



UHS Hospitals

- UHS Wilson Medical Center
- UHS Binghamton General Hospital

Community Health Needs Assessment





**United Health Services Hospitals, Inc.
Community Health Needs Assessment (CHNA)
2013-2016**

Approved by Board of Directors on 3/25/14

Hospital Mission Statement

UHS Hospitals (UHS Wilson Medical Center and UHS Binghamton General Hospital) is a not-for-profit provider of health care services and is part of UHS, an integrated health care delivery system serving New York's Southern Tier and surrounding areas.

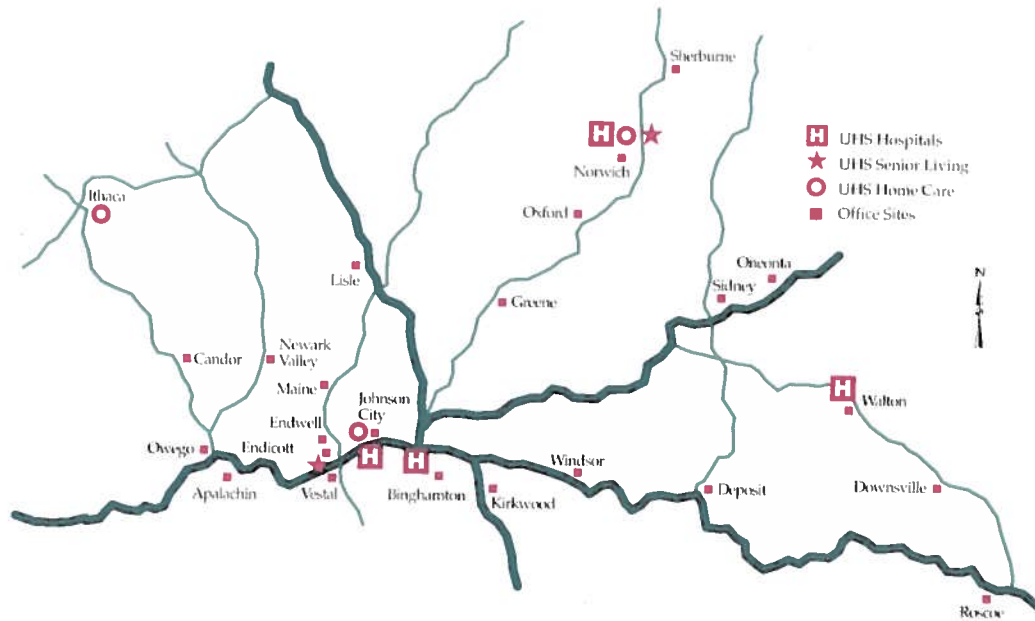
The Mission of UHS Hospitals is to serve the people of our region, to improve or maintain their health, and to provide patient-centered, contemporary health services in a caring, competent, and convenient manner. Services will be affordable and well organized to meet the needs of our patients and their families.

UHS Hospitals fulfills this mission by working together with the community, physicians, and other health care providers to continuously improve the availability and quality of services and our ability to provide:

- A comprehensive range of short-term inpatient acute and rehabilitative services, as well as outpatient diagnostic and treatment services, on its UHS Wilson Medical Center and UHS Binghamton General Hospital campuses.
- Primary care services which are the foundation for serving the community with a coordinated system of care, with special attention to underserved areas.
- Select specialized services that serve a broad geographic service area.
- Education programs in which graduate, undergraduate, and continuing medical education, as well as nursing and other professional and technical training and scholarship programs, make available well-trained health care professionals and advanced clinical services and medical practices.

Programs and services which educate our patients, their families, businesses and the community at large about promoting healthy lifestyles, facilitating understanding of personal health status, increasing knowledge of health care options, and encouraging effective utilization of the health care system.

Definition and Description of the Community Served



UHS Hospitals' (UHS) service area is centered in Broome county but also includes parts of Tioga, Chenango, Delaware, Sullivan and Otsego counties. The service area was determined by examining inpatient origin by zip code and by county. Because the majority of the service area falls into Broome and Tioga Counties, collaboration to identify Public Health Priorities took place at the county level. UHS's service area is centered in Broome County, with 70% of patients coming from Broome County communities, and another 20% from Chenango, Tioga, Delaware and Otsego counties. UHS's 75% zip code service area includes the Broome and Tioga communities of: Binghamton, Endicott, Johnson City, Vestal, Norwich, Owego, Apalachin, Windsor, Greene, Deposit, Port Crane, Kirkwood, Oxford, Conklin and Bainbridge. Since the last filing, Harpursville and Whitney Point were removed from the 75% service area, with Kirkwood, Oxford, Conklin and Bainbridge added in.

Broome and Tioga counties have a total combined 2013 population of 253,125 and 88% of the population is white. Otsego County has a total 2013 population of 61,403 and 92% of the population is white. Broome and Tioga counties have an average household income of \$60,380, and Otsego county has an average household income of \$56,925.

UHS Hospitals Community Impact

Based in Greater Binghamton, NY, UHSH is composed of providers and supporting facilities serving primarily New York's Southern Tier and surrounding areas. It is a locally owned, not-for-profit organization, governed by a volunteer Board of Directors made up of citizens of the community.

UHS Binghamton General Hospital is the birthplace of hospital care in Broome County. Founded in 1888, UHS Binghamton General has offered patients comprehensive, high-quality health care services for more than 100 years.

Today, UHS Binghamton General is a 220-bed facility, one of two full-service hospitals operated by UHS Hospitals, a member of the UHS Health Care System. Millions of dollars have been invested in improvements and new equipment to enable UHS Binghamton General to remain a vital, full-service community hospital one of the centerpieces of the UHS system.

UHS Wilson Medical Center in Johnson City, NY, is a 280-bed teaching hospital providing a full range of medical-surgical services, including cardiology, emergency medicine, neonatology, nephrology, maternity care, pediatrics, perinatology, pulmonary medicine, neuroscience, ophthalmology, and renal dialysis.

In addition to providing the traditional services typically found at a community hospital, UHS Wilson Medical Center is the gateway to high-intensity acute care and high-technology diagnostics at UHS Hospitals. These services are available at the Decker Center for Advanced Medical Treatment, one of the newest UHS facilities.

UHS Wilson Medical Center is a Johnson City and regional referral center for the advanced practice of emergency medicine, neurosurgery and newborn intensive care. It also is the UHS site for the practice of open-heart surgery and other advanced cardiac procedures

UHS also operates primary care centers and walk-in clinics in many locations throughout Broome, Tioga and Otsego counties (see facility locations map-page 2). These health-care center physicians are on the front lines of patient care. They respond to a broad range of medical problems people encounter throughout their lifespan. Primary care physicians deliver the basic diagnostic, treatment and preventive medical care patients most often needed.

UHS Walk-In Centers provide the community with minor, urgent care. With no appointment necessary, patients can expect quality medical attention at their convenience.

In addition, our school-based health centers located at Theodore Roosevelt and Benjamin Franklin schools, offer primary and preventive care to students in the Binghamton school district.

The UHSH Medicaid Health Home Program (which received its first patient assignment in 2013), offers a free Case Manager to Medicaid eligible patients who meet at least one of three diagnostic criteria (HIV/AIDS diagnosis, a diagnosis of a Serious, Persistent Mental Illness, or Two Chronic Conditions). This is a collaboration of health and community agencies that work together to provide free care coordination services and health information.

UHS also proudly supports the efforts of the Garabed A. Fattal Community Free Clinic located in Binghamton, NY. UHSH provides practitioners, equipment and medication to the uninsured adults of New York's Southern Tier. Medical services and medications are delivered free of

charge by volunteer health care professionals and other community volunteers in partnership with UHS as well as other health care institutions.

The UHS Center for Community Health is housed at the Stay Healthy Center located at the Oakdale Mall in Johnson City, NY. This is a mall “store-front” with easy access to the public and provides health education needs and referrals to health care services. This Center also collaborates with numerous community agencies and promotes healthy lifestyles. There are childbirth and parenting classes, lectures and presentations, screenings, plus friendly, knowledgeable nurses and other health professionals to answer questions. We served more than 19,000 New York State residents from our Oakdale Mall location in 2012, helping more than 16,400 people keep track of their blood pressure and more than 2,700 people get the health and wellness information they needed.

The staff at UHS Stay Healthy offers several programs and services to individuals, schools and businesses. These are offered to improve the health of our community and include many partnerships with local organizations. Programs are available for: Asthma, Eating Disorders, Healthy Living Resources, Just Ask Us, Living with Cancer, Tobacco Cessation and BC Walks. Services offered include: Care-A-Van shuttle service, Childbirth and Parenting Classes, Lactation Consultations, Nurse Direct, Stay HealthyKids, Stay Healthy Seniors and Team ACT: Allies in Conquering Tobacco.

Assessment of Community Needs and Identification of Initiatives

The Community Health Needs Assessment is a process for examining the health of a community. Importantly, this assessment serves as a baseline for evaluating progress toward the New York State’s *Prevention Agenda 2017* goals. These goals are designed to improve the health of all New Yorkers. As part of this process, many community organizations and health service agencies worked together. We examined data, explored issues, and developed a list of what we thought were the most pressing concerns.

Our partners in this process include:

Community-Based health and Human Service Agencies [*Rural Health Network of SCNY, Broome County Urban League, Mothers and Babies Perinatal Network of SCNY, United Way of Broome County, Action for Older Persons, Mental Health Association of the Southern Tier, Keep Youth Doing Something (KYDS) Coalition, Aging Futures Partnership, Family Enrichment Network, Senior Centers, Local diabetes and heart disease support groups*], Government agencies with special knowledge of Public Health issues [*Broome County Health Department, Tioga County Health Department, Broome County Department of Social Services, Community Alternative Systems Agency (CASA), Broome County Mental Health Department, Broome County Office for Aging, Broome County Environmental Management Council, Broome County Parks and Recreation, NYS DOT, Binghamton Metropolitan Transportation Study (BMTS), Strategic Alliance for Health*], Governmental and Non-Governmental Agencies [*Broome-Tioga BOCES, BOCES Food Service, Southern Tier Health Link, American Heart Association, American Cancer Society*], Communities [*Law Enforcement, Broome County Council of Churches, Catholic Charities of Broome County*], Academia [*Binghamton University, SUNY Upstate Medical University Clinical Campus at Binghamton, Cornell Cooperative Extension*], Employers, Businesses, Unions, Policymakers and Elected Officials.

The Broome County Community Health Assessment Steering Committee (see member list below) played a major role in completing the Community Health Needs Assessment for Broome County. The following New York State Prevention Agenda 2013-2017 priority areas and goals were identified by the Broome County Community Health Assessment Steering Committee as the local health priorities.

1. **Priority Area:** Promote Healthy Women, Infants and Children
2. **Priority Area:** Prevent Chronic Disease
3. **Priority Area:** Promote a Healthy and Safe Environment

The Mobilizing Action through Planning and Partnerships (MAPP) model was used to assess the health needs of the community, prioritize health needs, and strategize about ways to improve the health of Broome County residents. This model functioned as a community-wide strategic planning tool and formed the basis for prioritizing key public health issues and identifying potential resources.

Broome County Community Health Assessment 2013–2017 Steering Committee:

INDIVIDUALS

Yvonne Johnston
 Claudia Edwards
 Mary McFadden
 Dr. Christopher Ryan
 Leigh Ann Scheider
 Anthony Fiala
 Lynne Esquivel
 Kathleen Bunnell
 Don Bowersox
 Alan Buyck
 Dr. John Harding
 Sharon Chesna
 Christy Finch
 Lisa Bobby
 Dr. Hemant Gupta
 Cameron Soule
 Wayne Mitteer
 Pam Guth
 Leslie Kannus
 Jack Salo
 Lenore Boris
 Karen Bayer
 Robin Kinslow-Evans
 Pat Williams
 Nikki French
 Amelia LoDolce
 Lea Webb

COMMUNITY ORGANIZATIONS

Binghamton University, Decker School of Nursing
 Broome County Health Department

 Broome County Legislature
 Broome County Mental Health Department
 Broome County Office for Aging
 Broome County Social Services Department
 Broome Tioga BOCES
 Community Representative
 Mothers and Babies Perinatal Network

 Our Lady of Lourdes Hospital

 Rural Health Network of SCNY

 SUNY Upstate Medical University Clinical Campus at Binghamton
 United Health Services Hospitals

 United Way of Broome County

 WEBB Consulting

Three Year Plan of Action

Priority Area: Promote Healthy Women, Infants and Children

For Broome County, the percentage of infants who were fed any breast milk in the delivery hospital was 74.1% and who were exclusively breastfed in the hospital was 66.1%. This latter figure was higher than both NYS (42.5%) and the Prevention Agenda 2017 objective of 48.1%. The percentage of WIC mothers who breastfed for at least six months was 19.8%, and Broome County was significantly lower than NYS (39.7%) and Upstate NY (28.7%) for this indicator.

Goal: Increase Breastfeeding

Tactics

- Labor and delivery nursing staff encourage skin-to-skin contact immediately after birth.
- Stay Healthy nursing staff contacts all mothers upon 3-5 days of discharge and offers guidance and support in any breast-feeding strategies and (if needed) equipment rental; free lactation consultant made available to all mothers.

Performance Actions and Measures

- Track the number/percentage of mothers contacted upon discharge.
- Monitor decreased formula usage at the post-partum unit.
- Track enrollment in pre-natal classes and breastfeeding courses.
- Track the percentage of women enrolled in the WIC program who initiate breastfeeding during the first 48 hours of birth.

Breastfeeding is a rewarding and challenging choice for mothers. UHS Stay Healthy has Registered Nurses in New York who are lactation counselors or consultants on staff to answer questions and get patients the needed information on breastfeeding with confidence. From the proper positioning of a baby while feeding to dealing with discomfort and soreness, our nurses are trained to work with patients in a professional and understanding manner so that they are able to bond with their baby and relax in the process.

Priority Area: Prevent Chronic Disease

In Broome County, there is an average of 65 deaths per year due to diabetes mellitus. The age-adjusted diabetes mortality rate was estimated to be 24.4 per 100,000 population, and this rate was higher than both NYS (16.6 per 100,000) and Upstate NY (14.9 per 100,000). Among NYS counties, Broome County ranked in the fourth quartile for diabetes. The diabetes mortality was slightly less than the 65.8 deaths per 100,000 population objective set by *Healthy People 2020*. The average number of hospitalizations per year was 283 for diabetes as a primary (admitting) diagnosis and 4,971 for any diabetes diagnostic code associated with the hospitalization. The age-adjusted hospitalization rate for those with a primary (admitting) diagnosis of diabetes was 12.9 per 10,000 population compared with 19.0 per 10,000 for NYS and 14.3 per 10,000 for Upstate NY. The age-adjusted hospitalization rate for those with any diagnosis of diabetes was 195.7 per 10,000 population for Broome County compared to 226.1 per 10,000 for NYS and 198.2 per 10,000 for Upstate NY. In both of these areas (primary or any diagnosis of diabetes), Broome County was significantly lower than both NYS and was significantly less than Upstate NY for hospitalizations with diabetes as a primary diagnosis.

Goal: Increase screening rates for Diabetes

UHS has provided specialty services for people with the treatment and management of diabetes in Binghamton, Norwich and Southern Tier community for over 35 years. The UHS Diabetes and Endocrinology Center teaches patient responsibility and self management to help the person with diabetes achieve and maintain optimal health. Everyone affected by diabetes—patients, families and friends—can acquire skills to successfully manage their diabetes. Our Norwich, Walton and Binghamton diabetes treatment programs serve the entire Southern Tier community and offers comprehensive resources for diabetics and their families.

Tactics

- Track the number of patients identified as having diabetes or pre-diabetes who will then receive follow-up by Stay Healthy Center.
- Track the number and percentage of adults diagnosed with pre-diabetes or type 2 diabetes who then are referred to diabetes self-management training.
- Track the number of rural residents participating in chronic disease self-management and the number of patients receiving diabetes education.

Performance Actions and Measures

- Monitor and track the Diabetes Education that is provided by Certified Diabetes Educators, Registered Nurses and Registered Dietitians [include: Individual and group counseling, insulin starts, instruction on injectable diabetes medication and Insulin pump and continuous glucose monitoring (CGM) education.]
- For Type 1 Diabetes, assist in obtaining individual appointments for diabetes education.
- For Type 2 Diabetes pre-diabetes, recommend attendance of the introductory sessions as well as assistance in meal planning and meter classes (90-120 minutes) for newly diagnosed or no prior education and the Take control of your Diabetes class,(90 minute) refresher class for those with prior education.
- Monitor and expand the comprehensive diabetes self management education programs on nutrition, meal planning and carbohydrate counting, blood glucose monitoring, prevention of complications/decreasing risks associated with diabetes, increased physical activity, diabetes disease process and treatment options and living with diabetes.

Goal: Increase screening rates for cardiovascular disease

Through UHS Wilson Medical Center, patients have access to the region's largest and most comprehensive array of cardiac services, as well as a dedicated and highly skilled team of heart specialists. These specialists have been on the leading edge of disease prevention, diagnosis, treatment, research and rehabilitation, and are joined by staffs of health care professionals who are equally talented and determined to providing the very best care to every cardiac patient who walks through our doors. With locations in Binghamton, Norwich, Walton and Johnson City, our heart care specialists serve the entire New York Southern Tier.

Tactics

- Measure the number/percentage of adults with hypertension whose blood pressure is controlled (<140/90); number/percentage of Black/African American adults with hypertension whose blood pressure is controlled (<140/90); the number/percentage of patients receiving education related to hypertension, weight loss; medical compliance.

- Evaluate rural disease management programs including barriers and issues and effectiveness of strategies that are used.

Performance Actions and Measures

- Measure the percentage of health plan members ages 18-85 years, with hypertension who have controlled their blood pressure (<140/90). Track data among Medicaid Managed Care and among Black/African American adults.
- In 2013, UHSH Stay Healthy provided 11,400 free blood pressure screenings to the public. Continue to offer and expand this service to rural populations through established community event participation

Goal: Increase access to comprehensive array of Cancer services

Each year an estimated 1,287 people are diagnosed with cancer, and it is responsible for 445 deaths per year in Broome County. Incidence and mortality is somewhat higher for males than females. Between 2000 and 2009, overall cancer rates in Broome County remained relatively stable. For the period 2007-2009, the crude mortality from all cancers was 233.1 per 100,000 population and the age-adjusted mortality was 176.2 per 100,000 population. Although the overall rate is significantly higher than NYS as a whole (163.0 per 100,000), it ranks Broome County in the second quartile. Both the crude and age-adjusted rates were higher than the *Healthy People 2020* objective of 160.6 deaths per 100,000 population.

The Cancer Program at UHS Wilson Medical Center has received the accreditation from the Commission on Cancer of the American College of Surgeons. The award is given only to facilities that voluntarily commit to providing the highest quality of cancer care. It confirms that our patients have access to comprehensive care, state-of-the-art technology and a multispecialty team to coordinate the best treatment options.

Tactics

- In conjunction with the American Cancer Society's Road to Recovery Program and the Rural Health Network's GetThere Program, coordinate free rides for patients to and from treatment sessions.
- Continue education programs such as Tea with Ruth, Mugs for Men, Lymphedema Support Group, Lymphedema Therapy, and Breast Cancer Support Groups.
- UHSH will continue to use the Stay Healthy Magazine (which is a free insert within the local newspaper) to communicate to the public the various cancer prevention programs and services available for Cancer care.
- UHSH will use all available media (radio; TV; mass transit; internet) to promote available cancer screenings and cancer services to the community.

Performance Actions and Measures

- Stay Healthy will continue to measure the number and percentage of individuals who participate in the support groups and the number of cancer screenings (breast, cervical, prostate etc.) provided to the community.
- The UHS Cancer Nurse Navigator will continue to provide support and education to the cancer patients utilizing UHS Hospitals, as well as help with service referrals for this population.

Goal: Reduce Obesity in Children and Adults

A healthy weight in adults is defined as a Body Mass Index (BMI) greater than or equal to 18.5 but less than 25 kg/m². Overweight is defined as a BMI greater than or equal to 25 but less than 30 kg/m² and obesity is defined as a BMI greater than or equal to 30 kg/m². BMI is calculated as weight (in kilograms) divided by square height (in meters) and is used as a body weight standard and an indicator of the degree of adiposity. This index is also used to provide an estimate of relative risk for disease such as heart disease, diabetes, and hypertension. Information about obesity related indicators are located in Appendix E19 and additional tables, charts, and maps appear in Appendices E20-E44 for both adults and children. In children, BMI standards are based on growth chart percentiles with overweight defined as a BMI at or above the 85th percentile but below the 95th percentile for BMI by age and gender, and obese as a BMI at or above the 95th percentile for BMI by age and gender.

Tactics

- Identify and track children at risk for obesity by utilizing the primary care providers conducting BMI screenings.
- Use the school-based health centers to communicate healthier food and beverage options to children and parents.
- Track data from questionnaires (we CAN and CATCH) as well as pre and post BMI data.
- Increase the number of programs such as BC Walks and Mall walkers at the Oakdale Mall in Broome County.

Performance Actions and Measures

- Track the percentage of children who are overweight [age/gender specific BMI at $\geq 85^{\text{th}}$ to 95^{th} percentile] and percentage of children who are obese [age/gender specific BMI at $\geq 95^{\text{th}}$ percentile].
- Use changes in BMI to identify and recommend children in need for nutrition counseling;
- Expand implementation of Stay Healthy's Small Steps program, which promotes increased physical activity, consuming fruits and vegetables and decreasing screen time, to other schools.
- Collaborate with health care providers by providing them education on behavior modifications and meal portion sizes to adults and children and with obesity information/guidelines and encourage compliance to NYS guidelines.

Goal: Reduce Tobacco Use

Data for smoking behaviors come from the BRFSS (adults), the YRBS (high school students), and the 2012 Prevention Needs Assessment Survey (grades 7-12). Based on the 2009 NYS Expanded BRFSS, smoking prevalence among adults in Broome County was 20.5% which was similar to the state. This rate is higher than the *Healthy People 2020* objective of 12%. The percentage of adults living in homes where smoking is prohibited was 79.3% for Broome County. Trend analysis for BRFSS data between 1995 and 2012 showed that prevalence peaked in 1998 at 24.1% and that there was a steady decline in prevalence from 23.2% in 2001 and to

15.5% in 2010. Unfortunately, the prevalence of smoking appears to be increasing with a prevalence of 16.2% in 2011 and 18.1% in 2012.

Tobacco cessation is a critical step in staying healthy. Tobacco use is responsible for heart disease, cancer, emphysema, and many other chronic and debilitating illnesses. The UHS Stay Healthy Center, based in New York, has many available opportunities for individuals who wish to quit tobacco use and to stop smoking. There are currently 3 nurses who are New York State grant funded, who are reaching out to providers to educate them on Tobacco Cessation strategies that can be shared with their patient populations.

Tactics

- Utilize the Tobacco Cessation Program by offering free weekly cessation classes and strategies to cut tobacco dependence.
- Utilize the pre-admission testing (PAT) process to reach the community (patients who go through PAT will receive a tobacco cessation redemption coupon).

Performance Actions and Measures

- Increase the usage/redemption rate of coupons that can be used to obtain nicotine replacement therapies.
- Increase contact made to health care providers to reach 20 new providers every year.

Priority Area: Promote a Healthy and Safe Environment

Injuries are a leading cause of death and disability in New York State and are the leading cause of death between ages one and 44.51 Almost 7,500 New Yorkers die every year, as a result of an injury. Non-fatal injuries also result in adverse health outcomes ranging from temporary pain to long-term disability, chronic pain, and diminished quality of life. Hospitalization and rehabilitation services are also often needed. Injuries are consistently among the leading cause of hospitalization for New Yorkers of all ages. About 160,000 individuals annually are injured severely enough to require hospitalization. In New York State, falls are the leading cause of unintentional injury and deaths, among people ages 65 and over, and the leading cause of nonfatal injuries in this age group - more than one in three people over 65 years of age fall each year. These falls account for \$2 billion in annual hospitalization charges and \$624.4 million in annual outpatient emergency department charges. Approximately 95% of the hospitalization charges for older adults are billed to publicly funded programs, such as Medicaid and Medicare. In addition, half of adults 65 and older who are hospitalized due to a fall, end up in a nursing home or rehabilitation center.

Goal: Reduce fall risks among residents age 65 or older

With the goal of decreasing falls and fall-related hospital admissions among older adults (age 65+), UHS is 1) conducting fall risk assessments and preparing a plan of care with CPT codes, 2) identifying number of Medicare patients found to be at risk for falls and 3) monitoring all outpatient providers to ensure that fall risk assessments are done annually for the 65+ population, and 4) expanding fall risk assessments to 3 surrounding counties-Tioga, Chenango, Delaware.

Tactics

- Monitor the number of hospital primary care sites and primary care providers that have received fall prevention training.
- Track the number of Medicare patients evaluated per unit time frame and the number of clinical risk assessments performed per unit time frame,
- Monitor the number of patients with fall prevention care plan of care per unit time frame, and the number of referrals to physical therapy programs and community programs.

Performance Actions and Measures

- Track the number of provider sites screening older adults using evidence-based Fall Risk Assessments.
- Track the percentage of fall prevention clinical risk assessments conducted for older adults 65+ (hospital CPT code data).
- Track the percentage of fall prevention plan of care completed for older adults age 65+ determined to be at risk for falls (hospital CPT code data).

Dissemination of the Plan to the Public

The Community Health Needs Assessment is made available to the public through a link on our website <http://www.uhs.net> in our “About Us” section. The report is downloadable in Adobe Acrobat format (PDF) and information is provided regarding how to obtain free hard copy. A free paper copy will also be available at the Office of the President, Patient Registration as well as in the Community Relations Department.