more than two decades. Section II.2.a.v. describes the persistence of the problem in the period from 2008 to 2010. Young women from low income neighborhoods and racial minorities are especially impacted by this problem. Information provided to the coalition allowed us to understand some of the complex social variables that are in play.

A review of the published literature and purported best practices were not encouraging. These facts were shared with the Coalition. Nonetheless the consensus was to keep adolescent pregnancy as a priority. It was suggested that supporting the efforts at soon to be opened school-based clinics and Planned Parenthood was worthy of time and resources. The wider availability of Plan B (the “morning after pill”) for young women was considered by some to be possibly beneficial.

Adolescent Pregnancy Interventions

Project Period Objective:

1) Reduce rate of adolescent pregnancy among 15-17 age group by 5/1,000

Annual/Multi-Year Objective:
1) Increase awareness of existing adolescent pregnancy prevention programs among 10 community partners and HCPs

*Community Resources Participating in this Effort:*

Planned Parenthood has a peer-based pregnancy prevention program called Teens Helping Teens. Their outreach workers are involved with programs to try to reduce adolescent pregnancies. They have also formed a coalition in Schenectady focused on adolescent pregnancy prevention efforts.

The Schenectady School System is about to open three school-based clinics; two operated by Hometown Health and one by Ellis Medicine. The Coalition will work with the School to be certain that they have measurement tools if they need them. In addition, the after-school “Revolution Studios” project is developing a video to engage teens in discussions of adolescent pregnancy issues.

The ob-gyn, pediatrics, and family medicine communities are eager to support these efforts as is Schenectady County Public Health Services and its Sexually Transmitted Illness program.

**2.f. Interdisciplinary Priority**

The Coalition has developed a profoundly simple, yet potentially game-changing, additional priority: twice-annual formalized information sharing among Schenectady’s healthcare and community service organizations, with the goal of increasing effective and efficient information sharing and client referrals along existing services and service providers.

**3. Crosswalks to Legal Requirements**

**3.a. Hospital Community Service Plan – Ellis and NYSDOH**

Section 2803-l of the New York State Public Health Law requires each non-profit general hospital in the State to, at least every three years: review the hospital’s mission statement, solicit the views of the community on the hospital’s performance and service priorities, demonstrate the hospital’s commitment to meeting community health needs through charity care and improved access to the underserved, and to summarize the provision of free or reduced charge services. In addition, each hospital must at least annually make available a report on its performance in meeting health needs through charity care and improved access to the underserved.

The New York State Department of Health has devised a Statewide health assessment and health improvement plan: the *Prevention Agenda*. The *Prevention Agenda* establishes five broad priority areas:

- Prevent Chronic Diseases
- Promote a Healthy and Safe Environment
- Promote Healthy Women, Infants, and Children
- Promote Mental Health and Prevent Substance Abuse
- Prevent HIV, STDs, Vaccine Preventable Diseases, and Healthcare Associated Infections.
The Department then requires each hospital and local public health department to select at least two priority areas, at least one of which must address a disparity, and to then develop a plan to jointly address the problems. As part of this plan, the hospital must describe: 1) Goals and Objectives, 2) Improvement Strategies, 3) Performance Measures, and 4) Measureable and Time-Framed Targets. These required components are arrayed as the columns of the grid on the following pages. The interventions must be measured over the three year period of 2013-2015 and must represent evidence-based or promising practices. NYSDOH enumerates several specific guidance documents which may be utilized to select acceptable interventions.

Hospitals and health departments in the three Capital Region counties (Albany, Rensselaer, and Schenectady) engaged in two separate, but overlapping and coordinated, exercises to identify health needs. (See section I.1. for Schenectady and section V.4. for information on Albany and Rensselaer.) Although conducted independently, all three counties identified the same three Prevention Agenda items (Asthma and Smoking (Chronic Disease), Diabetes and Obesity (Chronic Disease), and Mental Health and Substance Abuse) as having the highest priority. This unplanned but fortuitous result will enable a combined, concerted, and collaborative region-wide approach over the next three years.

This “Community Service Plan” was adopted by resolution of the Ellis Hospital Board of Trustees at their regular meeting on November 5, 2013 and the report is being made widely available on the Ellis Medicine website http://www.ellismedicine.org/pages/community-report.aspx and as a paper copy for public inspection at the administrative office of Ellis Hospital (1101 Nott Street, Schenectady, New York 12308) on November 15, 2013.
## Prevention Agenda Priority

### Asthma and Smoking

**Goal:** Reduce the burden of preventable symptoms/conditions related to asthma and smoking

Increase number of asthma patients who participate in a three-tiered care model (care coordination, home visits/assessments, and asthma education) from 0 to 50/year

**Replicate model from Boston Children’s Hospital that includes care management, home visiting, and education. Has demonstrated reduction in ED visits and hospitalization. [Home environmental assessments and education recommended by Guide to Community Preventive Services.]**

- **Performance Measures:**
  1. Number of patients completing three levels of care
  2. Change in ED utilization for asthma among participants
  3. Change in hospital admissions for asthma among participants

- **Time-Framed Targets:**
  1. Number of patients participating in three-tiered model will increase by 50 each year
  2. Change in ED utilization will be measured monthly
  3. Change in hospital admissions will be measured monthly

**Implement smoke free policy at two mental health offices**

1. Partner with the Capital Region Tobacco Free Coalition and Seton Health to provide smoking cessation classes and tools to mental health outpatients.

2. Establish clinic site(s) as smoke-free.

[Smoke-free policies recommended by Guide to Community Preventive Services.]

- **Performance Measures:**
  1. Number of Ellis outpatient mental health clinic sites designated smoke-free
  2. Number of consumers educated
  3. Number of consumers quit smoking
  4. Number quit for at least 1 year

- **Time-Framed Targets:**
  1. Designate one site as smoke-free by the end of 2014 and the other by the end of 2015
  2. Classes will be ongoing throughout project period. Seton Health and Tobacco Free Coalition will set dates
  3. Program participants (staff and consumers) will be followed for 1 year post-program/education completion

**Increase number of practices prescribing by NIH guidelines by 5/year**

- **HNLBI clinical guidelines for asthma**

- **Performance Measures:**
  1. Number of practices/providers meeting metric
  2. Change in ED utilization for asthma
  3. Change in hospital admissions for asthma

- **Time-Framed Targets:**
  1. Practices/providers will be assessed on an annual basis for compliance
  2. ED visits for asthma will be tracked throughout project period
  3. Hospital admissions for asthma will be tracked throughout project period
## Diabetes and Obesity

**Goal:** Impact primary, secondary, and tertiary prevention of diabetes  
Increase access to comprehensive medical care for people with diabetes

**Evidence-based Improvement Strategy:** Continue and expand availability of shared medical appointments for primary care patients with diabetes.  
[Shared medical appointments for diabetes a model practice of NACCHO.]

**Performance Measures:**  
1. Number of patients with diabetes participating in shared medical appointments at Family Health Center  
2. Change in clinical outcomes among participating patients

**Time-Framed Targets:**  
1. Change in program participation will be measured annually  
2. Clinical outcomes will be measured annually

- Implement a policy at the Family Health Center to screen all new West Indian patients for diabetes, regardless of BMI or age  
Respond to racial/ethnic health disparity which shows 30% of the adult West Indian population has type 2 diabetes even in the absence of traditional indicators such as obesity and age.

**Performance Measures:**  
Number (percent) of new West Indian patients screened for diabetes

**Time-Framed Targets:**  
Rate of screening will be assessed annually

- Continue services and support to children and adolescents with type 1 diabetes  
Continue Sugar Free Gang Kamp and other support activities.  
[Diabetes self-management education in-home for children and adolescents with type 1 diabetes recommended by Guide to Community Preventive Services, although insufficient evidence regarding recreational camp as setting.]

**Performance Measures:**  
1. Number of participants in Sugar Free Gang Kamp and Teen Camp  
2. Number of participants in family support and self-management education programs

**Time-Framed Targets:**  
Kamp and support/self-management program participation is collected annually; goal is to provide services as needed
### Goals and Objectives

**Goal:** Organize community behavioral health services into a coherent system

- Increase the availability and accessibility of mental health workers in primary care and community settings

### Improvement Strategy

1. Resume the position of psychiatric social worker on staff at the Family Health Center.
2. Add a mental health navigator to Care Central (health home).
3. Increase capacity of Care Central’s peer mentor program.

[Collaborative care linking primary care providers, patients, and mental health specialists recommended by Guide to Community Preventive Services.]

### Performance Measures

1. Number of patients seen by the psychiatric social worker
2. Number of patients navigated by the mental health navigator
3. Number of patients working with a peer mentor
4. Change in ED utilization for mental health patients in peer mentor program
5. Change in hospital readmissions for mental health patients in peer mentor program

### Time-Framed Targets

1. Number of patients seen by the psychiatric social worker will be tracked on a monthly basis
2. Number of patients navigated by the mental health navigator will be tracked on a monthly basis
3. Number of patients working with a peer mentor will be tracked on a monthly basis
4. Change in ED utilization for mental health will be measured monthly
5. Change in hospital readmissions for mental health will be measured monthly
<table>
<thead>
<tr>
<th>Prevention Agenda Priority</th>
<th>Goals and Objectives</th>
<th>Evidence-based Improvement Strategy</th>
<th>Performance Measures</th>
<th>Time-Framed Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluate reported data showing: 1) high rates of newborn drug-related hospitalization, and 2) high rates of post-partum depression</td>
<td>Conduct of, and results from, medical chart reviews</td>
<td>Chart reviews to commence 1st quarter 2014</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.b. Hospital Implementation Strategy – Ellis and Internal Revenue Service

Provisions of the Patient Protection and Affordable Care Act (PPACA) of 2010 require non-profit hospitals to conduct a Community Health Needs Assessment (CHNA) and to then devise an Implementation Strategy containing specific descriptions of how the hospital intends to address (or not address) the significant health needs of its community. The CHNA must be conducted and made available to the public during the first taxable year following March 23, 2012 (which for Ellis Hospital is calendar 2013), and the Implementation Strategy must be included in the hospital’s IRS form 990 non-profit tax return for that year. A new CHNA and Implementation Strategy must be conducted at least each third year thereafter.

Regulations specifically provide that “a hospital facility may conduct its CHNA in collaboration with other organizations and facilities (including, but not limited to, related and unrelated hospital organizations and facilities, for-profit and governmental hospitals, governmental departments, and nonprofit organizations...”

This full document is being submitted by Ellis Hospital in fulfillment of the requirements for a written “CHNA Report,” with section II constituting the general requirements of 26 CFR sec. 1.501(r)-3 and the appendices (section V) containing more detailed descriptions of methodology and data.

The grid contained in this section will be appended to Ellis Hospital’s IRS 990 non-profit tax return for taxable year 2013, constituting the Implementation Strategy. The requirements of 26 CFR sec. 1.501(r)-3 (c) are that the Implementation Strategy must either describe how the hospital plans to address each significant health need – specifying:

- “the actions the hospital facility intends to take to address the health need,
- the anticipated impact of these actions, ...
- a plan to evaluate such impact...
- the programs and resources the hospital facility plans to commit to address the health need...
  [and] ...
- any planned collaboration between the hospital facility and other facilities or organizations...” – or

“why it does not intend to address” the need. These required components are arrayed as the columns of the grid on the following pages.

The written “CHNA Report” and the associated Implementation Strategy were adopted by resolution of the Ellis Hospital Board of Trustees at their regular meeting on November 5, 2013 and the report is being made widely available on the Ellis Medicine website http://www.ellismedicine.org/pages/community-report.aspx and as a paper copy for public inspection at the administrative office of Ellis Hospital (1101 Nott Street, Schenectady, New York 12308) on November 15, 2013.
<table>
<thead>
<tr>
<th>Community Health Need</th>
<th>Community Action Item</th>
<th>Hospital Action Planned</th>
<th>Hospital Program Involved</th>
<th>Hospital Resources Used</th>
<th>Collaborations Planned</th>
<th>Anticipated Impact of Hospital Action</th>
<th>Plan to Evaluate Hospital Impact</th>
<th>If no hospital action, why not?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma and Smoking</td>
<td>Create three-tiered care model (care coordination, environmental assessments, and asthma education)</td>
<td>Care Central’s nurse navigators and CHWs will assist with care coordination</td>
<td>- Care Central (health home) - Asthma Education Program</td>
<td>Care Central’s nurse navigators and CHWs, Asthma Education Program’s Respiratory Therapists</td>
<td>SCPHS Healthy Neighborhoods Program</td>
<td>More patients receiving comprehensive asthma care</td>
<td>Measure change in ED utilization and hospital admissions pre/post</td>
<td>Action taken</td>
</tr>
<tr>
<td></td>
<td>Educate PCPs to follow NIH guidelines when prescribing for asthma</td>
<td>Provide training in these guidelines as a Grand Rounds topic; make a quality metric</td>
<td>- Professional Medical Education - Practices seeing asthma patients</td>
<td>Make a quality metric/training of PCPs</td>
<td>Hometown Health, Capital Care</td>
<td>More PCPs prescribing by guidelines</td>
<td>Load guidelines in QUEST Population Advisor, measure compliance</td>
<td>Action taken</td>
</tr>
<tr>
<td></td>
<td>Reduce tobacco use among persons who attend outpatient mental health programs</td>
<td>Assist with efforts to make clinics smoke-free and reduce smoking among clinic staff and clients</td>
<td>Adult Outpatient Mental Health Unit and PROS Program</td>
<td>Mental Health staff</td>
<td>Capital District Tobacco-Free Coalition, Center for Smoking Cessation program, Schenectady County</td>
<td>Increase access to smoking cessation for mental health clients</td>
<td>Number of mental health clients receiving smoking cessation counseling; % who quit smoking</td>
<td>Action taken</td>
</tr>
<tr>
<td></td>
<td>Continue smoking cessation classes with major employers</td>
<td>Continue to host and promote “Butt Stops Here” for employees</td>
<td>Human Resources</td>
<td>Rooms for programs and continued incentivizing of smoking cessation</td>
<td>Capital District Tobacco-Free Coalition, Seton Health’s “Butt Stops Here” program</td>
<td>Reduced number of hospital employees who smoke</td>
<td>Number of hospital employees receiving non-smoker health insurance discount</td>
<td>Action taken</td>
</tr>
<tr>
<td>Community Health Need</td>
<td>Community Action Item</td>
<td>Hospital Action Planned</td>
<td>Hospital Program Involved</td>
<td>Hospital Resources Used</td>
<td>Collaborations Planned</td>
<td>Anticipated Impact of Hospital Action</td>
<td>Plan to Evaluate Hospital Impact</td>
<td>If no hospital action, why not?</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------</td>
<td>-------------------------</td>
<td>--------------------------</td>
<td>------------------------</td>
<td>-----------------------</td>
<td>----------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Diabetes and Obesity</td>
<td>Increase access to comprehensive medical care for people with diabetes</td>
<td>Continue shared medical appointments for primary care patients with diabetes</td>
<td>Primary Care Practices</td>
<td>Physician and other clinician (diabetes educators, nutritionists) time (insurance billable)</td>
<td>Continue and increase number of diabetes patients receiving comprehensive care</td>
<td>Count number of patients participating in shared medical appointments</td>
<td>Action taken</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continue the Health Shares program of “prescribing” fresh vegetables</td>
<td>Continue participation of Ellis Primary Care Practices in the Health Shares program</td>
<td>Primary Care Practices</td>
<td>Physician time in explaining vegetable vouchers to patients, staff time in data collection</td>
<td>Health Shares program (Cooperative Extension, SCPHS, Schenectady ARC)</td>
<td>Continue increasing number of Health Shares participants</td>
<td>Change in clinical outcomes (BMI, BP), amount of produce distributed to participants</td>
<td>Action taken</td>
</tr>
<tr>
<td></td>
<td>Implement self-management classes (Faith Fights Diabetes) in faith-based communities</td>
<td>Support training of CHWs from faith communities</td>
<td>Diabetes Education Program</td>
<td>Certified Diabetes Educators</td>
<td>Faith-based communities, neighborhood associations</td>
<td>Increased number of patients engaged in self-management activities</td>
<td>Changes in clinical outcomes (BMI, A1c)</td>
<td>Action taken</td>
</tr>
<tr>
<td></td>
<td>Continue services and support to children and adolescents with type 1 diabetes</td>
<td>Continue Sugar Free Gang Kamp and other support activities</td>
<td>Diabetes Education Program</td>
<td>Annual Sugar Free Gang Kamp, Teen Camp, and support programs</td>
<td>Continued involvement of families of children with type 1 diabetes</td>
<td>Number of participants</td>
<td>Action taken</td>
<td></td>
</tr>
<tr>
<td>Community Health Need</td>
<td>Community Action Item</td>
<td>Hospital Action Planned</td>
<td>Hospital Program Involved</td>
<td>Hospital Resources Used</td>
<td>Collaborations Planned</td>
<td>Anticipated Impact of Hospital Action</td>
<td>Plan to Evaluate Hospital Impact</td>
<td>If no hospital action, why not?</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------</td>
<td>-------------------------</td>
<td>--------------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
<td>-------------------------------------</td>
<td>-------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Holding physical activity events in the community</td>
<td>Support planning and execution of events</td>
<td>Communications and Volunteer Services</td>
<td>Staff and Advertising</td>
<td>City of Schenectady, Neighborhood Associations, YMCA, SCSD, SCPHS</td>
<td>Increasing opportunities for physical activity</td>
<td>Number of hours of physical activity; change in % of obese students</td>
<td>Action taken</td>
<td></td>
</tr>
<tr>
<td>Screening of ALL West Indian (WI) adults for diabetes</td>
<td>Education of practices and PCPs; make a policy to screen</td>
<td>Practices seeing patients with diabetes</td>
<td>Make a policy to screen/ training of PCPs</td>
<td>Hometown Health, Capital Care</td>
<td>Increased number of WIs screened</td>
<td>% of WIs screened/compliance</td>
<td>Action taken</td>
<td></td>
</tr>
<tr>
<td>Need to move point of care</td>
<td>Certified Diabetes Educators will be located in Primary Care settings</td>
<td>Primary Care Practices</td>
<td>Evaluation of potential for such co-location</td>
<td>More patients with diabetes will have direct access to a CDE</td>
<td>Change in number of patients seen by CDEs, change in clinical outcomes (A1c)</td>
<td>Action taken</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inappropriate Emergency Department Utilization</td>
<td>Increase awareness of Care Central (health home) as an alternative to ED visits</td>
<td>Expand Care Central to patient populations beyond Medicaid and Medicare</td>
<td>Care Central (health home)</td>
<td>Marketing, Administration to negotiate with additional payors</td>
<td>Other payors</td>
<td>Larger number of patients under active care management</td>
<td>Number of Care Central patients, change in number of ED visits pre/post consent</td>
<td>Action taken</td>
</tr>
<tr>
<td>Community Health Need</td>
<td>Community Action Item</td>
<td>Hospital Action Planned</td>
<td>Hospital Program Involved</td>
<td>Hospital Resources Used</td>
<td>Collaborations Planned</td>
<td>Anticipated Impact of Hospital Action</td>
<td>Plan to Evaluate Hospital Impact</td>
<td>If no hospital action, why not?</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------</td>
<td>-------------------------</td>
<td>--------------------------</td>
<td>------------------------</td>
<td>-----------------------</td>
<td>--------------------------------------</td>
<td>---------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Provide alternatives to ED that offer the same advantages (speed, no charge, etc.)</td>
<td>Continue “Right Care, Right Place” initiatives such as Urgent Care and “Fast Track”</td>
<td>-Emergency Department -Primary Care Practices -Urgent Care</td>
<td>Additional hours and services at Primary Care and Urgent Care locations</td>
<td>Patients using Urgent Care or after-hours primary care instead of ED</td>
<td>Number of patients at various care locations, shift in geography of visits</td>
<td>Action taken</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase effectiveness of in-community provision of urgent and emergent care</td>
<td>Tie the “Care Team Connect” Community Health Repository to first responders</td>
<td>Care Central (health home)</td>
<td>Information Technology to develop computer connection</td>
<td>Mohawk Ambulance</td>
<td>Improved transfer of knowledge about patients and their community setting</td>
<td>Reduced care requirements or improved care of identified patients</td>
<td>Action taken</td>
<td></td>
</tr>
<tr>
<td>Devise affirmative community programs to prevent emergencies</td>
<td>Organize falls prevention campaign in Woodlawn neighborhood</td>
<td>Communications and Care Central (health home)</td>
<td>Staff to organize community volunteer program (apply for grant)</td>
<td>Mohawk Ambulance, Habitat for Humanity, neighborhood associations, colleges, faith-based communities</td>
<td>Reduce falls by improving in-home safety among high-risk seniors</td>
<td>Measure any change in ambulance calls for falls in Woodlawn neighborhood</td>
<td>Action taken</td>
<td></td>
</tr>
<tr>
<td>Community Health Need</td>
<td>Community Action Item</td>
<td>Hospital Action Planned</td>
<td>Hospital Program Involved</td>
<td>Hospital Resources Used</td>
<td>Collaborations Planned</td>
<td>Anticipated Impact of Hospital Action</td>
<td>Plan to Evaluate Hospital Impact</td>
<td>If no hospital action, why not?</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
<td>--------------------------------------------</td>
<td>----------------------------------</td>
<td>------------------------------------------------------------</td>
<td>--------------------------------------</td>
<td>---------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td><strong>Mental Health and Substance Abuse</strong></td>
<td>Reconfigure community mental health collaborations along the lines of the successful “suicide prevention task force” to prioritize mental health needs</td>
<td>Actively participate on county-wide task force</td>
<td>Psychiatry, Inpatient and Outpatient Mental Health</td>
<td>Professional staff to participate on task force, physical facilities</td>
<td>County Office of Community Services, Northeast Parent and Child Society, other mental health providers</td>
<td>Multi-agency group will emphasize collaboration to identify and solve specific mental health needs</td>
<td>Measure outcomes of objectives developed by the task force</td>
<td>Action taken</td>
</tr>
<tr>
<td><strong>Increase the availability of peer mentors in outpatient settings</strong></td>
<td>Increase the availability of peer mentors in outpatient settings</td>
<td>Continue and expand the peer mentoring program at Care Central</td>
<td>Care Central (health home)</td>
<td>Employment of peer mentors in Care Central</td>
<td>Improved mental health status of Care Central’s mental health patients</td>
<td>Change in ED visits and hospital readmissions among mental health patients pre/post consent</td>
<td>Action taken</td>
<td></td>
</tr>
<tr>
<td><strong>Increase the availability and accessibility of mental health workers in primary care and community settings</strong></td>
<td>Increase the availability and accessibility of mental health workers in primary care and community settings</td>
<td>Resume the social worker assigned to Family Health Center, add mental health navigator to Care Central</td>
<td>Family Health Center -Care Central (health home) -Outpatient Mental Health</td>
<td>Employment of social worker (CDPHP grant), additional navigator</td>
<td>CDPHP</td>
<td>More opportunities for direct patient access to MH services at FHC, Care Central, and outpatient clinics</td>
<td>Surveys of patient satisfaction, number of patients connected to community services by navigator</td>
<td>Action taken</td>
</tr>
<tr>
<td>Community Health Need</td>
<td>Community Action Item</td>
<td>Hospital Action Planned</td>
<td>Hospital Program Involved</td>
<td>Hospital Resources Used</td>
<td>Collaborations Planned</td>
<td>Anticipated Impact of Hospital Action</td>
<td>Plan to Evaluate Hospital Impact</td>
<td>If no hospital action, why not?</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------</td>
<td>------------------------</td>
<td>--------------------------</td>
<td>------------------------</td>
<td>-----------------------</td>
<td>--------------------------------------</td>
<td>-------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Increase focus on substance abuse in primary care settings</td>
<td>Expand involvement of the Family Medicine Residency and the FHC by establishing an Addictions Medicine Fellowship and reviewing drug-related newborn hospitalization</td>
<td>Family Medicine Residency, Family Health Center</td>
<td>Establishment and administration of Addictions Medicine Fellowship (grant funded) and time of residents to study drug-related newborn hospitalization</td>
<td>St. Mary’s Hospital (Amsterdam) collaboration for Fellowship</td>
<td>Two projects at Residency and FHC with formal focus on substance abuse</td>
<td>Reports from Addictions Medicine Fellow and from resident(s) studying drug-related newborn hospitalization</td>
<td>Action taken</td>
<td></td>
</tr>
<tr>
<td>Evaluate/confirm reported high rate of post-partum depression</td>
<td>Conduct chart review</td>
<td>-Family Health Center -Bellevue Woman’s Center</td>
<td>Staff to design and conduct study</td>
<td>Union College</td>
<td>Accurate estimate of post-partum depression rate, development of intervention if needed</td>
<td>Measure outcomes of intervention</td>
<td>Action taken</td>
<td></td>
</tr>
<tr>
<td>Adolescent Pregnancy</td>
<td>Continue high quality care for high-risk adolescent pregnancies</td>
<td>Continue top-quality care for high-risk adolescents at FHC, cooperate with Hometown Health, continue</td>
<td>-Family Health Center -Bellevue Woman’s Center -Care Central (health home)</td>
<td>Family Health Center services (Medicaid and Charity Care), staff at Care Central and Bellevue to operate BYBB</td>
<td>Hometown Health collaboration with high-risk adolescents patients</td>
<td>Continued good outcomes in spite of high-risk pregnancies</td>
<td>Maternity outcomes reports from FHC and Hometown Health, participation in BYBB</td>
<td>Action taken</td>
</tr>
<tr>
<td>Community Health Need</td>
<td>Community Action Item</td>
<td>Hospital Action Planned</td>
<td>Hospital Program Involved</td>
<td>Hospital Resources Used</td>
<td>Collaborations Planned</td>
<td>Anticipated Impact of Hospital Action</td>
<td>Plan to Evaluate Hospital Impact</td>
<td>If no hospital action, why not?</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
<td>---------------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
<td>---------------------------------------</td>
<td>---------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td><strong>Interdisciplinary</strong></td>
<td>Improve awareness of existing programs in the community</td>
<td>“Before Your Baby Basics” pre-natal education</td>
<td>Care Central and Communications</td>
<td>Care Central staff to coordinate training</td>
<td>All Care Central partners</td>
<td>Improved awareness of programs among community providers</td>
<td>Change in number of referrals to community programs</td>
<td>Action taken</td>
</tr>
<tr>
<td><strong>Arthritis and Disability</strong></td>
<td>Continue the Health Shares program of “prescribing” fresh vegetables</td>
<td>Continue participation in the Health Shares program</td>
<td>Primary Care Practices</td>
<td>Physician time in explaining vegetable vouchers to patients, staff time in data collection</td>
<td>Health Shares program (Cooperative Extension, SCPHS, Schenectady ARC)</td>
<td>Continue increasing number of Health Shares participants</td>
<td>Count number of patients who are Health Shares participants, change in clinical outcome (BMI)</td>
<td>Action taken</td>
</tr>
<tr>
<td><strong>Dental Health</strong></td>
<td>Increase access of urban low-income residents, especially children, to dental care</td>
<td>Expand Dental Health Center programs, specifically pediatric dental and dental surgery</td>
<td>Dental Health Center</td>
<td>Equipment &amp; facilities for pediatric dental and dental surgery (part grant-funded)</td>
<td>Hometown Health dental program</td>
<td>Additional dental services to Medicaid and uninsured patients, especially children</td>
<td>Dental Health Center patient counts by payor</td>
<td>Action taken</td>
</tr>
<tr>
<td>Community Health Need</td>
<td>Community Action Item</td>
<td>Hospital Action Planned</td>
<td>Hospital Program Involved</td>
<td>Hospital Resources Used</td>
<td>Collaborations Planned</td>
<td>Anticipated Impact of Hospital Action</td>
<td>Plan to Evaluate Hospital Impact</td>
<td>If no hospital action, why not?</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------</td>
<td>-------------------------</td>
<td>--------------------------</td>
<td>------------------------</td>
<td>-----------------------</td>
<td>--------------------------------------</td>
<td>-------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Falls</td>
<td>Reduce falls among the elderly</td>
<td>Organize falls prevention campaign in Woodlawn neighborhood</td>
<td>Communications and Care Central (health home)</td>
<td>Staff to organize community volunteer program (apply for grant)</td>
<td>Mohawk Ambulance, Sunnyview Rehabilitation Hospital, Habitat for Humanity, neighborhood associations, colleges, faith-based communities</td>
<td>Reduce falls by improving in-home safety among high-risk seniors</td>
<td>Measure any change in ambulance calls for falls in Woodlawn neighborhood</td>
<td>Action taken</td>
</tr>
<tr>
<td>Food Security</td>
<td>Continue the Health Shares program of “prescribing” fresh vegetables</td>
<td>Continue participation in the Health Shares program</td>
<td>Primary Care Practices</td>
<td>Physician time in explaining vegetable vouchers to patients, staff time in data collection</td>
<td>Health Shares program (Cooperative Extension, SCPHS, Schenectady ARC)</td>
<td>Continue increasing number of Health Shares participants</td>
<td>Count number of patients who are Health Shares participants, pounds of produce distributed</td>
<td>Action taken</td>
</tr>
<tr>
<td>Neighborhood Safety</td>
<td>Improve the physical appearance of targeted neighborhoods to increase citizen activities and reduce opportunities for crime</td>
<td>Participate in the Mayor’s “Northside Walk to Work Initiative” to improve housing and public facilities in the Nott Street neighborhood</td>
<td>Communications</td>
<td>Staff to attend meetings and organize volunteers, volunteer workers on neighborhood projects</td>
<td>City of Schenectady, neighborhood associations, Price Chopper</td>
<td>Physical improvement (house repairs, sidewalks) of Nott Street neighborhood, possible increase in number of hospital employees living nearby</td>
<td>Report of Mayor’s initiative, number of employees living in neighborhood</td>
<td>Action taken</td>
</tr>
</tbody>
</table>

Ellis Hospital 2013-2015 Community Health Needs Assessment Implementation Strategy
<table>
<thead>
<tr>
<th>Community Health Need</th>
<th>Community Action Item</th>
<th>Hospital Action Planned</th>
<th>Hospital Program Involved</th>
<th>Hospital Resources Used</th>
<th>Collaborations Planned</th>
<th>Anticipated Impact of Hospital Action</th>
<th>Plan to Evaluate Hospital Impact</th>
<th>If no hospital action, why not?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programs for Youth and Adolescents</td>
<td>Review potential opportunities for programs through school and community resources, such as increased access to public parks</td>
<td>Participate in any school or community initiatives</td>
<td>Communications</td>
<td>Staff to attend meetings</td>
<td>Schenectady City School District, City of Schenectady</td>
<td>Possible additional programs for youth and adolescents</td>
<td>Meetings attended</td>
<td>Action taken</td>
</tr>
<tr>
<td>Community and Coalition Building</td>
<td>Continue current support for community and regional coalitions</td>
<td>Continue participation in community and regional collaborations</td>
<td>Administration, Communications</td>
<td>Staff to participate in meetings and events, in-kind support (e.g., meeting rooms), dues</td>
<td>Schenectady Coalition, HCDI, SCPHS</td>
<td>Continued participation in coalitions</td>
<td>IRS 990 Community Benefit expenditures</td>
<td>Action taken</td>
</tr>
<tr>
<td>Community Health Improvement</td>
<td>Continue the hospital’s Community Health Improvement and Community Benefit operations</td>
<td>Continue the hospital’s Community Health Improvement and Community Benefit operations</td>
<td>Various inpatient and outpatient programs and services</td>
<td>Staff support for community and patient education, other in-kind and direct support</td>
<td>SCPHS</td>
<td>Continued availability of programs to the community and patients</td>
<td>IRS 990 Community Benefit expenditures</td>
<td>Action taken</td>
</tr>
<tr>
<td>Community Health Need</td>
<td>Community Action Item</td>
<td>Hospital Action Planned</td>
<td>Hospital Program Involved</td>
<td>Hospital Resources Used</td>
<td>Collaborations Planned</td>
<td>Anticipated Impact of Hospital Action</td>
<td>Plan to Evaluate Hospital Impact</td>
<td>If no hospital action, why not?</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------</td>
<td>-------------------------</td>
<td>--------------------------</td>
<td>------------------------</td>
<td>----------------------</td>
<td>-------------------------------------</td>
<td>-------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Health Professions Education</td>
<td>Continue the programs of the teaching hospital: Residencies, medical student training, School of Nursing, Grand Rounds and other CME, preceptors</td>
<td>Continue the programs of the teaching hospital: Residencies, medical student training, School of Nursing, Grand Rounds and other CME, preceptors</td>
<td>Residencies, School of Nursing, Medical Education, units and services with preceptors</td>
<td>Net costs of operating formal education programs, professional staff time when serving as preceptors</td>
<td>Albany Medical College, educational institutions which send students for precepted clinical education, community physicians</td>
<td>Continued training of new doctors, nurses, and other medical professionals; continued CME for community physicians</td>
<td>IRS 990 Community Benefit expenditures</td>
<td>Action taken</td>
</tr>
<tr>
<td>Subsidized and Free Health Services</td>
<td>Continue subsidized and free health services to underserved, low-income, and uninsured populations</td>
<td>Continue to provide services to all patients, regardless of ability to pay; continue participation in Medicare, Medicaid, and Charity Care</td>
<td>Administration, Finance</td>
<td>Net losses from serving Medicare and Medicaid patients, cost of Charity Care, bad debts from uninsured patients</td>
<td>Continued medical services to all patients, regardless of ability to pay; continued participation in Medicare, Medicaid, and Charity Care</td>
<td>IRS 990 Community Benefit expenditures</td>
<td>Action taken</td>
<td></td>
</tr>
</tbody>
</table>
**IV. Communications, Dissemination, and Implementation Strategy**

A community-wide action plan is only as useful as its knowledge in, and participation by, the community. This document, and the information supporting it, is being made available to the Schenectady community through a variety of means. Implementation will also be, in effect, “self-enforcing” through discussions at the regular meetings of the Schenectady Coalition for a Healthy Community.

In accordance with legal responsibilities imposed by federal and State law, this document and annual supplements will be posted on the Ellis Medicine (http://www.ellismedicine.org/pages/community-report.aspx) and the SCPHS (http://www.schenectadycounty.com/FullStory.aspx?m=39&amid=808) websites. It will also be available for public review in printed form at the offices of Ellis Medicine and the Schenectady County Public Health Services. Efforts will be made to include distribution through local public libraries and educational institutions. The CHNA Implementation Strategy will be attached to and filed with the Ellis Hospital IRS form 990 schedule H.

In addition, the regional news media actively covered inauguration of the UMatter Schenectady survey and have been invited to cover the survey results and this associated document. The survey, with a particular focus on its role in engaging and listening to the community, was the subject of a presentation at The Schenectady Foundation’s “Community Partnership Conference” on November 6, 2013.

The Schenectady Coalition for a Healthy Community continues to meet monthly to review progress implementing each of the items in the Community Action Plan (section III.2.). Although certain aspects of the Plan are the responsibilities of Ellis Medicine and SCPHS (sections III.3.a.,b.,c.), many of the specific components are being handled by a broad variety of agencies on the Coalition. The regular meetings ensure coordination, continued involvement, and the opportunity for any required mid-course corrections.

Dissemination of the plan is occurring through formal and informal contact with various community-wide organizations. For example, the various neighborhood associations were consulted and engaged during the UMatter survey, and have since been briefed on the resulting data and recommendations. Ongoing communication is maintained with Schenectady United Neighborhoods (SUN). Similarly, outreach is being undertaken to faith-based organizations, to healthcare organizations (through the Schenectady Alliance for Health), and to community foundations.

Ellis Medicine and SCPHS will file annual updates with the federal and State governments as required by law, and will post these updates on their websites (see addresses above) and in paper copies at their administrative offices.
V. Appendices

1.a. UMatter Community Survey Description

The UMatter Schenectady community survey, funded by The Schenectady Foundation and the Carlilian Foundation, has its roots in a series of neighborhood-based community surveys conducted in Chicago over the past decade. The Sinai Urban Health Institute (SUHI), affiliated with Mt. Sinai Hospital (http://www.suhichicago.org/), has built a nationally-recognized foundation for urban population health research from a series of tightly-focused, neighborhood-based surveys which started in 2002. Building on the results of the surveys and other community-focused research reports, SUHI published over 70 articles in peer-reviewed journals and raised over $25 million in government and foundation grants to support health services in largely underserved neighborhoods.

Inspired by the Chicago experience, James W. Connolly, President and CEO of Ellis Medicine, enlisted the “Medical Home Group” to lead an ambitious, door-to-door, neighborhood-based, comprehensive health needs and resources survey in Schenectady. Conducted between February and May 2013, the initial phase of the survey covered adults in all ten neighborhoods in the City of Schenectady. The City was chosen as the initial focus because of general data showing the highest level of need, and adults (age 18 and over) only were surveyed because of the complexities of obtaining consent to interview children and adolescents. The goal is to eventually expand the survey to the entire County and to all age groups, collecting data not only in suburban areas but also in underserved rural areas service area. Potential future interviews of children and adolescents could help shape services to these populations. And tightly focused future surveys can help determine the efficacy of specific interventions.

The survey itself was developed with input from the community. The epidemiologist who helped SCPHS to develop the REACH survey (see Appendix 1.b.) was retained using a combination of funding from Ellis and The Schenectady Foundation, and worked with a University at Albany School of Public Health professor of Epidemiology and a community advisory group to develop the survey instrument. The instrument contains a potential 283 questions, with the actual number of questions in a given interview depending on branching logic, e.g., a respondent who acknowledges being diagnosed with a specific disease may be asked a series of questions about the status and treatment of that disease. Questions fall into three categories: some are previously-tested questions which may be used for direct comparison with benchmarks and other survey results, some are specific to health issues identified or
anticipated in Schenectady, and some are designed to confirm others, such as a series of questions to test for depression which can be compared with reported diagnoses. There are also a number of open-ended questions, including “What is the best/what is the worst thing about living in Schenectady?”

Questions addressed a range of information from demographics to employment and numerous medical conditions. Additionally questions were asked about transportation, safety, maternal and child health, mental health, access to and quality of care. The survey was reviewed and approved by the Ellis Medicine Institutional Review Board (IRB).

The survey was physically conducted by about a dozen paid Community Health Workers (CHWs) who were engaged and trained by the Schenectady Community Action Program (SCAP) and a similar number of college student volunteers drawn from Union College, Union Graduate College, and the University at Albany. Several of the CHWs were graduates of the Health Professions Opportunity Grant (HPOG) program administered by SCAP and the Schenectady County Community College (SCCC), which trains disadvantaged community residents to become Certified Nursing Assistants (CNA). CHWs reflected the racial and ethnic diversity of the City, with bi-lingual CHWs including Spanish and Arabic. (Following completion of the survey, three of the CHWs have obtained employment with Ellis Medicine.)

Surveys were loaded on iPads using the iSurvey application (https://www.isurveysoft.com/). Surveyors were instructed to read the survey questions to the respondent and to record their answers on the iPad. Each survey took between 20 and 40 minutes, and respondents received $10 gift cards valid at a local supermarket. (The gift cards cannot be used to purchase alcohol or cigarettes.) Surveyors went door-to-door in each neighborhood based on a weekly schedule which assured coverage of each of the ten City neighborhoods, with planned oversampling of high needs area. The process included weekend “saturation” of each neighborhood, with multiple teams of surveyors covering assigned neighborhood streets working from central locations (which ranged from churches to a West Indian diner to a parking lot) in each neighborhood. Surveyors worked in teams of two, typically one CHW and one student. Other survey collection techniques included assignment of surveyors to in-city events (including an indoor Farmers’ Market, the Hibernian Hall on St. Patrick’s Day, and a neighborhood garage sale), rotating stationing of surveyors at public locations (including social service agencies, food

![A UMatter Saturation Survey Team](image)

### Responses by Neighborhood

<table>
<thead>
<tr>
<th>Neighborhood</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bellevue</td>
<td>7.90%</td>
</tr>
<tr>
<td>Central State St.</td>
<td>10.50%</td>
</tr>
<tr>
<td>Downtown</td>
<td>9.50%</td>
</tr>
<tr>
<td>Essex Ave</td>
<td>4.70%</td>
</tr>
<tr>
<td>Hamilton Pl</td>
<td>20.20%</td>
</tr>
<tr>
<td>Mont Pleasant</td>
<td>16.80%</td>
</tr>
<tr>
<td>Northside</td>
<td>6.80%</td>
</tr>
<tr>
<td>St. Peter's</td>
<td>5.50%</td>
</tr>
<tr>
<td>Union St.</td>
<td>8.90%</td>
</tr>
<tr>
<td>Woodlawn</td>
<td>9.30%</td>
</tr>
</tbody>
</table>

Source: UMatter
pantries, and the public library), and targeted coverage, in which a survey team focused on a specific few blocks over the course of several weeks. Although the survey provided a “convenience sample,” the large number of responses (2,074 useable responses from City residents, which is 3.14% of the total City population and 4.15% of the population 18 and over) suggests validity. Responses by neighborhood reflected relative populations of each neighborhood, with oversampling in the neighborhoods of highest need.

Following completion of the survey, the results were downloaded from the iSurvey site to an SPSS application running on a PC at Ellis. These results were initially reviewed by the Ellis epidemiologist, and then more fully analyzed by a team consisting of this epidemiologist, the professor who helped design the survey, and the SCPHS medical consultant (a physician with a degree in public health who was the County Health Commissioner at the time of the SCPHS REACH survey). They were assisted by two graduate student interns, one a MPH candidate and the other a medical student.

Overall, 2,229 surveys were completed, with 2,074 of these useable responses from City residents. Responses covered all ten neighborhoods, with absolute numbers and relative shares oversampling the areas of expected highest need. The survey somewhat oversampled women (58.8%).

A potentially significant data issue is the apparent skewing of the sample toward the lowest income population, with 31.7% of respondents reporting an annual income of less than $10,000. For the purposes of this report, which emphasizes programs and services for persons with low income, such a skew may be tolerated. Although data are currently being reported and used in their raw form, future uses of survey data may need to be income adjusted.

A second data issue concerns the time relationship of certain questions regarding chronic illnesses and mental health diagnoses. The initial question was typically phrased as, “have you ever been told by a health care professional that you have” a named disease or diagnosis. If a respondent answered “yes,” follow-up questions asked about current treatment and medications. In most cases, chronic diseases are managed, not cured, so a diagnosis at any time should lead to current treatment. In some cases, such as a patient’s significant weight loss leading to the disappearance of the symptoms of diabetes, the absence of current treatment for a previously diagnosed condition is not necessarily an indication of a problem. Conclusions from the analysis of these questions will be drawn with care.

Race and ethnicity questions on the survey specifically sought to measure Schenectady’s Guyanese population, which is not specifically identified in typical Census or other demographic data resources. Traditional demographic data standards classify persons of Guyanese (West Indian) descent as “Asian,” although some Guyanese of African descent self-identify as African-American, and, ancekd tally, some consider themselves “American Indian,” being persons of Indian descent who are now Americans. Also, 11.5% of the respondents are Hispanic or Latino(a).

Survey data are retained and can be manipulated using SPSS. Community organizations are beginning to use the information for grant applications and other purposes. The Schenectady/Amsterdam Land Bank
used income and homeownership data from two targeted neighborhoods in developing an application for residential housing rehabilitation funds.

1.b. SCPHS REACH MAPP and CAP Description

In early 2010 SCPHS applied for and received a two year CDC grant to address a unique health problem in the County. The CDC has a strong interest in addressing ethnic and racial disparities in chronic disease. As such it created grant opportunities for local communities entitled REACH – Racial and Ethnic Approaches to Community Health. The REACH grant for Schenectady County was a two year community – based planning activity focused on the diabetes rate disparity between the Indo-Guyanese population and other county residents. The ultimate goal of the program is to reduce the burden of diabetes for the Indo-Guyanese by using primary, secondary, and tertiary prevention methods developed in the planning process. The planning part of the program required the use of a specific planning method entitled Mobilizing for Action through Planning and Partnership (MAPP). At the conclusion of the MAPP activity a Community Action Plan (CAP) was developed to be used as a road map for the reduction of the burden. The two year budget was $400,000. The planning process was completed and both MAPP and CAP documents were created. Unfortunately, budget limitations and shifting priorities at CDC did not allow the implementation phase of this effort to come to fruition. During the grant period, the staff successfully collected over 800 diabetes surveys, completed a pilot project to train a dozen indigenous diabetes health promoters, engaged a local elementary school in type 2 diabetes prevention education (including an art contest) and conducted a diabetes health screening for the at-risk West Indian population in collaboration with our health partners and over 70 community volunteers.

MAPP Overview

In Schenectady it has been a unique and rewarding challenge to work through the MAPP process utilizing a health equity perspective. Introducing these concepts through existing coalitions enabled us to tap the community for resources and participation. REACH has allowed us to further strengthen our partnerships with stakeholders and has helped to refocus community energy and thinking related to public health’s mission. During the Visioning process, Schenectady gathered the newly formed West Indian Diabetes Action Coalition to define a meaningful image of our ideal community. Mobilizing for Action through Planning and Partnerships Process (MAPP) followed these steps:

- The Local Public Health Assessment (LPHSA) was held with community partners at Ellis Medicine and set the groundwork for the other three MAPP assessments.
- The Community Themes and Strengths Assessment (CTSA) was developed and implemented in partnership with the Siena Research Institute. Over 620 surveys were conducted through a random digit dialing survey (land lines and cell phones) to learn more about our community’s perception of their own environments, strengths, and needs in the County and their satisfaction with their current circumstances.
- A concise Community Health Status Assessment (CHSA) was researched and compiled by the REACH staff, much of it completed by Public Health Leaders of Tomorrow (PHLOT) students who interned with SCPHS over the life of the grant.
• Finally, the Forces of Change Assessment (FOC) was completed in partnership with Guyanese youth and adults as well as community leaders and stakeholders. Creative engagement through the use of PhotoVoice, reflective questioning, and introspective thinking led to the synthesis of the MAPP process.

Next we were challenged with the development of goals and strategies related to the strategic issues identified through the MAPP assessments and numerous meetings and community activities related to our REACH grant.

CAP Summary

The Community Action Plan (CAP) was developed based on all of the thousands of hours of work put in by the community and the REACH team. The highlights of the CAP included these action items:

1. Increase access to and improve quality of care, promote healthy behaviors and environment, and encourage chronic disease self-management behaviors:
   - Address environments through systems and “health-in-all” policy changes to have sustainable outcomes that address the root causes of health inequity.
   - Implementation of the “Chronic Care Model” at pilot medical providers, so that diabetes and other chronic diseases can be more effectively prevented and managed.
   - Train an indigenous health care workforce in the neighborhoods where the needs are the highest that will help to ensure culturally appropriate and sensitive engagement to address the barriers to holistic health.
   - Continual dialogue must occur throughout our community to ensure adequate resources, tools and motivation to improve the quality of life.

2. Encourage, improve and sustain safe and healthy, physical, social and domestic environments:
   - Promote equity throughout Schenectady neighborhoods to improve the physical environment to the underserved as “place matters.”
   - Address the root causes of domestic abuse, bullying and violence; this is a complex issue but embedded attitudes toward those affected must be changed.
   - Decrease adolescent pregnancy and birth rates - both being intricately linked to the social determinants of health; we will work to decrease the adolescent birth rates in order to improve the lives of those who will lead our community into the future.

3. Create opportunities for employment, education, and empowerment through community development and capacity building:
   - Increase opportunities for building human capital.
Increase policy and environmental changes to foster a positive business climate.

Increase opportunities for youth development by improving outreach, availability and capacity of programs.

Increase opportunities for social engagement and community cohesiveness.

1.c. HCDI Community Health Profile Description

The Healthy Capital District Initiative (HCDI) is a regional health improvement organization located in New York’s Capital Region. Members are the not-for-profit hospitals, federally qualified health centers (FQHCs), county public health departments, and not-for-profit health insurance plans located in or serving Albany, Rensselaer, and Schenectady Counties. Representatives from Schenectady organizations including Schenectady County Public Health Services, Ellis Medicine, Hometown Health Centers, and St. Peter’s Health Partners (the parent corporation for Sunnyview Rehabilitation Hospital) sit on the HCDI Board. HCDI collaborates with other regional health research organizations, particularly the School of Public Health at the University at Albany.

HCDI has been contracted by the New York State Department of Health as a “facilitated enroller” of Medicaid patients in the three counties. The entity also serves as the “In-person Assistor” organization in the three counties for the New York State Health Benefit Exchange.

HCDI has produced four iterations of a regional Community Health Profile, the most recent of which was published in 2013 and is included as Appendix 4. The Profile uses publicly available secondary data, largely from New York State Health Department sources, to compare healthcare metrics among the three counties, between the regional counties and standards such as national and Statewide (often shown as excluding New York City in order to provide a more appropriate comparison with the rest of the State) data, and against aspirational goals such as the State’s Prevention Agenda. Although the three counties vary in both population and geographic size, each includes a central city (Albany, Troy, and Schenectady respectively) with surrounding suburbs and rural areas, and there is enough other relative homogeneity from cross-border employment, shopping, and entertainment/recreation to make county-to-county comparisons useful.
HCDI also worked with the University at Albany’s School of Public Health to complete a Community Health Survey. The survey gathered data on general health, mental health and oral health, as well as chronic conditions, behavioral health factors and access to care issues that are not available from existing data sets. The survey was conducted online and on paper, through the HCDI website, in community-based health organizations, and among general service locations within Albany, Rensselaer, and Schenectady counties. There were 3,059 surveys included in the analysis from adult residents of Albany, Rensselaer, or Schenectady Counties, 649 of which lived in Schenectady County. Over 800 survey respondents lived in high need areas, providing a point of comparison for some of the results of the UMatter survey.

Data from the Profile augmented results of the UMatter survey to paint a more complete picture of health needs and health disparities in Schenectady. Profile data includes hospitalization, emergency room use, and prevention quality indicators at the ZIP code level, with the remaining indicators at the county level; while UMatter survey results are from the ten neighborhoods of the City of Schenectady. Analysis of the combined data sources helped to validate survey data, to demonstrate disparities between the City (and neighborhoods within the City) and the rest of the County, and to identify differences between Schenectady and the other two counties.

### 2.a. Schenectady Coalition for a Healthy Community Membership List*

- American Cancer Society of Northeastern New York – services to cancer patients
- Asthma Coalition of the Capital Region – support for preventing/treating asthma
- Bethesda House – housing and support services to low-income population
- Bigelow Corners Partnership – representatives of low-income, minority population
- BOCES Capit – services to youth and adolescents
- Boys and Girls Clubs of Schenectady – services to youth and adolescents
- Capital District Center for Independence – services to disabled individuals
- Capital District Child Care Coordinating Council – services to youth and adolescents
- Capital District Physicians Health Plan – non-profit health plan
- Capital District Tobacco Free Coalition – advocate for tobacco-free communities
- Capital District Transportation Authority – municipal transportation authority
- Catholic Charities – services to low-income, underserved, minority populations
- City Mission of Schenectady – services to low-income, underserved, minority populations
- City of Schenectady – local government
- Community Fathers, Inc. – services to low-come, minority males
- Cornell Cooperative Extension of Schenectady County – evidence-based nutrition education and youth development
- Ellis Medicine – non-profit general hospital and long-term care facility
- Fidelis Care – non-profit health plan
- Girls, Inc. – services to young women
- Guyanese American Association of Schenectady – representatives of minority population
- Habitat for Humanity of Schenectady County, Inc. – services to low income population
Healthy Capital District Initiative – regional health planning expertise
Hometown Health Center – federally qualified health center (FQHC) serving underserved
League of Women Voters of Schenectady County – good government organization
Mohawk Ambulance Service – regional ambulance service
MVP Health Care – non-profit health plan
Northeast Parent and Child Society – services to children with disabilities
Optimum Health Chiropractic – healthcare provider
Parsons Child and Family Center – services to children with disabilities
Planned Parenthood Mohawk Hudson – healthcare provider
Price Chopper – locally-owned supermarket chain
Rainbow Access Initiative – representatives of minority (LGBTQ) population
Rehabilitation Support Services, Inc. – services to individuals diagnosed with mental illness
SAFE, Inc. – services for homeless youth
Schenectady ARC – services to disabled
Schenectady City School District – urban school district with “majority minority” students
Schenectady Community Action Program – services to low-income, underserved, minorities
Schenectady County Community College – local, public two-year college
Schenectady County Department of Social Services – special knowledge of public health
Schenectady County Department of Probation – services to low-income, minority populations
Schenectady County Human Rights Commission – services to minorities
Schenectady County Office of Community Services – mental health, substance abuse, and developmental disability services
Schenectady County Public Health Services – special expertise in public health
Schenectady County Senior and Long Term Care Services – assistance for individuals in need of long-term care services
Schenectady Day Nursery – services to children
Schenectady Free Health Clinic** – services to low-income, underserved, minorities
Schenectady Inner City Ministry – services to low-income, underserved, minorities
Schenectady Municipal Housing Authority – housing services to low-income population
Schenectady Stand Up Guys – services to low-income males
Schenectady United Neighborhoods – association of neighborhood associations
Seton Health Center for Smoking Cessation – smoking cessation services
Sunnyside Rehabilitation Hospital – non-profit specialized rehabilitation hospital
The Albany Damien Center – services to chronic disease (HIV/AIDS) population
The Chamber of Schenectady County – chamber of commerce
The Schenectady Foundation – private foundation with family services focus
Union College – private liberal arts and engineering college
Union Graduate College – private college with special expertise in public health
United Way – services to low-income, underserved, minority populations
University at Albany, School of Public Health – public university with public health expertise
Visiting Nurse Service of Schenectady and Saratoga – non-profit home health agency
YMCA of the Capital District – local services include housing for homeless
YWCA – local services include housing for battered women

* As of October 30, 2013
** Free Clinic was consolidated with Ellis Medicine and Hometown Health, August 2013
2.b. Lists of Meetings and Participants

Schenectady Coalition for a Healthy Community (full group)

- **November 15, 2012**

**Topics**: Overview of the community assessment project and timeline. Visioning (targets and outcomes), survey topics, and subcommittees. Organize subcommittee for survey questions and development. Establishment of a separate committee of community members (the “Community Committee”). Open discussion.

**Attendees**: Schenectady County Public Health Services, Ellis Medicine, Schenectady Inner City Ministry, Visiting Nurse Service of Schenectady and Saratoga, Price Chopper Supermarkets, Union Graduate Collage, Schenectady Free Clinic, Schenectady ARC, Schenectady Community Action Program, Schenectady YMCA, Tobacco Free Coalition, League of Women Voters, University at Albany School of Public Health, Cornell Cooperative Extension, Schenectady Municipal Housing Authority, Schenectady County Probation Department, Mohawk Valley Physicians Health Plan, Union Graduate College, HCDI, United Way of the Greater Capital Region, Capital Region BOCES

- **December 13, 2012**

**Topics**: Naming of the Coalition. Detailed review of the survey goals, targets, and topics. Open discussion.

**Attendees**: Schenectady County Public Health Services, Ellis Medicine, Price Chopper Supermarkets, Schenectady YMCA, Tobacco Free Coalition, University at Albany School of Public Health, Schenectady Free Clinic, Cornell Cooperative Extension, League of Women Voters, Schenectady ARC, Catholic Charities, Northern Rivers (Parsons Center), Schenectady Inner City Ministry, Mohawk Valley Physicians Health Plan, Schenectady County Youth Bureau, Schenectady County Probation Department

- **January 17, 2013**

**Topics**: UMatter survey project updates: Schenectady Foundation grant, IRB approval of survey, start date of data collection and kickoff event, Community Health Workers, Student Volunteers, iPads and survey app, spreading the word and ideas for advertisement, venue planning. Update on the HCDI profile and survey. Open discussion.

**Attendees**: Schenectady County Public Health Services, Ellis Medicine, The
Chamber of Schenectady County, Schenectady ARC, League of Women Voters, University at Albany School of Public Health, Cornell Cooperative Extension, Catholic Charities Senior Services, Schenectady Inner City Ministry, HCDI, Schenectady County Department of Social Services, Capitol Region BOCES, Schenectady Community Action Program

- **February 21, 2013**

  **Topic:** “Kick-off” event held at Schenectady City Hall to announce the start of the door-to-door UMatter survey. The event was covered by local news media including both the daily newspapers and several television stations.

- **March 21, 2013**

  **Topics:** UMatter survey updates including survey progress and venue/event planning. Review of substance of preliminary survey data. Open discussion.

  **Attendees:** Schenectady County Public Health Services, Ellis Medicine, Schenectady Inner City Ministry, Schenectady ARC, Mohawk Ambulance, Schenectady Community Action Program, Rehabilitation Support Services, Cornell Cooperative Extension, Capital Region BOCES, University at Albany School of Public Health, independent consultant, The Chamber of Schenectady County, League of Women Voters, Habitat for Humanity, Schenectady Community Action Program, Schenectady County Office of Senior and Long Term Care, Catholic Charities Senior Services

- **April 18, 2013**


  **Attendees:** Schenectady County Public Health Services, Ellis Medicine, HCDI, Schenectady Community Action program, League of Women Voters, University at Albany School of Public Health, independent consultant, Schenectady YMCA, Capitol Region BOCES, SAFE, Inc., Schenectady Inner City Ministry, Mohawk Valley Physicians Health Plan, Habitat for Humanity, Schenectady Day Nursery, Catholic Charities Senior Services, Schenectady Municipal Housing Authority, Schenectady ARC, The Chamber of Schenectady County, The Schenectady Foundation

- **May 16, 2013**

  **Topics:** Project updates on UMatter survey completion, HCDI data, and CMS Innovation Awards. Establish post-survey analysis and evaluation subcommittees, including meeting schedule. Seek recruitment of additional Coalition partners and attendance at June 20th meeting for presentation of survey results. Availability of Community Health Workers for employment. Open discussion.

  **Attendees:** Schenectady County Public Health Services, Ellis Medicine, HCDI, Schenectady Community Action program, League of Women Voters, University at Albany School of Public Health, independent
consultant, Schenectady YMCA, Capitol Region BOCES, SAFE, Inc., Schenectady Inner City Ministry, Mohawk Valley Physicians Health Plan, Habitat for Humanity, Schenectady Day Nursery, Catholic Charities Senior Services, Schenectady Municipal Housing Authority, Schenectady ARC, The Chamber of Schenectady County, The Schenectady Foundation

- **June 20, 2013**

**Topics:** Presentation of the initial results of the U Matter survey.

**Attendees:** Schenectady County Public Health Services, Ellis Medicine, CDPHP, Schenectady ARC, University at Albany School of Public Health, Schenectady Free Clinic, Schenectady Day Nursery, The Chamber of Schenectady, Schenectady Community Action Program, Mohawk Ambulance, Tobacco Free Coalition, Schenectady Inner City Ministry, The Schenectady Foundation, Schenectady YMCA, HCDI, Visiting Nurse Service of Schenectady and Saratoga.

- **July 18, 2013**

**Topics:** Discussion of work of Strategic Issues Development subcommittee. Voting (Multi-Voting Method) to determine the highest priority community health needs. Open discussion.

**Attendees:** Schenectady County Public Health Services, Ellis Medicine, Schenectady YMCA, Schenectady ARC, University at Albany School of Public Health, Capital Region BOCES, Schenectady Free Clinic, CDPHP, Union Graduate College, Mohawk Ambulance, Schenectady Community Action Program, HCDI, Visiting Nurse Service of Schenectady and Saratoga, Tobacco Free Coalition

- **August 15, 2013**

**Topics:** Review recommendations of the Implementation Plan Development subcommittee. Discussion of Action Plan contents for the top five significant community health needs.

**Attendees:** Schenectady County Public Health Services, Ellis Medicine, Tobacco Free Coalition, Seton Health Center for Smoking Cessation, Mohawk Valley Physicians Health Plan, Community Fathers, Schenectady Free Clinic, Schenectady Community Action Program, Bigelow Corners Partnership, Schenectady Day Nursery, Schenectady ARC, Habitat for Humanity, Chamber of Schenectady County, The Schenectady Foundation, Union Graduate College, Schenectady Inner City Ministry, Foundation for Ellis Medicine, CDPHP, HCDI, Schenectady Community Action Program, Schenectady County Office of Community Services, Northeast Parent and Child Society, Schenectady YMCA

- **September 19, 2013**

**Topics:** Review and comment on draft of this document. Meet new PPACA health insurance navigators for Schenectady County.

**Attendees:** Schenectady County Public Health Services, Ellis Medicine, Schenectady ARC, SCAP Head Start, Bigelow Corners Partnership, University at Albany School of Public Health, Schenectady Free Health Clinic, Habitat for Humanity, Schenectady County Senior and Long-Term Care Services, Citizen...
Action Public Policy and Education Fund, Capital District Tobacco Free Coalition, The Schenectady Foundation, Schenectady League of Women Voters, Center for Smoking Cessation, University at Albany School of Social Welfare, MVP Health Care, Mohawk Ambulance, Schenectady County Department of Social Services, Chamber of Schenectady, Schenectady YMCA, Healthy Capital District Initiative, Schenectady Day Nursery, Catholic Charities Senior Services, Price Chopper Supermarkets

- October 17, 2013

**Topics:** Final review and approval of the Community Action Plan. Particular discussion of upcoming agenda regarding Smoking and Asthma issues. Presentation by Schenectady High School students regarding planned approach to adolescent pregnancy issues.

**Attendees:** Schenectady County Public Health Services, Ellis Medicine, Catholic Charities, League of Women Voters, University at Albany School of Public Health, Visiting Nurse Service of Schenectady and Saratoga Counties, Bigelow Corners Partnership, Union Graduate College, Schenectady Free Health Clinic, The Chamber of Schenectady, Capital District YMCA, Schenectady Inner City Ministry, Mohawk Ambulance, MVP Health Care, Schenectady Community Action Program, Schenectady County Community College, Sunnyview Rehabilitation Hospital, Healthy Capital District Initiative, Capital District Tobacco Free Coalition, The Foundation for Ellis Medicine, Schenectady Day Nursery, Capital District Physicians Health Plan

**Community Committee**

- December 6, 2012

  **Associations represented:** Guyanese American Association of Schenectady, Community Fathers Inc., Northeast Parent and Child Society, Center for Independence, Parsons Child and Family Center, Schenectady Stand-up Guys, Schenectady Community Action Program, Schenectady United Neighborhoods, Schenectady County Community College

- January 8, 2013

  **Associations represented:** Parsons Child and Family Center, Schenectady United Neighborhoods, Northeast Parent and Child Society, Center for Independence

- February 5, 2013

  **Associations represented:** Schenectady United Neighborhoods, Parsons Child and Family Center, Schenectady Community Action Program, Northeast Parent and Child Society, Schenectady United Neighborhoods, Optimum Health Chiropractic

- March 5, 2013

  **Associations represented:** Schenectady United Neighborhoods, Parsons Child and Family Center, Optimum Health Chiropractic
April 2, 2013

Associations represented: Schenectady United Neighborhoods, Parsons Child and Family Center, Optimum Health Chiropractic

May 20, 2013

Associations represented: Parsons Child and Family Center, Faith Deliverance Tabernacle, Schenectady United Neighborhoods

June 25, 2013

Associations represented: Parsons Child and Family Center

August 28, 2013

Associations represented: Schenectady United Neighborhoods

Coalition Subcommittees

- **Survey Development Subcommittee:**
  - Attendees: Ellis Medicine, University at Albany School of Public Health, YMCA, Cornell Cooperative Extension

- **Strategic Issues Development (priority recommendations) Subcommittee:**
  - Meeting: June 27, 2013
  - Attendees: Schenectady County Public Health Services, Ellis Medicine, Capital Region BOCES, independent consultant, League of Women Voters, Mohawk Ambulance, Catholic Charities, HCDI, Cornell Cooperative Extension, Tobacco Free Coalition, Union Graduate College, Seton Health Center for Smoking Cessation, Schenectady Community Action Agency

- **Implementation Plan Development Subcommittee:**
  - Meetings: July 25, 2013, August 1, 2013, August 8, 2013
  - Attendees: Schenectady County Public Health Services, Ellis Medicine, Schenectady ARC, Price Chopper, Mohawk Ambulance, Schenectady Inner City Ministry, Cornell Cooperative Extension, Tobacco Free Coalition, Schenectady County Office of Community Services, Schenectady City School District, Seton Health Center for Smoking Cessation, Seton Health Pediatric Obesity Prevention Program

This will also serve as the CHIP (Community Health Improvement Plan 2013 - 2017) for Schenectady County Public Health Services as required by NYSDOH.

Priority #1: Smoking and Asthma

Goal: Reduce the burden of preventable symptoms/conditions related to asthma and smoking

Project Period Objectives:

1) Decrease asthma hospitalization rate by 5/10,000 within pediatric population

2) Decrease prevalence of smoking among mental health patients by 5%

3) Decrease prevalence of smoking among Schenectady city residents by 5%

**Annual / Multi-Year Objective #1:** Increase number of asthma patients who participate in a three-tiered care model (care coordination, home visits/assessments, and asthma education) from 0 to 50/year

**Target Population:** patients who frequent the ED and hospital for asthma-related symptoms

**Health Disparity:** pediatric population- In Schenectady County, the asthma hospitalization rate per 10,000 for ages 0-17 is 18.3 compared to 11.9 for all ages

<table>
<thead>
<tr>
<th>Milestones/Activities</th>
<th>Timeline Year/Qtr.</th>
<th>Short Term Outcome/Measure</th>
<th>Lead Person / Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create system within Care Central to identify patients utilizing the ED for asthma</td>
<td>Y1Q1</td>
<td>Policies and procedures</td>
<td>Schenectady County Public Health Services, Ellis Medicine, Care Central</td>
<td>Hometown Health, Schenectady County Strategic Alliance for Health, Asthma Coalition of the Capital Region, Sunnyview Rehabilitation Hospital</td>
</tr>
<tr>
<td>Develop policies and procedures for referrals to Healthy Neighborhoods and Asthma Education programs</td>
<td>Y1Q1</td>
<td>Policies and procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consent patients into Care Central/Care Team Connect</td>
<td>ongoing</td>
<td># of consented patients</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

70
<table>
<thead>
<tr>
<th>Patients assigned to Navigator</th>
<th>ongoing</th>
<th># of patients assigned to Navigator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients referred to Healthy Neighborhoods and Asthma Education programs</td>
<td>Y1Q2</td>
<td># of referrals to Healthy Neighborhoods program # of referrals to Asthma Education program</td>
</tr>
<tr>
<td>Evaluate</td>
<td>ongoing</td>
<td># of patients completing three levels of care Change in ED utilization Change in hospital admissions</td>
</tr>
</tbody>
</table>

**Annual / Multi-Year Objective #2:** Increase number of practices prescribing by NIH guidelines by 5/year

**Target Population:** patients with asthma

<table>
<thead>
<tr>
<th>Milestones/Activities</th>
<th>Timeline Year/Quarters</th>
<th>Short Term Outcome/Measure</th>
<th>Lead Person / Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess number of practices prescribing by guidelines</td>
<td>Y1Q1</td>
<td># of practices</td>
<td>Ellis Medicine</td>
<td>Hometown Health, Capital Care, MVP</td>
</tr>
<tr>
<td>Conduct outreach and education to practices not prescribing by guidelines</td>
<td>Y1Q3</td>
<td># of practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make prescribing by guidelines a quality metric</td>
<td>Y1Q3</td>
<td>Prescribing by guidelines added as QI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluate</td>
<td></td>
<td># of practices meeting metric Change in ED utilization Change in hospital admissions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Annual / Multi-Year Objective #3:** Increase by 100, the number of municipal housing units that are smoke-free by 2016; Increase by 100, the number of affordable housing units that are smoke-free by 2016
**Target Population:** Low income population in the city of Schenectady

<table>
<thead>
<tr>
<th>Milestones/ Activities</th>
<th>Timeline Year / Qtr.</th>
<th>Short Term Outcome / Measure</th>
<th>Lead Person /Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educate municipal housing association board members and executive director on dangers of secondhand smoke and the benefits of a smoke free housing policy</td>
<td>Y1Q1</td>
<td># of board members educated</td>
<td>Capital District Tobacco-Free Coalition, Schenectady County Public Health Services</td>
<td>Center for Smoking Cessation, Schenectady Municipal Housing Authority, Schenectady County Strategic Alliance for Health</td>
</tr>
<tr>
<td>Assess progress of the current smoke-free housing policy that began on April 1, 2013 in the senior &amp; disabled municipal housing</td>
<td>Y1Q2</td>
<td># of policy violations &amp; support for the policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Train Schenectady Municipal Housing Authority staff member to be cessation counselor &amp; provide cessation services</td>
<td>Y1Q2</td>
<td># of cessation programs held at SMHA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct outreach to affordable housing managers / owners to provide education &amp; technical assistance on smoke-free housing policy development</td>
<td>Y1Q3</td>
<td># of affordable housing owners/managers that request assistance with smoke-free housing policy development</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Annual / Multi-Year Objective #4:** Increase by 5 the number of tobacco-free outdoor policies for government, non-profit and private sector organizations that serve the population with the highest tobacco use rates by 2016

**Target Population:** Organizations, non-profits and government organizations that serve the low income population in the City of Schenectady
<table>
<thead>
<tr>
<th>Milestones/ Activities</th>
<th>Timeline</th>
<th>Short Term Outcome / Measure</th>
<th>Lead Person /Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment the current tobacco free outdoor policies that exist at all county and city leased and owned properties</td>
<td>Y1Q1</td>
<td>Database of which city / county owned facilities have TFO policies</td>
<td>Capital District Tobacco-Free Coalition, Schenectady County Public Health Services</td>
<td>City of Schenectady, Schenectady County Strategic Alliance for Health, Schenectady County Department of Social Services</td>
</tr>
<tr>
<td>Assessment the current tobacco free outdoor policies that exist at the non-profit and private organizations that serve the low income population in the city of Schenectady</td>
<td>Y1Q1</td>
<td>Database of non-profit &amp; private organizations that serve the low income population &amp; any TFO policies that they have</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct education and outreach to these gov’t, non-profit and private orgs. on the dangers of secondhand smoke and the benefits of a tobacco free grounds policy</td>
<td>Y1Q2</td>
<td># of gov’t, non-profit &amp; private orgs. that express interest in developing a TFO policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide technical assistance with policy development and implementation to interested organizations</td>
<td>Y1Q2</td>
<td># of interested organizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrate cessation information and services into organizations that interface with low income population</td>
<td>Y1Q3</td>
<td># of organizations that provide cessation information and services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Educate the organizations that provide services & interact with the low SES population on the availability of smoking cessation assistance

<table>
<thead>
<tr>
<th>Year</th>
<th>Short Term Outcome / Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of organizations that provide cessation information and services</td>
</tr>
</tbody>
</table>

**Annual / Multi-Year Objective #5:** Decrease the number of licensed tobacco retailers (LTR) in Schenectady County by 5%

**Target Population:** Community members & decision makers in Schenectady County

<table>
<thead>
<tr>
<th>Milestones/ Activities</th>
<th>Timeline Year / Qtr.</th>
<th>Short Term Outcome / Measure</th>
<th>Lead Person / Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educate the Schenectady County Public Health Advisory Board on the tobacco retailer density &amp; the impact on tobacco use</td>
<td>Y1Q1</td>
<td># of Public Health Advisory Board members educated</td>
<td>Capital District Tobacco-Free Coalition, Schenectady County Public Health Services</td>
<td>City of Schenectady, Schenectady County Strategic Alliance for Health, Reality Check, Schenectady United Neighborhoods, League of Women Voters</td>
</tr>
<tr>
<td>Educate the health committee members of the Schenectady County Legislature on tobacco retailer density, the impact on tobacco use and what other communities have done to decrease LTR density</td>
<td>Y1Q1</td>
<td># of health committee members educated</td>
<td>Capital District Tobacco-Free Coalition, Schenectady County Public Health Services</td>
<td>City of Schenectady, Schenectady County Strategic Alliance for Health, Reality Check, Schenectady United Neighborhoods, League of Women Voters</td>
</tr>
<tr>
<td>Educate members of neighborhood associations</td>
<td>Y1Q2</td>
<td># of neighborhood associations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
where there is a highest density of tobacco retailers on the connection between retailer density, tobacco marketing and the impact on the community

Mobilize neighborhood association and community organizations to sign resolutions in support of decreasing tobacco marketing in their community

Attend community events to provide community education on tobacco marketing, retailer density and what can be done to decrease the impact on tobacco use in the city of Schenectady

**Annual / Multi-Year Objective #6:** Two mental health service provider facilities in Schenectady County will create a tobacco-free environment and integrate practices that support employee and consumer cessation by January 1, 2015

**Target Population:** mental health population, staff

<table>
<thead>
<tr>
<th>Milestones/Activities</th>
<th>Timeline Year/ Qtr.</th>
<th>Short Term Outcome/ Measure</th>
<th>Lead Person / Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convene a meeting with local partners to identify potential MH facilities</td>
<td>Y1Q1</td>
<td># of partners</td>
<td>Capital District Tobacco Free Coalition, Center for Smoking Cessation</td>
<td>Ellis Medicine, Schenectady County Office of Community Services, YMCA</td>
</tr>
<tr>
<td>Provide ongoing training and technical assistance to identified facilities</td>
<td>Y1Q2</td>
<td># of facilities with a tobacco-free grounds policy # of consumers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Help facilities access existing community resources  
Y1Q3  
# of staff trained as cessation facilitators  
# of tobacco-free signs displayed

Evaluate  
ongoing  
# of staff and consumers quit smoking

**Priority #2: Diabetes and Obesity**

**Goal:** Impact primary, secondary, and tertiary prevention of diabetes

**Project Period Objectives:**

1) Decrease prevalence of obese students/adults by 5%

2) Increase screening among the West Indian population by 10%

3) Decrease rate of diabetes short-term complication hospitalizations among 18+ population by 2/10,000

**Annual Objective #1:** Increase availability of diabetes self-management classes in 5 faith-based (FB) communities/year

**Target Population:** patients with Type 2 diabetes

<table>
<thead>
<tr>
<th>Milestones/Activities</th>
<th>Timeline Year/Quarters</th>
<th>Short Term Outcome/Measure</th>
<th>Lead Person/Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess potential FB communities</td>
<td>Y1Q1</td>
<td># of FB communities</td>
<td>Ellis Medicine, UAlbany School of Public Health</td>
<td>Schenectady County Public Health Services, Schenectady Inner City Ministry, Schenectady United Neighborhoods, faith-based communities, Cornell Cooperative Extension, Catholic Charities, Sunnyview Rehabilitation Hospital, Schenectady ARC, Schenectady County Strategic Alliance for</td>
</tr>
</tbody>
</table>
### Health, City Mission

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeline</th>
<th>Outcome/Measure</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit FB communities that will participate in Faith Fights Diabetes</td>
<td>Y1Q1</td>
<td># of FB communities</td>
<td></td>
</tr>
<tr>
<td>Identify CHWs</td>
<td>Y1Q2</td>
<td># of CHWs</td>
<td></td>
</tr>
<tr>
<td>Recruit participants</td>
<td>Y1Q2</td>
<td># of participants</td>
<td></td>
</tr>
<tr>
<td>CHW training</td>
<td>Y1Q2</td>
<td># trained</td>
<td></td>
</tr>
<tr>
<td>Hold classes</td>
<td>Y1Q3</td>
<td># of classes</td>
<td></td>
</tr>
<tr>
<td>Evaluate</td>
<td>ongoing</td>
<td># of participants completing classes Changes in clinical outcomes (A1c, BMI) Changes in ED utilization</td>
<td></td>
</tr>
</tbody>
</table>

**Annual / Multi-Year Objective #2:** Increase number of opportunities for physical activity from 0 to 5/year

**Target Population:** youth

**Health Disparity:** Schenectady County has the highest percentage of students classified as obese (19.5) compared to Albany County (17.9), Rensselaer County (17.4), NYS (17.6), and the US (16.9).

<table>
<thead>
<tr>
<th>Milestones/Activities</th>
<th>Timeline Year/Quarters</th>
<th>Short Term Outcome/Measure</th>
<th>Lead Person / Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess locations in the city for physical activity events</td>
<td>Y1Q1</td>
<td># of locations</td>
<td>Schenectady United Neighborhoods</td>
<td>City of Schenectady, YMCA, Schenectady City School District, Ellis Medicine, Hometown Health, Union College, Schenectady County Community College, Schenectady County Strategic Alliance for Health, Sunnyview Rehabilitation Hospital, Schenectady ARC, Cornell Cooperative Extension</td>
</tr>
<tr>
<td>Create an event schedule</td>
<td>Y1Q1</td>
<td># of events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>------</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess number of volunteers needed to staff events</td>
<td>Y1Q1</td>
<td># of volunteers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruit volunteers</td>
<td>Y1Q2</td>
<td># of volunteers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan activities</td>
<td>Y1Q2</td>
<td># of activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess supplies needed for activities</td>
<td>Y1Q2</td>
<td># of supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advertise events</td>
<td>Y1Q3</td>
<td># of partners/locations advertising events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hold events</td>
<td>Y1Q3</td>
<td># of events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluate</td>
<td>ongoing</td>
<td># of youth participating Accumulated hours of physical activity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Annual / Multi-Year Objective #3:** Three medical practices providing primary care will implement a policy to screen all West Indian adults for diabetes, regardless of BMI or age

**Target Population:** West Indian population

**Health Disparity:** 30% of the adult West Indian population has Type 2 diabetes

<table>
<thead>
<tr>
<th>Milestones/Activities</th>
<th>Timeline Year/Qtr.</th>
<th>Short Term Outcome/Measure</th>
<th>Lead Person / Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess practices screening all WIs</td>
<td>Y1Q1</td>
<td># of practices</td>
<td>Ellis Medicine, UAlbany School of Public Health</td>
<td>Hometown Health, Capital Care</td>
</tr>
<tr>
<td>Conduct outreach/education to practices not screening all WIs</td>
<td>Y1Q3</td>
<td># of practices/HCPs educated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluate</td>
<td>ongoing</td>
<td># of WIs screened Presence of complications at time of diagnosis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Annual / Multi-Year Objective #4:** Increase the number of municipalities and community based organizations in Schenectady County that have adopted food procurement standards and policies based on the Dietary Guidelines for Americans by 10

**Target Population:** Residents of Schenectady County, participants of community based organizations, municipalities

<table>
<thead>
<tr>
<th>Milestones/Activities</th>
<th>Timeline Year/Qtr.</th>
<th>Short Term Outcome/Measure</th>
<th>Lead Person / Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with leadership team to</td>
<td>Y1Q1</td>
<td># of organizations</td>
<td>Schenectady</td>
<td>Schenectady</td>
</tr>
</tbody>
</table>
continue to identify and engage at least 3 community organizations and/or municipalities that are willing to learn about the benefits and importance of adoption FP standards

| Provide technical assistance to municipalities regarding policy development and implementation | Ongoing | Product changes, policy development |
| Develop and conduct a survey of community based organizations to determine need and interest level | Y1Q2 | Survey development and results |
| Conduct educational sessions for leadership of community organizations and municipalities | Ongoing | # of sessions # of people educated |

### Priority #3: Inappropriate ED Utilization

**Goal:** Ensure patients are seeking appropriate levels of care

**Project Period Objectives:**

1) A 15% reduction in preventable ED visits over 36 months

2) A 15% reduction in inappropriate ambulance transport

3) Decrease rate of mortality due to falls among the 65+ population by 30/100,000

**Annual / Multi-Year Objective #1:** Expand the number of self-referrals to Care Central by 10%

**Target Population:** High utilizers of the ED

**Health Disparity:** Among city residents who reported making less than $10,000/year, 42.1% said they received care at an emergency department in the past 12 months. Among city residents who reported making more than $71,000/year, 16% said they received care at an emergency department in the past 12 months.

The highest rate of non-emergent Emergency Department visits (206.5 non-emergent visits per 1,000 population) comes from the Hamilton Hill neighborhood.

<table>
<thead>
<tr>
<th>Milestones/Activities</th>
<th>Timeline Year/ Qtr.</th>
<th>Short Term Outcome/Measure</th>
<th>Lead Person / Organization</th>
<th>Key Partners</th>
</tr>
</thead>
</table>

79
Conduct community outreach/education | ongoing | # of events | # of partners | educated | Care Central | Ellis Primary Care, Capital Care, Hometown Health, Care Central partners, Mohawk Ambulance

Measure change in ED use among consented patients | ongoing | ED use pre/post consent |

Measure change in utilization of PCPs among consented patients | ongoing | PCP use pre/post consent |

**Annual / Multi-Year Objective #2:** Conduct study of 500 ambulance calls to assess Paramedics’ estimate of overuse of ambulance transport to ED

**Target Population:** Patients utilizing Mohawk Ambulance

<table>
<thead>
<tr>
<th>Milestones/Activities</th>
<th>Timeline Year/Quar.</th>
<th>Short Term Outcome/Measure</th>
<th>Lead Person/Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess run records for inappropriate use</td>
<td>Y1Q2</td>
<td>Estimate rate of overuse</td>
<td>Ellis Medicine, Mohawk Ambulance</td>
<td>Hometown Health, Union College</td>
</tr>
<tr>
<td>Explore reasons for overuse and interventions</td>
<td>Y2Q1</td>
<td>Analysis of utilization Proposed intervention</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Annual / Multi-Year Objective #3:** Conduct falls assessments in 100 homes in the Woodlawn Neighborhood

**Target Population:** 65+ population in the Woodlawn Neighborhood

**Health Disparity:** 30% of calls to Mohawk Ambulance for falls come from the Woodlawn Neighborhood

<table>
<thead>
<tr>
<th>Milestones/Activities</th>
<th>Timeline Year/Quar.</th>
<th>Short Term Outcome/Measure</th>
<th>Lead Person/Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess target within Woodlawn</td>
<td>Y1Q1</td>
<td>Selected streets in Woodlawn/map</td>
<td>Ellis Medicine</td>
<td>Mohawk Ambulance, Sunnyview Rehabilitation Hospital,</td>
</tr>
<tr>
<td>Identify assessment tool</td>
<td>Y1Q2</td>
<td>Assessment tool</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>------</td>
<td>----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create assessment schedule</td>
<td>Y1Q2</td>
<td>Schedule</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify staff/volunteers to conduct assessments</td>
<td>Y1Q3</td>
<td># of people participating in project</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct awareness campaign</td>
<td>Y1Q4</td>
<td># of venues/partners promoting project</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete assessments/home modifications</td>
<td>Y2Q1</td>
<td># of homes assessed # of modifications made</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluate</td>
<td>ongoing</td>
<td>Reduction in calls for falls to Mohawk from Woodlawn</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Priority #4: Mental Health / Substance Abuse**

**Goal:** Organize community behavioral health services into a coherent system through reactivation of the Mental Health Task Force that had success in teen suicide reduction

**Project Period Objective:** Decrease rate of newborn drug-related hospitalization by 20/10,000 newborn discharges

**Annual / Multi-Year Objective #1:** Hold 4 meetings/year of the Mental Health Task Force

**Target Population:** mental health population

<table>
<thead>
<tr>
<th>Milestones/Activities</th>
<th>Timeline Year/ Qtr.</th>
<th>Short Term Outcome/Measure</th>
<th>Lead Person / Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Meeting</td>
<td>Y1Q1</td>
<td># in attendance</td>
<td>Schenectady County Office of Community Services</td>
<td>Ellis Medicine, Hometown Health, Care Central,</td>
</tr>
</tbody>
</table>
Quarterly meetings set | Y1Q1 | # of meetings |
---|---|---|
Systems subcommittee assigned | Y1Q1 | # participating on subcommittee # of meetings |
Goals and objectives set | Y1Q3 | Goals and objectives |
Evaluate | ongoing | Outcomes of proposed objectives |

### Annual / Multi-Year Objective #2: Conduct study of 100 drug-addicted mother/child pairs

**Target Population:** Drug-addicted pregnant women

**Health Disparity:** TBD

<table>
<thead>
<tr>
<th>Milestones/Activities</th>
<th>Timeline Year/Qtr.</th>
<th>Short Term Outcome/Measure</th>
<th>Lead Person / Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subcommittee on addicted infants</td>
<td>Y1Q1</td>
<td>Design chart review</td>
<td>Ellis Medicine</td>
<td>Hometown Health, Healthy Schenectady Families, Planned Parenthood, Schenectady City School District, Union College</td>
</tr>
<tr>
<td>Evaluate opportunities for interventions</td>
<td>Y1Q3</td>
<td># of prenatal visits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Design intervention strategy and deploy

<table>
<thead>
<tr>
<th>Milestones/Activities</th>
<th>Timeline Year/Qtr.</th>
<th>Short Term Outcome/Measure</th>
<th>Lead Person / Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subcommittee on Maternal depression</td>
<td>Y1Q1</td>
<td>Design chart review of 100 consecutive cases</td>
<td>Ellis Medicine</td>
<td>Hometown Health, Schenectady County Office of Community Services, Healthy Schenectady Families, Schenectady City School District, Union College</td>
</tr>
<tr>
<td>Assess rates as recorded</td>
<td>Y1Q4</td>
<td>Express rate in terms of national average</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncertain data</td>
<td>Y2Q1</td>
<td>Design prospective assessment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Priority #5: Adolescent Pregnancy**

**Goal:** Fully assess community resources at work on this issue; support and expand successes

**Project Period Objective:** Reduce rate of adolescent pregnancy among 15-17 age group by 5/1,000

**Annual / Multi-Year Objective #1:** Increase awareness of existing teen pregnancy prevention programs among 10 community partners and HCPs

**Target Population:** young women 12-17 years old

**Health Disparity:** In Schenectady County, adolescent pregnancy rate, ages 15-17, among Black, non-Hispanic females is 68.7/1,000 and among Hispanic females is 49.4/1,000 compared to 19.8/1,000 among White, non-Hispanic females.
The Hamilton Hill neighborhood in the City of Schenectady has the highest adolescent pregnancy rate in the entire region which, at 278.0 per 1,000, is ten times the rate in nearly adjacent Niskayuna (27.6/1,000).

<table>
<thead>
<tr>
<th>Milestones/Activities</th>
<th>Timeline Year/Quarters</th>
<th>Short Term Outcome/Measure</th>
<th>Lead Person / Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gather interested parties currently making efforts in this area</td>
<td>Y1Q1</td>
<td># attending meeting</td>
<td>Revolution Studios at the Schenectady City School District</td>
<td>Ellis Medicine, Hometown Health, Girls Inc., Boys and Girls Club, Planned Parenthood, Schenectady Day Nursery, Schenectady County Public Health Services</td>
</tr>
<tr>
<td>Develop a document describing current activities and gaps</td>
<td>Y1Q3</td>
<td>Report available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan gap closure</td>
<td>Y2Q1</td>
<td>Objectives developed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide comprehensive training on sexuality and pregnancy prevention to HCPs, particularly in school-based clinics</td>
<td>Y2Q2</td>
<td># of HCPs trained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct outreach/education on available resources</td>
<td>Y2Q2</td>
<td># of venues/partners advertising resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluate</td>
<td>ongoing</td>
<td>Outcomes of proposed objectives</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Priority #6: Interdisciplinary Priority**

**Goal:** Improve awareness of existing programs in the community

**Project Period Objective:** Increase number of Care Central partners that refer their clients to existing programs by 15

**Annual / Multi-Year Objective #1:** Hold 2 forums/trainings annually for all case managers who work for Care Central downstream providers

**Target Population:** Schenectady County residents
<table>
<thead>
<tr>
<th>Milestones/Activities</th>
<th>Timeline Year/Quart.</th>
<th>Short Term Outcome/Measure</th>
<th>Lead Person / Organization</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compile all community resources/programs of interest</td>
<td>Y1Q1</td>
<td># of identified programs</td>
<td>Ellis Medicine</td>
<td>Care Central, Schenectady Community Action Program, Schenectady ARC, all coalition partners</td>
</tr>
<tr>
<td>Explore potential electronic resource guide development/ social media programs</td>
<td>Y1Q2</td>
<td>Creation of social media program # of partners using program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach to community partners</td>
<td>Y1Q2</td>
<td># of partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advertise training</td>
<td>Y1Q3</td>
<td># of partners advertising</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hold training</td>
<td>Y1Q4</td>
<td># of case managers/partners trained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluate</td>
<td>ongoing</td>
<td># of referrals to identified programs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>