Glens Falls Hospital

Community Service Plan

2019 - 2021

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1. Counties Covered:

Warren, Washington and Saratoga Counties

2. Participating Local Health Departments:

Warren County Public Health
Dan Durkee, Senior Health Educator
1340 State Route 9
Lake George, New York 12845

Washington County Public Health
Patty Hunt, Director
415 Lower Main Street #1
Hudson Falls, New York 12839

Saratoga County Public Health
Catherine Duncan, Director
31 Woodlawn Avenue #1
Saratoga Springs, New York 12866

3. Participating Hospitals/Hospital Systems:

Glens Falls Hospital-Lead Agency
Cathleen Traver
100 Park Street
Glens Falls, New York 12801

Saratoga Hospital-collaborative hospital partner within the service area
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Saratoga Spring, New York 12866

4. Assessment and Planning Coalition:

Adirondack Rural Health Network led by Adirondack Health Institute

Note: Saratoga Hospital and Saratoga County partnered with the Healthy Capital District Initiative for their community needs assessment and planning. Glens Falls Hospital representatives were present during this process.

Executive Summary

Glens Falls Hospital (GFH) conducted the following Community Service Plan (CSP) to identify and prioritize the community health needs of the patients and communities within the GFH service area, and develop a three-year plan of action to address the prioritized needs. The plan was developed in collaboration with Warren, Washington and Saratoga County Public Health Departments, and includes strategies that are evidence-based and aligned with the NYS Prevention Agenda 2019 - 2024. Glens Falls Hospital coordinated the planning through the Adirondack Rural Health Network (ARHN). ARHN provides a forum for local public health leaders, community health centers, hospitals, community mental health programs, emergency medical services, and other community-based organizations to assess regional population health needs and develop collaborative responses to priorities.

Through the ARHN collaborative, GFH coordinated with Warren and Washington counties to conduct a community health assessment in each county. Saratoga County conducted a separate, yet similar process to determine their community's heath needs. The process was mainly coordinated by Saratoga Hospital and Saratoga County Public Health and facilitated by a different regional planning group. GFH representatives were members of the prioritization planning group and actively contributed to the process.

Utilizing the results of the indicator analysis, regional survey and the other county-specific community assessment resources, each county prioritized the most significant health needs for their residents. Each counties' assessment provides the rationale behind the prioritization of significant health needs. In addition to evaluating the priorities and county level data indicators for our local county health departments, GFH considered our expertise and role in the community. To that end, GFH has

identified the following as the most significant health needs for the population served by GFH. These needs will be the major focus of GFH's community health strategies for 2019 – 2021:

Priority Area: Prevent Chronic Disease

- Focus Area 1 - Healthy Eating and Food Security
- Focus Area 2 - Physical Activity
- Focus Area 3 - Tobacco Prevention
- Focus Area 4 - Chronic Disease Preventive Care and Management

Priority Area: Prevent Communicable Diseases

- Focus Area 5 - Antibiotic Resistance and Healthcare-Associated Infections

It is important to note that GFH chose similar chronic disease related priorities during both our 2013-15 and our 2016-18 assessment process. Continuing to focus on these areas will improve, strengthen and sustain the impact of our interventions.

Improving health status in the five priority areas and reducing racial, ethnic, socioeconomic and other health disparities including those among persons with disabilities is an overarching goal of the NYS Prevention Agenda. Warren, Washington and Saratoga counties are predominately White and do not face the traditional racial or ethnic disparities typically found in more urban or populated areas. Instead, populations in upstate New York face a unique combination of factors that create health disparities, which are often rooted in the social determinants of health. Emphasis is placed on interventions that impact these disparate and underserved populations in the service area, especially low-income populations and those with limited access to healthcare and other community resources.

A variety of data sources were used to inform the county and hospital assessments. For GFH, Warren and Washington County, the two most significant resources used to inform the assessments were developed and provided by the ARHN collaboration: 1) publicly available county health indicator data and 2) data collected from a regional community stakeholder survey. Additional data used by

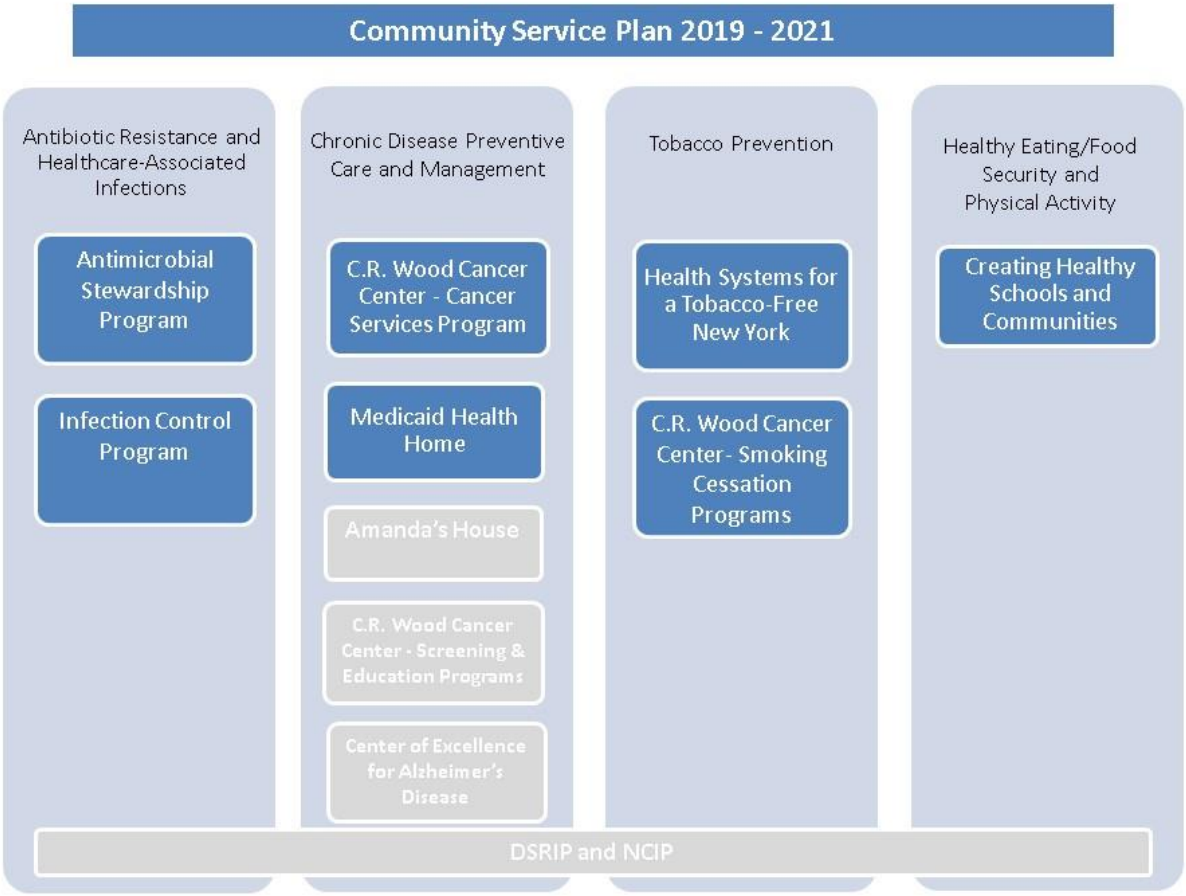
Glens Falls Hospital includes the Prevention Agenda Dashboard, County Health Rankings, the NYS Cancer Registry, Governor's Cancer Research Initiative – Warren County Cancer Incidence Report, and the Warren, Washington, and Saratoga County Tobacco Survey.

GFH will continue to partner with Warren, Washington and Saratoga county Public Health departments to implement the strategies in this action plan. GFH has a long-standing history of partnerships with these and other community-based organizations and agencies to support implementation of community health initiatives. These include a wide array of disciplines, such as schools, workplaces, providers, housing and transportation authorities, Offices for the Aging, county health departments, local economic opportunity councils, Chambers of Commerce and local decision makers. Many of these partners participated in the various county health assessments and planning processes and therefore are well versed in the need for these interventions and are poised to provide the support necessary to ensure the attainment of the proposed goals.

Many of these partnerships will be further enhanced through ongoing participation in the Adirondack Rural Health Network, Population Health Improvement Program, Delivery System Reform Incentive Payment Program, Adirondacks ACO, Health Home and the North Country Innovation Pilot. In addition, community engagement is integral to the success of improving health in our region. GFH will solicit the guidance and expertise of relevant content experts to ensure a coordinated approach and to best meet the needs of the population we serve. In addition, any feedback received from the public at large will also be considered in the planning and implementation. A list of partners and corresponding roles for each intervention is included in the required workplan table.

The visual below outlines the evidence-based interventions led by GFH to address the prioritized community health needs. The interventions were selected by GFH by aligning with the Prevention Agenda goals, building on existing initiatives and community assets, and identifying new initiatives to

complement and further enhance these existing programs. Capacity, funding, and potential impact were also major considerations. The inventions in blue are the selected strategies that are included in the formal DOH required Community Service Plan. The interventions in gray are included here to be comprehensive, as they are part of the IRS-required Implementation Strategy, but are not included in the DOH required Community Service Plan as they do not neatly align with Prevention Agenda goals and/or the required workplan format.

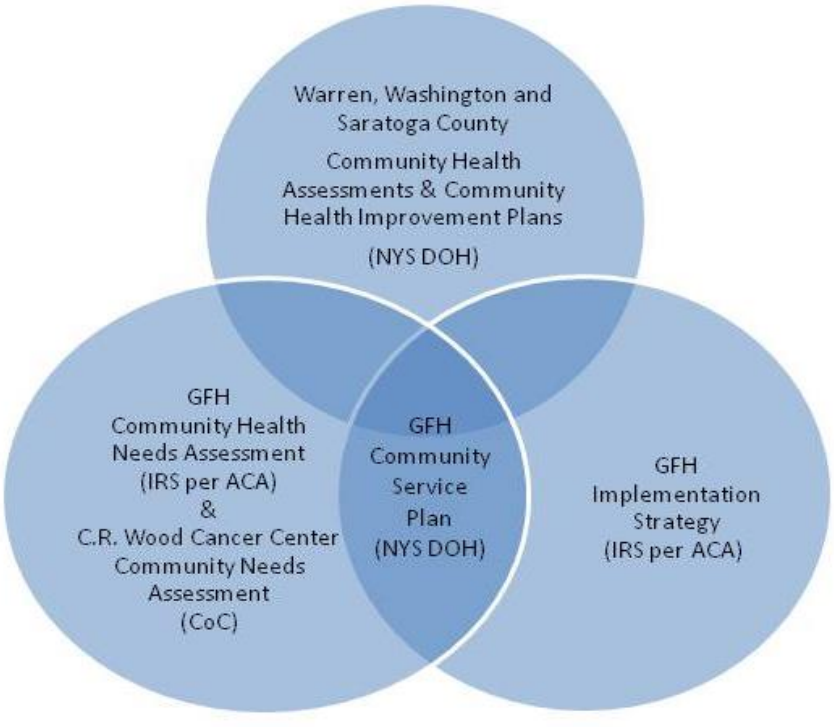


To ensure efficacy of the proposed interventions, GFH will work with Warren, Washington and Saratoga Public Health Departments to monitor and track progress using process and, where applicable, outcome evaluation. Each initiative has clearly defined process and/or outcome measures, as noted in the required workplan table.

Introduction

Glens Falls Hospital (GFH) conducted the following Community Service Plan (CSP) to identify and prioritize the community health needs of the patients and communities within the GFH service area, and develop a three-year plan of action to address the prioritized needs. The plan was developed in collaboration with Warren, Washington and Saratoga County Public Health Departments, and includes strategies that are evidence-based and aligned with the NYS Prevention Agenda 2019 - 2024. This CSP addresses the requirements set forth by the NYS DOH, which require hospitals to work with local health departments to complete a CSP that mirrors the Community Health Needs Assessment (CHNA) and Implementation Strategy (IS) required by the Affordable Care Act (ACA). GFH combined elements from our CHNA and IS documents to create this CSP. The community health needs assessment provision of the ACA (Section 9007) links hospitals' tax-exempt status to the development of a needs assessment and adoption of an implementation strategy to meet the significant health needs of the communities they serve, at least once every three years. The action plan for DOH includes elements from the IRS-required Implementation Strategy, however, the DOH Community Service Plan requirements are more prescriptive. Not all interventions included in the Implementation Strategy are included in the CSP.

The Public Health Accreditation board defines a community health assessment as a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues.[1] The findings in this Community Service Plan are the result of a collaborative process of collecting and analyzing data and consulting with stakeholders throughout the service area and the region. This Community Service Plan can be used to guide service providers, especially public health and healthcare sectors, in their efforts to identify potentially available resources and plan programs and services targeted to improve the overall health and well-being of people and communities in our region.



County health departments in New York State (NYS) have separate yet similar state requirements to conduct a Community Health

[1] Centers for Disease Control and Prevention, Community Health Assessments & Health Improvement Plans, October 2019. Available at https://www.cdc.gov/publichealthgateway/cha/plan.html

Assessment (CHA) and a corresponding Community Health Improvement Plan (CHIP). Beginning in 2012, all American College of Surgeons (ACoS) Commission on Cancer programs are required to complete a community needs assessment to identify needs of the population served, potential to improve cancer health care disparities, and gaps in resources. Consequently, cancer-specific information, data and needs will be highlighted throughout this assessment. Aligning and combining the requirements of these three entities ensures the most efficient use of hospital resources and supports a comprehensive approach to community health and population health management in the region.

Glens Falls Hospital

Founded in 1897, GFH today operates an advanced health care delivery system featuring more than 20 regional facilities. A vast array of specialized medical and surgical services are provided in addition to coronary care, rehabilitation and wellness and others. The main hospital campus is home to the C.R. Wood Cancer Center, the Joyce Stock Snuggery birthing center, the Breast Center and a chronic wound healing center. GFH is a not-for-profit organization and the largest employer in New York's Adirondack region, with over 2,500 employees and a medical staff of over 575 providers (see Appendix A). In September 2019, GFH and Albany Medical Center (AMC) announced that they have taken the next step toward a strategic affiliation, approving the Definitive Agreement for GFH to become an affiliate of AMC. The agreement was approved by both Boards following a nearly year-long due diligence process undertaken by both organizations. Both organizations are working through the necessary regulatory approvals needed to finalize the affiliation, which is expected to be complete in 2020.

The governance of GFH is vested in the Board of Governors (the Board), which is comprised of duly elected community members and physicians. The Board consists of not less than 12 and not more than 18 members, including two ex-officio voting members - the President of the institution and the President of the Medical Staff. The Board is required to meet at least twelve times per year. The officers of the Board include a Chairperson, a Vice Chairperson and a Secretary.

The primary and secondary service areas for GFH include Warren, Washington and northern Saratoga counties, covering over 2,000 square miles. However, patients often travel from as far away as Essex and Hamilton counties to obtain services within the health system. With an extended service area that stretches across five, primarily rural counties and over 6,000 square miles, GFH is responsible for the well-being of an extremely diverse, broad population and region.

As an article 28, not-for-profit, community hospital, GFH has worked to create healthier populations for over 115 years. GFH has established a diverse array of community health and outreach programs, bringing our expertise and services to people in outlying portions of our service area. These programs are especially important for low-income individuals and families who may otherwise fail to seek out health care due to financial or transportation concerns. Our history, experience and proven results demonstrate strong partnerships, regional leadership and active engagement in improving community health outcomes. GFH meets the criteria of an eligible safety net provider under the Delivery System Reform Incentive Payment (DSRIP) Program, as defined by the regional criteria of serving at least 30

percent of all Medicaid, uninsured and dual eligible members in the proposed county or multi-county catchment area.

GFH has worked to create healthier communities and is actively implementing numerous care transformation initiatives to support the Institute for Healthcare Improvement's Triple Aim of better health, better care and lower costs. Additional information on programs and initiatives underway at GFH follow later in this document.

Glens Falls Hospital Mission

The mission of GFH is to improve the health of people in our region by providing access to exceptional, affordable and patient-centered care every day and in every setting. Our fundamental values are: **C**ollaboration, **A**ccountability, **R**espect, **E**xcellence and **S**afety. The GFH Purpose combines our Mission - WHY we exist as an organization, our Pillar Goals -WHAT we need to accomplish in order to fulfill our mission and our Standards of Behavior and Core Values - HOW we interact and provide services as we strive to fulfill our mission.

C.R. Wood Cancer Center at Glens Falls Hospital

The C. R. Wood Cancer Center at GFH (The Center) opened in 1993, and is accredited as a Comprehensive Community Cancer Center by the ACoS CoC. The Center is multi-faceted with an integrated oncology program that provides comprehensive cancer services including: prevention, early detection, screenings, diagnostics, genetic risk evaluation, medical and radiation oncology, pharmacy, clinical research and survivorship care. Education and support services include psychological counseling, patient navigation, nutrition counseling, a children's camp, wellness programs and numerous support groups and weekend retreats.

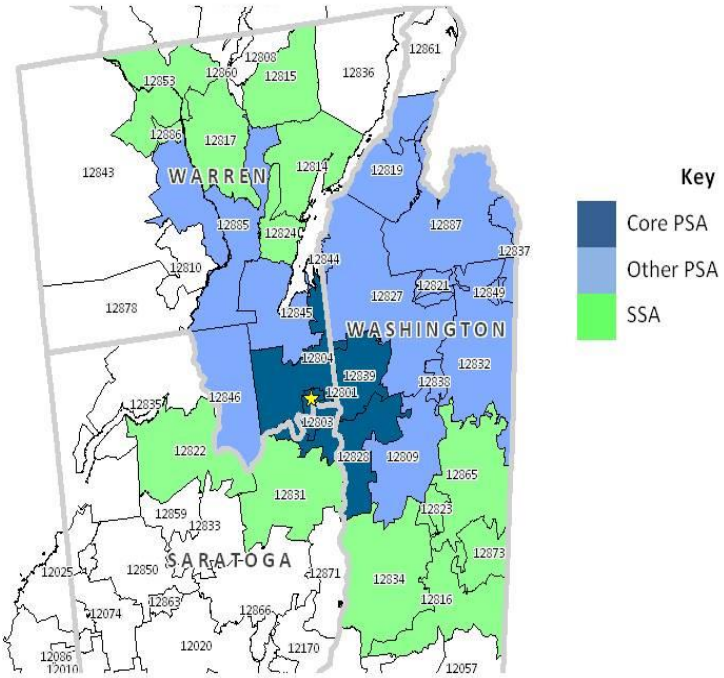
The CoC has recognized the C. R. Wood Cancer Center as an oncology program that offers high-quality cancer care. Only one in four cancer programs at hospitals across the United States receive this special accreditation. The CoC recognizes the quality of our comprehensive patient care and our commitment to provide our community with access to various medical specialists involved in diagnosing and treating cancer.

Patient navigation is facilitated through three nurse navigators and one social worker and a financial navigator that help patients find resources to remove barriers to care. They also provide education and support to patients diagnosed with cancer and their families and care givers. Nurses within the clinics and treatment areas refer to the navigators and/or care managers to help patients on an as needed basis. Patient navigation occurs through contact with newly diagnosed cancer patients. This process begins with an abnormal screening or diagnostic exam and continues through surgery, treatment and

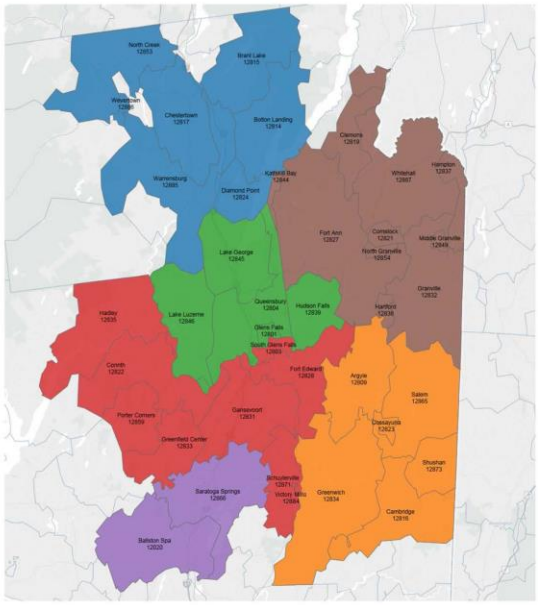
survivorship care. Patients that are identified for navigation are contacted by one of the navigators to provide education and support and identify and reduce any barriers throughout the continuum of care.

Glens Falls Hospital Service Area

Although GFH draws from neighboring communities to the North and West, our primary service area is defined by ZIP codes in Warren, Washington and northern Saratoga counties. This definition results from an analysis of patient origin, market share (which reflects how important GFH is to a particular community), and geographic considerations-



GFH Inpatient Service Area



GFH Ambulatory Service Area

including the need to ensure a contiguous area and takes into consideration both our inpatient and ambulatory services.

The GFH inpatient service area is defined by a Core Primary Service Area (PSA), Other Primary Service Area (Other PSA) and a Secondary Service Area (SSA). The Core PSA represents the ZIP codes immediately contiguous to the hospital. The SSA reflects more outlying areas where GFH has either a strong market share or a critical mass of patients that come to the hospital.

Additional analysis of our service area shows a similar, yet larger service area for our ambulatory population. In addition to those zip codes above, our ambulatory service area extends slightly farther South and West of the inpatient catchment area and captures additional municipalities located in northern Saratoga County that are serviced through our primary care offices and community-based services located throughout the region.

This service area definition also aligns with the counties included in the service area definition for the GFH Medical Staff Development Plan (MSDP).[2] It is important to note that an analysis of 2018 patient origin for the entire GFH health system revealed that approximately 50% of our total patient volume came from suburban areas, including our Primary Service Area and points south. Nearly 47% of total patient volume came from rural areas, mainly to the North, East and West of Glens Falls.

Health Care Transformation

Hospitals and public health departments are key partners in working with providers, agencies and community-based organizations to transform the way that our community members think about and receive health care. There are a number of federal, state, and regional initiatives to restructure the delivery system focusing on the Triple Aim. The Triple Aim is a framework that organizations and communities can use to navigate the transition from a focus on clinical care to optimizing health for individuals and populations. The Triple Aim is improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per capita cost of care for the benefit of communities. GFH plays an integral role in the region on the many health care transformation and delivery initiatives described below.

Population Health Improvement Program: The North Country Population Health Improvement Program (PHIP) is bringing together a variety of stakeholders in the North Country that impact, or are impacted by, health and health care issues. PHIP assists providers, agencies and organizations with identifying data and using data driven, collaborative decision making to address the social determinants of health that contribute to health disparities in the region. The PHIP is engaged with stakeholders in Franklin, Clinton, Essex, Hamilton, Warren and Washington counties. GFH is an active member of the North Country PHIP.

Adirondacks Accountable Care Organization: Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to provide coordinated, high-quality care to their patients. The Adirondacks ACO includes hospitals and participating primary and specialty care providers in Clinton, Essex, Franklin, Hamilton, Warren, Washington and northern Saratoga counties. In January of 2020, the ACO will add 14 behavioral health providers to the network. The Adirondacks ACO has value-based contracts with seven commercial health insurers as well as Medicare. The ACO was able to realize shared savings based on the performance for our commercial contracts in 2018. GFH is an active participant and serves as a member of the Board of Managers for the Adirondacks ACO as well as the Population Health and Quality Committee.

Adirondack Medical Home Initiative: The Adirondack Medical Home Initiative (AMHI) is a collaborative effort by health care providers and public and private insurers to transform health care delivery by emphasizing preventative care, enhanced management of chronic conditions, and assuring a close

[2] The MSDP justifies financial support for physician recruitment into private practices and is also a strategic tool to assess broader physician need including development of new programs and services. Consequently, there is significant overlap between both the content and purpose of the CHNA and MSDP (both federal requirements).

relationship between patients and their primary care providers. The AMHI includes provider partners in Clinton, Essex, Franklin, Hamilton, Warren, Washington and northern Saratoga counties. The Medical Home Initiative introduced the concept of care management in primary care. Through that project, primary care providers received funding to develop and support a care management infrastructure. In 2017, the Medical Home payments were folded into the ACO contracts. As with the Adirondack Medical Home Initiative, each provider is responsible for the care management. The ACO passes the funds along to the providers and does not provide centralized care management.

Health Home: A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that a patient's needs are addressed in a complete and comprehensive manner. This is done primarily through a "care manager" who oversees and provides access to the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency department and out of the hospital. Health records are shared among providers so that services are not duplicated or neglected. Health Home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively, they become a virtual "Health Home." Health Home focuses on people who have complex medical, behavioral, and long-term care needs, thus needing help navigating multiple systems of care. GFH is a care management agency of the Adirondack Health Institute's (AHI) Health Home.

Delivery System Reform Incentive Payment Program: On April 14, 2014 New York finalized terms and conditions with the federal government for a groundbreaking waiver to allow the state to reinvest $8 billion in federal savings generated by Medicaid Redesign Team reforms. The waiver amendment dollars have sought to address critical issues throughout the state and allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) program. The purpose of DSRIP is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program. Across NYS, there are 25 Performing Provider Systems (PPS) or networks of providers that have agreed to work together. GFH is a partner in the AHI PPS which includes Clinton, Essex, Franklin, Fulton, Hamilton, (western) St. Lawrence, (northern) Saratoga, Warren and Washington counties. The DSRIP program covers a five-year period beginning April 1, 2015 and ending March 31, 2020. On November 27, 2019 the NYS DOH submitted a 1115 Medicaid waiver amendment that establishes a framework for ongoing efforts to drive value. The formal request to the Centers for Medicare and Medicaid Services (CMS) seeks both a one-year extension of the current waiver program and a subsequent three-year renewal to allow the State to build upon the transformation started in the current waiver and continue toward value-based care.

DSRIP is an incentive payment model that rewards providers for performance on delivery system transformation that improve care for low-income patients. Over time measurement of performance has shifted from pay for reporting to pay for performance milestones. The milestones are designed to achieve transformation, leading to the primary goal of reducing avoidable hospital use by 25% over 5 years. In addition, there are a number of quality goals the PPS must achieve including measures of access, preventive care and care coordination, among others.

The AHI PPS coordinates activities in regional entities called Population Health Networks (PHN). Each PHN is led by an Executive Leadership Triad comprised of a regional physician champion, a regional community-based organization administrator and a hospital administrator with support from an AHI administrator. The PHN Management Triad is responsible for the collective quality and cost outcomes for the region as a whole. GFH maintains a leadership role in the Queensbury/Lake George regional triad.

North Country Innovation Pilot: The North Country Innovation Pilot (NCIP) is a unique partnership of providers and community members working together to improve the health of residents of the North Country by assuring access to needed care for those who are sick and promoting health for those who are well. At a very high level, NCIP is a proposed care delivery model supported by payment reform in the North Country, which build upon existing health care transformation initiatives currently underway. A focus will be on novel payment models that incentivize quality and efficiency, care supports and services unique to the needs of individuals in the region, measures to ensure high-value outcomes, and improved communication and integration. NCIP is still in the planning stages with more detailed design required and further partner engagement needed to reach a goal launch date of late 2020.

The common thread throughout these initiatives is the underlying objectives in the Triple Aim- to improve quality and experience while providing cost effective care.

Adirondack Rural Health Network

The Adirondack Rural Health Network (ARHN) is a program of AHI. AHI is a 501c3 not-for-profit organization that is licensed as an Article 28 Central Service Facility. AHI is a joint venture of Adirondack Health, GFH, Hudson Headwaters Health Network (HHHN), St. Lawrence Health System, and The University of Vermont Health Network – Champlain Valley Physicians Hospital. For thirty years the organization has supported hospitals, physician practices, behavioral health providers, community-based organizations, patients and others throughout the region in transforming health care and improving population health.

Established in 1992 through a NYS DOH, Rural Health Development Grant, ARHN provides a forum for local public health leaders, community health centers, hospitals, community mental health programs, emergency medical services, and other community-based organizations to assess regional population health needs and develop collaborative responses to priorities. As a multi-stakeholder regional coalition, ARHN informs regional health planning and assessment, provides education and training to further the NYS DOH Prevention Agenda and Delivery System Reform Incentive Payment (DSRIP) Program, and offers other resources that support the development of the regional health care system. ARHN includes organizations from New York's Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning in the region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of hospitals and county health departments working together to utilize a systematic approach to community health planning and assessment. The CHA Committee is made up of members from

Adirondack Health, Clinton County Health Department, UVM Health Network-Alice Hyde Medical Center, UVM Health Network- Elizabethtown Community Hospital, Essex County Public Health, Franklin County Public Health, Fulton County Public Health, GFH, Hamilton County Public Health Services, Nathan Littauer Hospital, UVM Health Network – CVPH, Warren County Health Services, and Washington County Public Health Services. See Appendix B for a full list of ARHN members and meeting dates.

New York State Prevention Agenda 2019 – 2024

The Prevention Agenda 2019-2024 is New York State's health improvement plan, the blueprint for state and local action to improve the health and well-being of all New Yorkers and to promote health equity in all populations who experience disparities. The vision of the Prevention Agenda is that New York is the Healthiest State in the Nation for People of All Ages. The overarching strategy of the Prevention Agenda is to implement public health approaches that improve the health and well-being of entire populations and achieve health equity. In addition, the Prevention Agenda serves as a guide for local health departments as they work with their community to develop CHIPs and CHAs and for hospitals as they develop mandated CSPs and CHNAs and an IS as required per the ACA requirements.

The Prevention Agenda 2019-2024 has five priorities with priority-specific action plans developed collaboratively with input from community stakeholders. Each priority-specific action plan includes focus areas, goals, objective and measures for evidence-based intervention to track their impacts- including reduction in health disparities among racial, ethnic, and socioeconomic groups, age groups and persons with disabilities.

These priority areas were used as a foundation for determining the most significant health needs for the GFH service area. The plan features five priority areas and corresponding focus areas that highlight the priority health needs for New Yorkers:

- Prevent Chronic Disease
    - Focus Area 1: Healthy Eating and Food Security
    - Focus Area 2: Physical Activity
    - Focus Area 3: Tobacco Prevention
    - Focus Area 4: Preventive Care and Management
- Promote a Healthy and Safe Environment
    - Focus Area 1: Injuries, Violence and Occupational Health
    - Focus Area 2: Outdoor Air Quality
    - Focus Area 3: Built and Indoor Environments
    - Focus Area 4: Water Quality
    - Focus Area 5: Food and Consumer Products
- Promote Healthy Women, Infants, and Children
    - Focus Area 1: Maternal and Women's Health
    - Focus Area 2: Perinatal and Infant Health
    - Focus Area 3: Child and Adolescent Health
    - Focus Area 4: Cross Cutting Healthy Women, Infants, and Children

- Promote Well-Being and Prevent Mental and Substance Use Disorders
    - Focus Area 1 - Well-Being
    - Focus Area 2 - Mental and Substance Use Disorders Prevention
- Prevent Communicable Diseases
    - Focus Area 1 - Vaccine Preventable Diseases
    - Focus Area 2 - Human Immunodeficiency Virus (HIV)
    - Focus Area 3 - Sexually Transmitted Infections (STIs)
    - Focus Area 4 - Hepatitis C Virus (HCV)
    - Focus Area 5 - Antibiotic Resistance and Healthcare-Associated Infections

Appendix C is attached for more detail on the 2019-2024 Prevention Agenda. In addition, more information on the Prevention Agenda can be found at https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/index.htm.

Community Health Needs Assessment Process

In NYS, hospitals and county health departments are required to work together to assess community health needs and develop a plan that addresses those identified needs. Working within the framework provided by the NYS Prevention Agenda, GFH collaborated with Warren, Washington and Saratoga County Public Health in the development of this Community Service Plan. Additionally, GFH coordinated with Fulton, Essex, Hamilton, Franklin and Clinton County Public Health, in addition to several other hospitals in the region, through the regional health assessment and planning efforts coordinated by ARHN.

The CHA Committee, facilitated by ARHN, is made up of hospitals and county health departments working together utilizing a systematic approach to community health planning. Members include:

- Adirondack Health
- Clinton County Health Department
- Essex County Public Health
- Franklin County Public Health
- Fulton County Public Health
- Glens Falls Hospital
- Hamilton County Public Health Services
- Nathan Littauer Hospital & Nursing Home
- UVM Health Network—Alice Hyde Medical Center
- UVM Health Network—Champlain Valley Physicians Hospital
- UVM Health Network—Elizabethtown Community Hospital
- Warren County Health Services
- Washington County Public Health Services

GFH serves a multi-county area, which fostered the need for a strategic approach to ensure alignment with each county assessment and planning process. Consistent with previous years, GFH determined that the most effective strategy would be twofold: 1) ensure the hospital coordinated with and/or

participated in each of the public health departments' community health assessment processes and 2) utilize the results of each of the county assessments to inform a coordinated and complementary regional Community Service Plan for the GFH service area.

This approach was utilized during the development of our last two Community Service Plans and after evaluating the effectiveness, it was determined that it would be beneficial to use this method again during the current planning cycle. The proceeding sections briefly describes each county's CHA process as well as the subsequent GFH process, followed by the data sources utilized to inform the processes.

Warren, Washington and Saratoga County Community Health Assessments

As a result of the collaborative efforts through ARHN, the information used to conduct a CHA in Warren and Washington County was fairly similar. Saratoga County worked with a different regional planning group to determine the needs of their residents. Representatives from GFH were members of the community-based groups that were assembled to review and assess the available health data and determine priority areas for each county.

Although Saratoga County worked with a different regional planning group, each county's CHA process was similar and involved both data analysis and consultation with key members of the community. Each county convened a group of community partners to review and discuss the data and information, and collectively identify and prioritize the most significant needs for the residents of each county. Because each county's public health department has different needs, capacities and resources, the actual prioritization process for each county varied. The partners included in each county's community health assessment teams (CHATs)[3] were slightly different, and each county also chose to consider slightly different data sources.

Glens Falls Hospital Community Health Needs Assessment

GFH used each county CHA to inform a complementary regional CHNA. GFH did not convene an additional regional team of community partners as this would have duplicated efforts and created confusion among community leaders. In addition, GFH played a slightly different role in each of the county processes. GFH directly participated in the planning of the Warren County CHA. GFH was a participant in the Washington County process. In Saratoga County, the process was mainly coordinated by Saratoga Hospital and Saratoga County Public Health and facilitated by a different regional planning group. However, GFH participated in the workgroup that determined the needs of the county.

Once the assessment process was complete for each county, GFH reviewed the results to coordinate with each county as appropriate, in addition to consideration of resources, expertise and strategic plans.

[3] Each county's group of partners was called something slightly different. However, for ease of reference the term CHAT is utilized in this report to describe the partners that collaborated to conduct the assessment and prioritize needs for each county.

Data Sources

A variety of data sources were used to inform the county and hospital assessments. For GFH, Warren and Washington County, the two most significant resources used to inform the assessments were developed and provided by the ARHN collaboration: 1) publicly available county health indicator data and 2) data collected from a regional community stakeholder survey. Despite the fact that Saratoga County and Saratoga Hospital collaborated with a different facilitator and conducted their own assessment, many of the same publicly available data sets were used to inform their process. Each county, as well as GFH, used additional data sources to supplement this information and inform the process based on their needs. The following is a list of the data sources considered by each county and/or GFH.

New York State Prevention Agenda Dashboard

The New York State Prevention Agenda Dashboard is an interactive visual presentation of the Prevention Agenda tracking indicator data at state and county levels. It serves as a key source for monitoring progress that communities around the state have made with regard to meeting the Prevention Agenda 2018[4] objectives. The state dashboard homepage displays a quick view of the most current data for New York State and the Prevention Agenda 2018 objectives for approximately 100 tracking indicators. The most current data are compared to data from previous time periods to assess the performance for each indicator. Historical (trend) data can be easily accessed and county data (maps and bar charts) are also available for each Prevention Agenda tracking indicator.

The county dashboard homepage includes the most current data available for 68 tracking indicators. Each county in the state has its own dashboard.

County Health Indicator Data

ARHN, a program of AHI, identified and collected data from a variety of sources on the seven counties in the Adirondack region and two adjacent counties to assist in developing individual county community needs assessments. Those counties include: Clinton, Essex, Franklin, Fulton, Hamilton, Montgomery, Saratoga, Warren, and Washington.

The initial step in the process was determining which data elements from the 2016 community needs assessment were still publicly available and updated. With the support of the CHA Committee, ARHN staff reviewed and compiled the data and then supplemented that information with data from other sources. Since most of the health behavior, status, and outcome data were only available at the county level, the data is displayed by county and aggregated to the ARHN region.[5]

The overall goal of collecting and providing this data to CHA Committee members was to provide a comprehensive picture of the individual counties within the Adirondack region as well as for two adjacent counties, including providing an overview of population health in addition to an environmental

[4] At the time this report was conducted, the Dashboard tracked indicators for Prevention Agenda 2013-2018. A new dashboard for Prevention Agenda 2019-2024 is scheduled to be available at the end of 2019.
[5] Aggregated data for the ARHN region included Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties but did not include Montgomery and Saratoga counties.

scan. In total, counties and hospitals were provided with about 400 data elements across the following four reports: Demographic Data; Education System Profile; Health Systems Profile; and Health Indicator Data for each County broken out by the Prevention Agenda focus areas. A complete description of the data collection and methodology is attached and labeled Appendix D.

Adirondack Rural Health Network Regional Community Stakeholder Survey

In conducting the CHNA, non-profit hospitals are required to take into account input from persons who represent the broad interests of the community served, including those with special knowledge of or expertise in public health such as local county health departments. In addition, members, leaders or representatives of medically underserved, low-income, minority populations should be consulted.

At the June 15, 2018 CHA meeting, it was decided that an Ad Hoc Data Sub-Committee would be created to review tools and processes used by CHA Committee members to develop their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), as well as identify ways to enhance the CHA/CHIP process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a stakeholder survey. The 2019 Community Stakeholder Survey was drafted over the course of seven meetings from mid-July through the end of October 2018. A report on the activities and outcomes of the Ad Hoc Data Sub-Committee was created and shared with the full CHA Committee and is attached as Appendix E. The final version of the survey was approved by the full CHA Committee at December 7, 2018 meeting. ARHN surveyed stakeholders in the seven-county service area, to provide the CHA Committee with input on regional health care needs and priorities. See Appendix F for a summary of the ARHN Stakeholder Survey

County Health Rankings

The County Health Rankings & Roadmaps program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The County Health Rankings show the rank of the health of nearly every county in the nation and emphasize the many factors that, if improved, can help make communities healthier places to live, learn, work and play. They help to simplify the complexity of data and provide context and a common language for those working in community health. See http://www.countyhealthrankings.org/ for additional information.

New York State Cancer Registry

Cancer is a reportable disease in every state in the United States. In NYS, Public Health Law Section 2401 requires that all physicians, dentists, laboratories, and other health care providers notify the Department of Health of every case of cancer or other malignant disease. Through the NYS Cancer Registry, the Department collects, processes and reports information about New Yorkers diagnosed with cancer. See http://www.health.ny.gov/statistics/cancer/registry/about.htm for additional information about the NYS Cancer Registry.

Governor's Cancer Research Initiative – Warren County Cancer Incidence Report

The most comprehensive and recent cancer data available was issued in the Fall of 2019, published in the Warren County Cancer Incidence Report. This report summarizes cancer patterns and trends for Warren County, NY and was conducted as part of Governor Cuomo's Cancer Research Initiative. Warren County was identified by the New York State Department of Health because it had the highest rate of all cancers combined in NYS based on 2011-2015 data. Data evaluated included sociodemographic, behavioral, healthcare, occupational, environmental, and cancer registry. With respect to the registry, brain and other nervous system cancer, colorectal cancer, laryngeal cancer, lung cancer, oral cancer and thyroid cancer were selected because their overall or sex-specific incidence rates were statistically significantly higher in Warren County than in New York State excluding New York City (NYS excluding NYC).[6] While a comparable report is not available for Washington and northern Saratoga counties, this information can be used to better understand the burden of cancer in these populations. See https://www.health.ny.gov/diseases/cancer/cancer_research_initiative/ for more information.

Warren, Washington and Saratoga County Tobacco Survey

The GFH Living Tobacco-Free initiative subcontracted with Siena Research Institute to conduct a community survey in the winter of 2015/2016. The purpose of the community survey was to gather information from community members about tobacco use, attitudes towards tobacco use, advertising and tobacco-related policies. Data was collected from 1,177 community members who are 18+ years of age that reside in Saratoga, Warren, and Washington counties. The data was collected, analyzed and compiled into a final report that we are able to share with community members and key stakeholders.

Regional Profile of Warren, Washington and Saratoga Counties[7]

Warren, Washington and Saratoga counties are part of the Capital Region, along with Albany, Columbia, Greene, Rensselaer, and Schenectady counties.[8] The Capital Region is an attractive

[6] Governor's Cancer Research Initiative – Warren County Cancer Incidence Report, Executive Summary, October 2019, available at https://www.health.ny.gov/diseases/cancer/cancer_research_initiative/

[7] Within this report, much of the data presented for Warren, Washington and Saratoga counties represents the entire county, not just the zip codes included in the GFH service area definition. There is very limited data available for an area that is smaller than the county-level. While this does not create a significant issue for Warren and Washington counties, it is important to note that Saratoga County is extremely diverse, and populations in the southern portion of the county have different demographics, health behaviors, health outcomes, and access to care when compared to those living in the northern portion of the county. Typically, the population in northern Saratoga County aligns more closely with Warren County, but Saratoga County data is still included for comparison.

[8] In 2011, Governor Cuomo created 10 Regional Councils to develop long-term strategic plans for economic growth for their regions. Additional information about these councils is available at the NYS Regional Economic Development Councils website, http://regionalcouncils.ny.gov/

place to do business. Among its assets are: a strategic location with proximity to all major markets in the northeast; an extraordinary quality of life with a mix of suburban rural communities and medium sized cities, including the Capital City; a highly skilled workforce and the many world renowned academic and research institutions. These intellectual centers provide unparalleled economic development potential as well as opportunities for companies to grow and expand, especially in high tech and knowledge-based industries. More and more the Capital Region is being nationally recognized as the place to be for cutting-edge research and development, making and moving goods, as well as a rich diversity of arts and cultural experiences. In 2019 the area jumped up 11 slots on U.S. News & World Report's "Best Cities to Live" rankings to 28th. The area ranked 10th on ZipRecruiter's list of the "Hottest Cities for Jobs" and 21st on WalletHub's "Most Educated Cities in America." At the region's core is strategic investment in the emerging new economy which encompasses the area's industry clusters: bio life sciences, nanotechnology, chemical manufacturing, semiconductor development and clean energy production.

County Specific Profiles

The following sections outline key features of Warren, Washington and Saratoga counties and is included in this report to provide an overview of the GFH service area, including geography, infrastructure and services, healthcare facilities, and the educational system. Please see the local economic development corporation for additional details on county attributes.[9] Additional data on the demographics, educational and health systems in each county is attached and labeled Appendix G.

Geography

Warren, Washington and Saratoga counties cover over 2,000 square miles. Warren, Washington and Saratoga counties are bordered by Essex County to the north, Hamilton, Fulton and Montgomery counties to the west, and Schenectady, Albany and Rensselaer counties to the south. Major cities and towns within these three counties include Saratoga Springs, South Glens Falls, Fort Edward, Glens Falls, Lake Luzerne and Queensbury. Many of the towns in the region are located right off of the Adirondack Northway (I-87), which runs from Albany, NY to the Canadian border.

Infrastructure and Services

Warren County[10]

Most of Warren County lies within the boundaries of the Adirondack State Park, which encompasses approximately 6 million acres. The county's population of just under 65,000 people enjoys a lower cost of living than other Capital Region locations with diverse communities, ranging from the small city/suburban environment of Glens Falls and Queensbury in the southern part of the county to the rural towns and villages in the Adirondack Park to the north.

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[9] See Saratoga County Economic Development Corporation at http://saratogaedc.com/
Warren County Economic Development Corporation at http://www.edcwc.org
and Washington County Economic Development Corporation http://washingtoncountyny.gov/470/Economic-Development

[10] Adapted from the Warren County Economic Development Corporation website, http://www.edcwc.org

The county offers many recreational and cultural opportunities with access to world-class golf courses, alpine ski centers, an extensive trail system spanning over 2000 miles for hiking, cross country skiing and snowmobiling and many camping facilities. The county is home to the Hyde Collection and the World Awareness Children's Museum, the Charles R. Wood Theater, and the Cool Insuring Arena - home to the Adirondack Thunder, an NHL affiliate of the New Jersey Devils. Some of Warren County's largest attractions include Lake George, which offers a bustling village as well as year-round recreational activities, the Six Flags Great Escape theme park and Splashwater Kingdom Water Park, and the Fort William Henry Museum, a French & Indian War stronghold.

Warren County's economy largely relies on recreation and tourism, medical device development and manufacturing, insurance, information management, business support services and financial services. Warren County is also an important healthcare provider for the southern Adirondack region. GFH is the area's largest employer with 2500 employees. In 2018, Glens Falls Hospital continued to invest in the community through employee salaries and benefits, community benefit, charity care and capital investments:

- $183 million in employee salaries, wages and benefits
- $29 million in community benefit and charity care to ensure all patients have access to critical healthcare services regardless of their ability to pay.
- More than $20 million in capital improvements to our facilities which helps create local jobs and strengthen our local economy.

GFH, along with many other local and community-based health care providers in the county, contribute to the several hundred ancillary jobs that are dependent on these providers of health care services in the North Country.

Washington County[11]

Washington County is largely rural in nature, with commercial and industrial development in and around nine villages. While over 1/3 of the county's land is agricultural, manufacturing maintains a predominant role in the economy, as does agri-manufacturing, along with tourism becoming a viable industry. Agriculture is a strong economic driver for the county and supports hundreds of local businesses ranging from farms to service providers and retail shops. Washington County is one of New York State's leading dairy counties, with maple syrup and apples being important cash crops. The economic importance of agriculture in the county is over $200 million annually, which includes numerous ancillary businesses. The county is also home to manufacturers of medical instruments, paper making machinery, paper products, furniture and electronic components. Numerous slate quarries are in the northeastern part of the county. Both residents and tourists alike take advantage of numerous recreational opportunities, including downhill and cross country skiing, biking, hiking, fishing, camping, horseback riding, snowmobiling, canoeing, kayaking, rafting, and golfing.

[11] Adapted from the Washington County Economic Development Corporation website, http://www.wcldc.org/906/About-Washington-County-NY

Saratoga County[12]

Saratoga County, made up of 19 towns, 9 villages, and 2 cities, is a thriving business community with fine dining and world-class entertainment. Saratoga Springs is home to the country's oldest thoroughbred race track, which is also the oldest operating sporting venue in the country. In addition to thoroughbred racing, there is harness racing, cross country skiing, downhill skiing, mineral water baths, numerous golf courses, stock car racing, polo, access to tennis, swimming, skating, horseback riding, and sailing, and numerous private country clubs within Saratoga County. There are public parks, trails and many lakes in the County offering public access. The New York City Ballet, The Philadelphia Orchestra, The Chamber Music Society of Lincoln Center, the Freihofer's Saratoga Jazz Festival, Opera Saratoga, and concerts by Live Nation visit the Saratoga Performing Arts Center annually, making it one of America's most prestigious summer festivals. The major companies doing business in Saratoga County include Quad Graphics Inc., State Farm Insurance, Momentive Performance Materials, Target Distribution Center, US Navy-Kesselring Site, Saratoga Hospital, Stewart's Ice Cream, Ace Hardware, Skidmore College and large school districts including Saratoga Springs City School District and Shenendehowa Central School District. GLOBALFOUNDRIES, the largest high-tech economic development project in the country, operates out of the Luther Forest Technology Campus in the Town of Malta and is the largest employer in the county. Amtrak Railways operates a train station in Saratoga Springs, which offers rail service on a daily basis.

Health Care Facilities

There are two hospitals in the three-county area, GFH and Saratoga Hospital. GFH and HHHN are the two largest providers of primary care services in Warren, Washington and northern Saratoga counties. HHHN is a federally-qualified, not-for-profit system of community health centers serving residents and visitors in the upstate New York region.

Warren County

Warren County has one hospital, Glens Falls Hospital, with 391 hospital beds, the majority of which are medical-surgical beds. There are a total of four nursing home facilities, accounting for 399 beds, and four adult care facilities, accounting for 248 beds, with rates per 100,000 of 616.7 and 452.9, respectively. The rate of primary care physicians per 100,000 in Warren County is 153.0 with a total physician rate per 100,000 of 442.5. Warren County consists of 6 health professional shortage areas (HPSAs), three in primary care, one in dental care, and two in mental health.

Washington County

There are total of four nursing home facilities, accounting for 528 beds, and four adult care facilities, accounting for 142 beds, with rates per 100,000 of 849.1 and 403.6, respectively. The rate of primary care physicians per 100,000 in Washington County is 66.4, with a total physician rate per 100,000 of

[12] Adapted from the Saratoga County Economic Development Corporation website, http://saratogaedc.com/saratoga-county, Saratoga Performing Arts Center website, www.spac.org, and Saratoga County website, https://www.saratogacountyny.gov/.

81.4. Washington County consists of 4 HPSAs, one in primary care, one in dental care, and two in mental health.

Saratoga County

Saratoga County has one hospital, Saratoga Hospital, with 171 hospital beds, resulting in a hospital bed rate per 100,000 of 75.5. This rate is significantly lower than the ARHN region (274.2 per 100,000). There are total of three nursing home facilities, accounting for 487 beds, and nine adult care facilities, accounting for 483 beds, with rates per 100,000 of 317.3 and 390.1, respectively. The rate of primary care physicians per 100,000 in Saratoga County is 87.5 with a total physician rate per 100,000 of 179.2.

Educational System

There are 33[13] school districts in Warren, Washington and Saratoga counties, with a total enrollment of approximately 51,200 students. Within Warren County, there are nine school districts, with a total enrollment of 8,880 students. Washington County has 12 school districts, with a total enrollment of 8,655 students and Saratoga County has 12 school districts, with a total enrollment of 33,728 students. In Saratoga County 23% of enrolled students are eligible for free and reduced lunch, with majority eligible for free lunch (87% or 6,646) compared to Warren County where 40% are eligible for free and reduced lunch, with majority eligible for free lunch (91% or 3,158) and Washington County where 48% are eligible for free and reduced lunch, with majority eligible for free lunch (88% or 3,511). The high school dropout rate is 1.0% in Warren County, 4.0% in Washington County and 2.0% in Saratoga County, all higher than the ARHN region (0.8%) and Upstate New York (0.64%). Both Warren and Saratoga Counties are lower than the New York State dropout rate of 3.0%, but Washington County is higher. The student- teacher ratios in both Warren County (11.4 students per teacher) and Washington County (10.8 students per teacher) are comparable to ARHN region but slightly lower than Upstate New York (12.37). There are 13.4 students per teacher in Saratoga County, which is higher than the ARHN region (10.9) and Upstate New York (12.37).

Community Health Needs in Warren, Washington and Saratoga Counties

This section presents a comprehensive overview of the demographics and community health needs for residents of Warren, Washington and Saratoga counties. The information below summarizes the data and information that informed the assessments in each county and for the GFH service area. In general, the information is presented by county because each county conducted independent assessments and thus only looked at the data for their particular geography. However, where applicable, aggregate or average information across the counties is included to demonstrate community health needs for the GFH service area. Each county looked at various aspects of the data to best determine their individual county health issues.

[13] This number includes the Washington-Saratoga-Warren-Hamilton-Essex Board of Cooperative Educational Services (BOCES), which was not included in the 2016-2018 CHNA.

Population and Demographics

The socio-demographic profile for the residents in Warren, Washington and Saratoga counties is shown in the table below.

	County			ARHN	Upstate	NYS
	Saratoga	Warren	Washington	Region*	NYS**	
Square Miles						
Total Square Miles[1]	810.0	867.0	831.2	8,372.2	46,823.75	47,126.4
Population per Square Mile [2]	280.32	74.48	74.35	42.5	239.4	418.9
Population[4]						
Total Population	226,632	64,701	62,183	355,996.0	11,238,156	19,798,228
Percent White, Non-Hispanic	93.2%	96.0%	98.5%	92.8%	79.8%	63.8%
Percent Black, Non-Hispanic	1.7%	1.2%	3.4%	3.3%	9.2%	15.7%
Percent Hispanic/Latino	3.0%	2.4%	2.6%	2.8%	10.9%	18.8%
Percent Asian/Pacific Islander, Non-Hispanic	2.8%	1.1%	0.5%	0.8%	3.9%	8.3%
Percent Alaskan Native/American Indian	0.2%	0.2%	0.2%	1.2%	15.2%	8.7%
Percent Multi-Race/Other	2.0%	1.6%	2.2%	2.3%	16.3%	10.7%
Number Ages 0-4	11,787	2,902	3,051	16,214	616,519	1,176,877
Number Ages 5-14	26,831	6,892	6,845	37,861	1,347,307	2,300,490
Number Ages 15-17	8,830	2,354	2,271	12,630	444,834	725,937
Number Ages 18-64	141,813	39,426	38,982	224,239	6,989,413	12,586,573
Number Ages 65+	37,371	13,127	11,034	64,358	1,840,083	3,008,351
Poverty[3,4]						
Mean Household Income	$96,086	$76,756	$ 65,798	$ 66,618	n/a	$ 93,443
Per Capita Income	$ 39,653	$ 33,127	$ 26,064	$ 27,377	$ 40,926	$ 35,752
Percent of Individuals Under Federal Poverty Level	6.6%	9.9%	12.8%	13.9%	11.7%	15.1%
Percent of Individuals Receiving Medicaid	12.7%	18.8%	25.1%	22.9%	43.1%	24.8%
Education[4]						
Total Population Ages 25 and Older	160,285	47,642	44,765	254,515	7,690,861	13,660,809
Percent with Less than High School Education	6.1%	8.3%	11.6%	11.6%	10.0%	13.9%
Percent High School Graduate/GED	24.8%	32.9%	39.2%	36.0%	28.0%	26.3%
Percent Some College, No Degree	17.1%	18.6%	18.7%	18.9%	17.4%	15.9%
Percent Associate's Degree	11.6%	11.0%	10.7%	11.2%	10.4%	8.7%
Percent Bachelor's Degree	23.3%	15.6%	11.6%	11.9%	18.7%	19.9%
Percent Graduate or Professional Degree	17.0%	13.7%	8.2%	10.4%	15.5%	15.4%
Employment Status[4]						
Percent Unemployed	3.0%	3.0%	3.9%	3.7%	3.8%	4.3%

*ARHN Region excludes Saratoga and Montgomery counties

**Upstate is all counties in New York, minus the New York City counties (Bronx, Kings, New York, Queens and Richmond)

(n/a) Data Not Available

Sources:

(1) US Department of Agriculture, National Agriculture Statistics Service, 2012

(2) NYS Department of Health, Vital Statistics of New York State 2016

(3) Centers for Medicare and Medicaid Services, CMS Enterprise Portal

(4) US Census Bureau, 2013-2017 American Community Survey 5-year Estimates

Over 350,000 people live within Warren, Washington and Saratoga counties. On average, the vast majority of the population is white, non-Hispanic (95.9%) and just over one in four people has obtained a Bachelor's degree or higher level of education (29.8%).

Warren County

Warren County's population is 64,701, making it the second most populated county in the ARHN region. Similar to the rest of Upstate New York, Warren County's population is very limited in its diversity, over 96% are White/non-Hispanics, followed by 1.2% Black/African American, non-Hispanics and 2.4% Hispanic/Latinos. Over 20% of the population is 65 years of age and older, which is slightly higher than the ARHN region (18.0%) and higher than Upstate New York (16.37%).

Household income on average is $76,756, with per capita income at $33,127, which is lower than that of New York State, $93,443 and $35,752 respectively. The percentage of individuals in Warren County living below the Federal Poverty Level is 9.9%, which is lower than the ARHN (13.9%) region and Upstate New York (11.7%). In Warren County, the unemployment rate is 3.0%.

Of the total population in Warren County, approximately 32.9% of individuals 25 years of age and older have a high school diploma or equivalent, and another 40.3% have an Associates or bachelor's degree or higher. Sixty three percent of the population 16 and older is in the workforce, with the highest percentage of individuals in the field of education (26.6%), followed by retail trade (13.3%), arts, entertainment, recreation, hotel & food service (12.7%), and manufacturing (8.4%).

Washington County

Washington County's population is 62,183. Similar to the rest of Upstate New York, Washington County's population is very limited in its diversity, over 93% are White/non-Hispanics, followed by 3.4% Black/African American, non-Hispanics and 2.6% Hispanic/Latinos. Over 17% of the population is 65 years of age and older, which is slightly lower than the ARHN region (18.0%) yet higher than Upstate New York (16.37%).

Household income on average is $65,798, with per capita income at $26,064, which is much lower than that of New York State, $93,443 and $35,752 respectively. The percentage of individuals in Washington County living below the Federal Poverty Level is 12.8%, which is lower than the ARHN (13.9%) region and higher than Upstate New York (11.7%). In Washington County, the unemployment rate is 3.9%.

Of the total population in Washington County, approximately 39.2% of individuals 25 years of age and older have a high school diploma or equivalent, and another 30.5% have an Associates or bachelor's degree or higher. Sixty percent of the population 16 and older is in the workforce, with the highest percentage of individuals in the field of education (23.0%), followed by retail trade (14.3%), manufacturing (14.0%), and arts, entertainment, recreation, hotel & food service (7.8%).

Saratoga County

Saratoga County's population is 226,632. Similar to the rest of Upstate New York, Saratoga County's population is very limited in its diversity, over 93% are White/non-Hispanics, followed by 1.7% Black/African American, non-Hispanics and 3.0% Hispanic/Latinos. Over 16% of the population is 65

years of age and older, which is slightly lower than the ARHN region (18.0%) and Upstate New York (16.37%).

Household income on average is $96,086, with per capita income at $39,653, which is higher than that of New York State, $93,443 and $35,752 respectively. The percentage of individuals in Saratoga County living below the Federal Poverty Level is 6.6%, which is lower than the ARHN (13.9%) region and Upstate New York (11.7%). In Saratoga County, the unemployment rate is 3.0%.

Of the total population in Saratoga County, approximately 24.8% of individuals 25 years of age and older have a high school diploma or equivalent, and another 51.9% have an Associates or bachelor's degree or higher. Sixty seven percent of the population 16 and older is in the workforce, with the highest percentage of individuals in the field of education (25.1%), followed by retail trade (12.1%), other professional occupations (11.9%), and manufacturing (10.5%).

New York State Prevention Agenda Priority Areas

The NYS Prevention Agenda is used as a framework to discuss the community health needs related to each identified priority area. In general, each county reviewed available data to assess each priority area to determine the most significant health needs for the individuals and communities within the counties. For more information on the Priority Areas and corresponding Focus Areas, please see the Action Plans, available at: https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/index.htm. See Appendix H for a table of the NYS Prevention Agenda indicators and other indicators for Warren, Washington and Saratoga counties.

Prevent Chronic Diseases

Chronic diseases such as cancer, diabetes, heart disease, stroke, asthma and arthritis are among the leading causes of death, disability and rising health care costs in New York State. However, chronic diseases are also among the most preventable. See Appendix I for the leading cause of premature death by County. The top two for all of Warren, Washington, Saratoga counties as well as New York State as a whole are chronic diseases, cancer and heart disease. Three modifiable risk behaviors - unhealthy eating, lack of physical activity, and tobacco use - are largely responsible for the incidence, severity and adverse outcomes of chronic disease. As such, improving nutrition and food security, increasing physical activity, and preventing tobacco use form the core of the Preventing Chronic Diseases Action Plan. The plan also emphasizes the importance of preventive care and management for chronic diseases, such as screening for cancer, diabetes, and high blood pressure; promoting evidence-based chronic disease management; and improving self-management skills for individuals with chronic diseases.[14] The following outlines the status of this Priority Area in Warren, Washington and Saratoga counties:

Note: In the summaries that follow, all rates are per 100,000 unless otherwise noted.

[14] Adapted from the Preventing Chronic Diseases Action Plan for the NYS Prevention Agenda, available at https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/chr.htm

Warren County

The percentages of adults (29.2%) and children who are obese (19.5%) in Warren County is higher than their respective Prevention Agenda Benchmarks of 23.2% and 16.7%. Additionally, the percentage of obesity in elementary school children (18.4%) is higher than Upstate New York (16.0%). In Warren County, the burden of obesity may contribute to higher rates of diabetes death (35.0) than Upstate New York (15.4) and higher rates of hospitalization per 10,000 due to diabetes, any diagnosis, (267.5) than in Upstate New York (237.2).

Smoking and smoking-related diseases seems to pose a significant challenge for Warren County, with seven of the indicators listing as worse than the comparison benchmark. The percentage of adults who smoke in Warren County (23.2%) is higher than the percentage of smokers in Upstate New York (16.2%), New York State (14.2%) and the Prevention Agenda Benchmark of 12.3%. In Warren County, the rate of chronic lower respiratory deaths (87.5) is higher than in Upstate New York (45.4) and the state as a whole (34.1). Similarly, in Warren County the rate of chronic lower respiratory hospitalizations per 10,000 (36.2) is higher than in Upstate New York (28.0) and the state as a whole (30.6). The percentage of adults with asthma in Warren County (10.4%) is slightly lower, in comparison to the ARHN region (12.0%), but higher than Upstate New York (10.1%), and New York State (9.5%).

The rates of lung and bronchus cancer cases are higher in Warren County (129.5) than in the ARHN region (112.2), Upstate New York (84.3), and New York State (69.7), and lung and bronchus cancer deaths in Warren County (68.9) are higher than the ARHN region (67.4), Upstate New York (53.0) and New York State (43.5). The rate of colon and rectal cancer cases and deaths in Warren County (61.2 and 21.6) is slightly higher than the ARHN region (55.0 and 18.9). The percentage of colorectal screenings for those 50 to 75 years of age in Warren County (75.1%) is higher than the ARHN region (73.6%), Upstate New York (68.5%), and New York State (69.7%).

Washington County

The percentages of adults (40.2%) and children who are obese (21.1%) in Washington County are higher than their respective Prevention Agenda Benchmarks of 23.2% and 16.7%. Additionally, the percentage of obesity in elementary school children (18.4%) is higher than Upstate New York (16.0%). In Washington County, the burden of obesity may contribute to higher rates of diabetes death (32.7) than Upstate New York (15.4) and higher rates of hospitalization per 10,000 due to diabetes, any diagnosis, (265.4) than in Upstate New York and (237.2).

Smoking and smoking-related diseases seems to pose a significant challenge for Washington County, with seven of the indicators listing as worse than the comparison benchmark. The percentage of adults who smoke in Washington County (22.3%) is higher than the percentage of smokers in Upstate New York (16.2%), New York State (14.2%) and the Prevention Agenda Benchmark of 12.3%. In Washington County, chronic lower respiratory deaths are higher (78.3) than in Upstate New York (45.4) and the state as a whole (34.1). Similarly, in Washington County the rates of chronic lower respiratory hospitalizations per 10,000 (40.3) are higher than in Upstate New York (28.0) and the state as a whole (30.6). The

percentage of adults with asthma in Washington County (9.3%) is slightly lower, in comparison to the ARHN region (12.0%), Upstate New York (10.1%), and New York State (9.5%).

The rates of lung and bronchus cancer cases are lower in Washington County (102.4) than in the ARHN region (112.2), but higher than Upstate New York (84.3) and New York State (69.7), and lung and bronchus cancer deaths in Washington County (67.2) are comparable to the ARHN region (67.4), and higher than Upstate New York (53.0) and New York State (43.5). The rate of colon and rectal cancer cases and deaths in Washington County (56.5 and 18.7) is comparable to those of the ARHN region (55.0 and 18.9). The percentage of colorectal screenings for those 50 to 75 years of age in Washington County (69.0%) is lower than the ARHN region (73.6%), and in line with Upstate New York (68.5%), and New York State (69.7%).

Saratoga County

The percentages of adults (27.0%) is higher and children who are obese (14.0%) is lower in Saratoga County than their respective Prevention Agenda Benchmarks of 23.2% and 16.7%. Additionally, the percentage of obesity in elementary school children (13.0%) is lower than Upstate New York (16.0%). The burden of obesity may contribute to higher rates of death due to diabetes (any diagnosis) in Saratoga County (17.8) than in Upstate New York (15.4).

Smoking and smoking-related diseases seems to pose a significant challenge for Saratoga County, with seven of the indicators listing as worse than the comparison benchmark. The percentage of adults who smoke in Saratoga County (16.5%) is higher than the percentage of smokers in Upstate New York (16.2%), New York State (14.2%) and the Prevention Agenda Benchmark of 12.3%. Chronic lower respiratory deaths rates are higher in Saratoga County (47.9) than in Upstate New York (45.4) and the state as a whole (34.1). The percentage of adults with asthma in Saratoga County (14.6%) is higher, in comparison to the ARHN region (12.0%), Upstate New York (10.1%), and New York State (9.5%).

The rates of lung and bronchus cancer cases are lower in Saratoga County (92.4) than in the ARHN region (112.2), but higher than Upstate New York (84.3) and New York State (69.7), and lung and bronchus cancer deaths in Saratoga County (62.8), slightly lower than the ARHN region (67.4), and higher than Upstate New York (53.0) and New York State (43.5). The rate of colon and rectal cancer cases and deaths in Saratoga County (46.7 and 16.4) is slightly lower than the ARHN region (55.0 and 18.9). The percentage of colorectal screenings for those 50 to 75 years of age in Saratoga County (75.6%) is higher than the ARHN region (73.6%), Upstate New York (68.5%), and New York State (69.7%).

Warren, Washington, Saratoga County Tobacco Survey

The results of the Warren, Washington and Saratoga County Tobacco assessment can also inform the community health needs related to chronic disease prevention and the potential for policy and environmental changes related to smoking cessation as a prevention measure. Highlights from the results of the survey are summarized below:

- Most residents think that tobacco should not be sold in stores that are located near schools (Saratoga 67%, Warren 65%, Washington 64%)

- Most residents are in favor of a policy that would prohibit smoking in entrance ways of public buildings and workplaces (Saratoga 74%, Warren 74%, Washington 64%)
- Most residents are in favor of policies that prohibit smoking in apartment buildings and other multi-unit complexes (Saratoga 69%, Warren 62%, Washington 61%)
- Most residents are in favor of a policy that would prohibit the use of e-cigarettes in all work places, including bars and restaurants (Saratoga 63%, Warren 57%, Washington 60%)
- Most residents think that teen smoking is a significant problem in their community (Saratoga 71%, Warren 69%, Washington 70%)

Additionally, New York State conducts annual tobacco surveys targeting both youth and adults. The results of the New York State Youth Tobacco Survey [15]show that emerging products in the tobacco landscape threaten to undo the substantial progress made in youth initiation. Cigarette smoking among high school youth declined by 82% between 2000 and 2018. From 2016 to 2018 the rate increased from 4.3% to 4.8%, the first increase in combustible cigarette use among youth in NYS since 2000. In contrast, use of e-cigarettes among high school youth continues to rise. Between 2014 and 2018, the rate increased fully 160%, from 10.5% to 27.4%. E-cigarettes remain the most commonly used tobacco product among youth surpassing cigarettes, cigars, smokeless tobacco, and hookah.

The results of the New York Adult Tobacco Survey (ATS)[16] show the continued downward trend in the prevalence of adult tobacco use in New York State. However, it highlights populations that continue to smoke at higher rates than the general population. This report also shows where additional resources should be allocated in an effort to further reduce adult smoking prevalence.

Highlights from the results of the ATS are summarized below:

- Percentage of NY Adults with Poor Mental Health Who Currently Smoke: 27.7% (State rate 14.2%)
- Percentage of NY Adults with Less Than a High School Diploma Who Currently Smoke: (21.5%)
- Percentage of NY Adults whose income is less than $25,000 who currently smoke: (20.4%)
- Percentage of Adult Smokers who made a Quit Attempt in the past 12 months: 62.8%

Percentage of Adult Smokers who report that their health care provider assisted them in smoking cessation in the past 12 months: 53.3%

[15] Based on methods developed by CDC, the New York State Youth Tobacco Survey (NYS-YTS) is a school-based survey of a representative sample of high school students in NYS. The average sample size of high school students in the NYS - YTS, for all years excluding 2008, is 4,286. In 2008, a special study was conducted and the sample was increased to 23,133. The NYS-YTS monitors the use of tobacco products available to and used by youth. Cigarettes, cigars, and smokeless tobacco have been monitored since 2000, while products such as hookah (2008) and e-cigarettes (2014) were added to the NYS-YTS as they gained popularity.

[16] The Adult Tobacco Survey (ATS) was developed by the New York Tobacco Control Program (NY TCP) in partnership with RTI International, the independent evaluator for the NY TCP. The survey has been fielded continually since June 2003 to the non-institutionalized adult population of New York State, aged 18 years or older.

Cancer Incidence in Warren County

The Warren County Cancer Incidence Report provides an extremely comprehensive overview of the findings, limitations, conclusions and recommendations for cancer patterns and trends in Warren County.[17]

The following is an excerpt of the key conclusions from the report[18]:

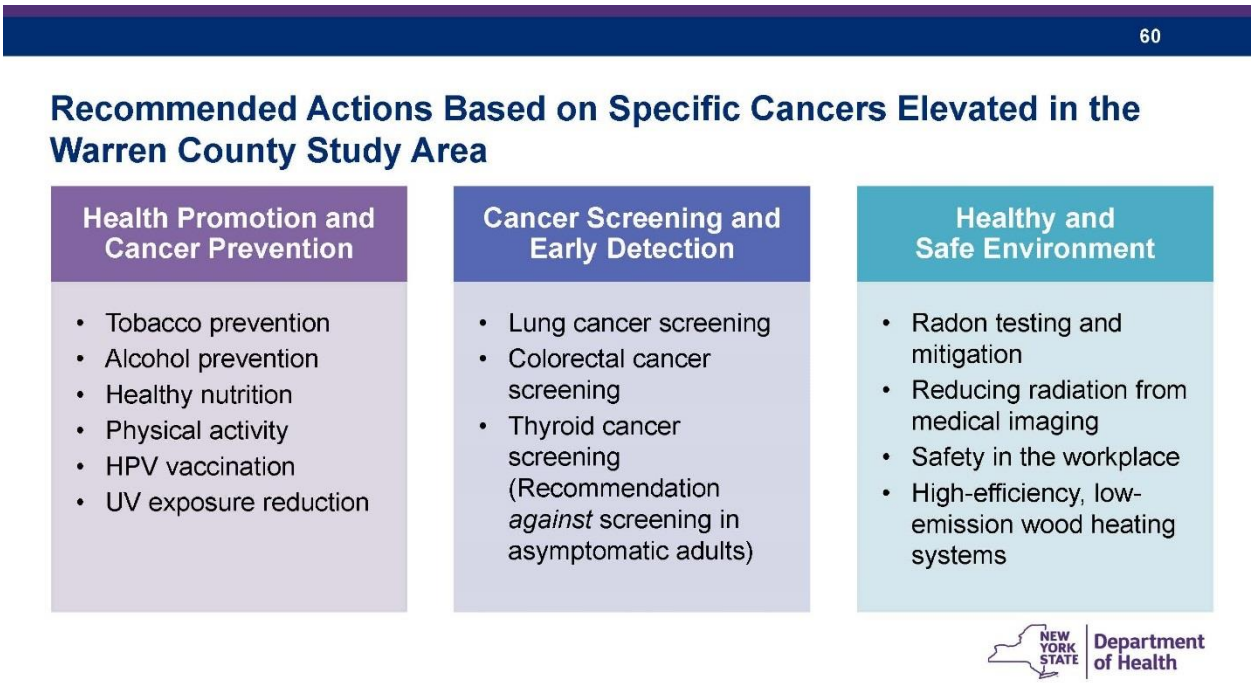
- Environmental factors evaluated in this study, including levels of radon in indoor air, environmental contaminants in outdoor air, contaminants in drinking water, industrial and inactive hazardous waste disposal sites, and proximity to traffic do not stand out from those in other parts of NYS excluding NYC.
- It is likely that a higher proportion of current and former tobacco use contributed to the elevated rates of lung, laryngeal, esophageal, and oral cancers in Warren County. The elevations in the rates for these cancers were more often observed in men.
- Alcohol consumption, independently or through a synergetic effect with tobacco use, might have contributed to the excess of oral, esophageal, and laryngeal cancers in Warren County, particularly among men.
- HPV infection may have contributed to the oral cancer excess.
- Most of the elevation in thyroid cancer incidence among women in Warren County is likely due to increased detection of small papillary tumors by medical imaging and other diagnostic techniques.
- The higher proportion of overweight or obese women in Warren County may have contributed to the excess in female thyroid cancer incidence as well as to the excess in female colorectal cancer incidence.
- The excess in leukemia rates among women in Warren County may represent a time-limited anomaly. DOH will continue to monitor.
- The investigation found no factors that might account for the elevated incidence of cancers of the brain and other nervous system in Warren County. DOH will continue to monitor.

The following recommendations were offered, as a result of the analysis[19]:

[17] Governor's Cancer Research Initiative – Final Report: Cancer Incidence Report for the Warren County Study Area, October 2019, available at https://www.health.ny.gov/diseases/cancer/cancer_research_initiative/

[18] Governor's Cancer Research Initiative – Warren County Cancer Incidence Investigation, October 2019, Presented at SUNY Adirondack Community College on November 7, 2019, Available at https://www.health.ny.gov/diseases/cancer/cancer_research_initiative/

[19] Governor's Cancer Research Initiative – Warren County Cancer Incidence Investigation, October 2019, Presented at SUNY Adirondack Community College on November 7, 2019, Available at https://www.health.ny.gov/diseases/cancer/cancer_research_initiative/



Opportunities exist to reduce the cancer burden within the GFH service area. Cancer risk can be reduced by avoiding tobacco, protecting skin, limiting alcohol use, maintaining a healthy weight, getting screened regularly, and seeking regular medical care. Ensuring guideline concordant vaccines, such as HPV and Hepatitis B, can also reduce the risk of certain cancers. [20]

Promote a Healthy and Safe Environment

The 2019-2024 State Health Improvement Plan to "Promote a Healthy and Safe Environment" in New York State focuses on five core areas that impact health. These are: the quality of the water we drink and enjoy for recreation; the air we breathe; the food and products we ingest and use; the built environments where we live, work, learn and play; as well as injuries, violence and occupational health. "Environment," as used here, incorporates all dimensions of the physical environment that impact health and safety.[21]

In general, water quality and outdoor air quality are not significant issues in Warren, Washington and northern Saratoga counties. While certain indicators for the built environment focus area are below the Prevention Agenda benchmarks, issues such as climate smart communities are beyond the capacity and scope of expertise of the healthcare sector. Efforts to address these focus areas are better lead by policymakers, elected officials and other community stakeholders, through collaboration with and support of the healthcare sector. Consequently, the following outlines the status of injuries and violence in Warren, Washington and Saratoga counties:

[20] Centers for Disease Control and Prevention, Division of Cancer Prevention and Control website, December 2019, https://www.cdc.gov/cancer/dcpc/about/.
[21] Adapted from the Promote a Healthy and Safe Environment Action Plan for the NYS Prevention Agenda, available at https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/env.htm

Note: In the summaries that follow, all rates are per 100,000 unless otherwise noted.

Warren County

Motor vehicle accidents are higher in Warren County while speed-related accidents are lower in Warren County (2,735.1 and 282.0 respectively) than in the ARHN region (2,162.0 and 364.7). Additionally, the rate of motor vehicle accident deaths is higher in Warren County (9.3) than the ARHN region (7.3), Upstate New York (7.1) and the state as a whole (5.0). The rate of violent crimes (165.8) is lower than the ARHN region (171.8) and significantly lower than that of Upstate New York (214.9) and New York State (355.6).

Washington County

Motor vehicle accidents and speed-related accidents are lower in Washington County (1,695.9 and 266.2 respectively) than in the ARHN region (2,162.0 and 364.7). Additionally, the rate of motor vehicle accident deaths is lower in Washington County (4.9) than the ARHN region (7.3), Upstate New York (7.1) and the state as a whole (5.0). The rate of violent crimes (124.8) is significantly lower than the ARHN region (171.8), Upstate New York (214.9) and New York State (355.6).

Saratoga County

Motor vehicle accidents and speed-related accidents are lower in Saratoga County (2,041.6 and 224.9 respectively) than in the ARHN region (2,162.0 and 364.7). Additionally, the rate of motor vehicle accident deaths is higher in Saratoga County (7.8) than the ARHN region (7.3), Upstate New York (7.1) and the state as a whole (5.0). The rate of violent crimes (122.0) is lower than the ARHN region (171.8), Upstate New York (214.9) and New York State (355.6).

Promote Healthy Women, Infants and Children

The health of women, infants, children, and their families is fundamental to population health. This Prevention Agenda priority aligns directly with the Maternal and Child Health Services Block Grant (Title V) Program, the core federal and state public health program for promoting the health and well-being of the nation's mothers, infants, and children, including children and youth with special health care needs, and their families.

The Prevention Agenda goals, objectives, and interventions for Healthy Women, Infants, and Children were drawn from the state's Title V plan, with special consideration for those areas that would benefit from enhanced local action and cross-sector collaboration, and for which local data are available to track progress across the state. Mirroring NY's Title V action plan, the Prevention Agenda Healthy Women, Infants, and Children (HWIC) priority focuses on health outcomes in three focus areas: Maternal and Women's Health, Perinatal and Infant Health, and Child and Adolescent Health, including children with special health care needs. In addition, the HWIC plan includes a fourth cross-cutting focus area on social determinants of health and health equity, intended to address the entire MCH life course.[22]

[22] Adapted from the Promote Healthy Women, Infants, and Children Action Plan for the NYS Prevention Agenda, available at https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/hwic.htm

There are 22 indicators for this particular Priority Area, so only the most significant information is highlighted to demonstrate need. The following outlines the status of this Priority Area in Warren, Washington and Saratoga counties:

Warren County

The percentage of births within 24 months of previous pregnancies in Warren County (22.0%) is higher than the Prevention Agenda Benchmark of 17.0%, as is the percentage of unintended pregnancies in Warren County (33.2%), with the Prevention Agenda Benchmark being 23.8%.

The percentages of women receiving WIC in Warren County with either gestational weight gain greater than ideal is worse than the ARHN region, Upstate New York, and New York State. The percentage of pre-pregnancy obesity (32.9%) is lower than that of the ARHN region (33.3%) and higher than that of Upstate New York (28.0%).

Washington County

The percentage of births within 24 months of previous pregnancies in Washington County (22.5%) is higher than the Prevention Agenda Benchmark of 17.0%, as is the percentage of unintended pregnancies in Washington County (39.1%), with the Prevention Agenda Benchmark being 23.8%.

The percentage of women receiving WIC in Washington County with either gestational weight gain greater than ideal is worse than the ARHN region. The percentage of pre-pregnancy obesity (31.7%) is lower than that of the ARHN region (33.3%) and higher than that of Upstate New York (28.0%).

Saratoga County

The percentage of births within 24 months of previous pregnancies in Saratoga County (21.1%) is higher than the Prevention Agenda Benchmark of 17.0%, while the percentage of unintended pregnancies in Saratoga County (20.1%) is lower than the Prevention Agenda Benchmark (23.8%).

The percentage of women receiving WIC in Saratoga County with either gestational weight gain greater than ideal is worse than the ARHN region. The percentage of pre-pregnancy obesity (34.5%) is higher than that of the ARHN region (33.3%) and Upstate New York (28.0%).

Promote Well-being and Prevent Mental and Substance Abuse Disorders

Mental and emotional well-being is essential to overall health. At any given time, almost one in five young people nationally are affected by mental, emotional and behavioral (MEB) disorders, including conduct disorders, depression and substance abuse. Adverse Childhood Experiences and many MEB disorders, such as substance abuse and depression, have lifelong effects that include high psychosocial and economic costs for people, their families, schools and communities. Mental and physical health problems are interwoven. Improvements in mental health help improve individuals and populations' physical health. The two Focus Areas for this Priority Area are: Promote Well-Being and Mental and

Substance Use Disorder Prevention.[23] The following outlines the status of this Priority Area in Warren, Washington and Saratoga counties:

Note: In the summaries that follow, all rates are per 100,000 unless otherwise noted.

Warren County

The percentage of adults in Warren County who binge drink (20.9%) is higher than the Prevention Agenda Benchmark (18.4%) and the percentage who reported 14 or more poor mental health days within the last month (12.0%) is higher than the Prevention Agenda Benchmarks of 10.1%. The rate of self-inflicted hospitalizations per 10,000 in Warren County (5.9) is higher than in Upstate New York (4.1). The rate of alcohol-related crashes in Warren County (82.1) is significantly higher than New York State (38.0).

Among 15 to 19-year old's, the 2016 Community Health Indicator Reports listed the rate of suicides at 9.3, which is lower than the ARHN region (10.7) and higher than Upstate New York (6.1).

Washington County

The percentage of adults in Washington County who binge drink (21.7%) is higher than the Prevention Agenda Benchmark (18.4%) and the percentage who reported 14 or more poor mental health days within the last month (13.1%) is higher than the Prevention Agenda Benchmarks of 10.1%. The rate of self-inflicted hospitalizations per 10,000 in Washington County (7.6) is higher than in Upstate New York (4.1). The rate of alcohol-related crashes in Washington County (71.4) is significantly higher than New York State (38.0).

Among 15 to 19-year old's, the 2016 Community Health Indicator Reports listed the rate of suicides at 9.2, which is lower than the ARHN region (10.7) and higher than Upstate New York (6.1).

Saratoga County

The percentage of adults in Saratoga County who binge drink (24.0%) is higher than the Prevention Agenda Benchmark (18.4%) and the percentage who reported 14 or more poor mental health days within the last month (9.9%) is lower than the Prevention Agenda Benchmarks of 10.1%. The rate of self-inflicted hospitalizations per 10,000 in Saratoga County (3.7) is lower than in Upstate New York (4.1). The rate of alcohol-related crashes in Saratoga County (77.0) is significantly higher than New York State (38.0).

Among those 15 to 19-year old's, the 2016 Community Health Indicator Reports listed the rate of suicides at 11.7, which is slightly higher than the ARHN region (10.7) and higher than Upstate New York (6.1).

Prevent Communicable Diseases

[23] Adapted from the Promote Well-Being and Prevent Mental and Substance Use Disorders Action Plan for the NYS Prevention Agenda, available at https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/wb.htm

A communicable disease is an illness or infection that can be spread from person to person, animal to person, animal to animal or person to animal. Communicable diseases contribute to sickness and death in New York State and are preventable.

The reduction of vaccine-preventable diseases is an extremely important public health goal achieved through immunization. Although vaccine-preventable disease rates are low in NYS and in the United States, the prevalence of certain diseases is beginning to increase due to pockets of underimmunization and global travel.

HIV/AIDS and sexually transmitted infections continue to be significant public health concerns. NYS remains at the epicenter of the HIV epidemic in the United States, with more people living with HIV/AIDS than in any other state.

Antibiotic resistance, part of a broader threat called antimicrobial resistance, occurs when antibiotics no longer work against bacteria that cause infections. Antibiotics can be lifesaving, but bacteria are becoming more resistant to treatment. Antimicrobial resistance has been found in all regions of the world, and newly discovered strains continue to emerge and spread. Factors such as increased globalization, poor infection control in hospitals and clinics, overprescribing of antibiotics, and unnecessary antibiotic use in agriculture are increasing the global threat. Infections acquired in the healthcare setting, both those with or without resistance, can lead to significant illness and death.

The Prevent Communicable Disease Action plan contains five focus areas: vaccine preventable diseases, Human Immunodeficiency Virus (HIV), Sexually Transmitted Infections (STIs), Hepatitis C Virus (HCV), and Antibiotic Resistance and Healthcare-Associated Infections.[24] The following outlines the status of this Priority Area in Warren, Washington and Saratoga counties:

Note: In the summaries that follow, all rates are per 100,000 unless otherwise noted.

Warren County

The immunization rate for children ages 19 – 35 months with the recommended 4:3:1:3:3:1:4 immunization series (77.9%) is lower than the Prevention Agenda benchmark (80.0%) and the percentage of females 13 to 17 with three dose HPV vaccine (47.2%) is lower than the Prevention Agenda benchmark of 50.0%. The rate of Pertussis cases in Warren County (0.5) is significantly lower than the ARHN region (11.7), Upstate New York (5.9) and New York State (5.1). The rate of pneumonia/flu hospitalizations for those 65 years of age or older per 10,000 is higher in Warren County (99.7) than in ARHN region (93.3), Upstate New York (93.7), and the state as a whole (87.3). The Rate of Community Onset, Healthcare Facility Associated Clostridium difficile infections (CDIs) per 10,000 Patient Days (7.8) is significantly higher than the NYS Prevention Agenda benchmark of 2.05.

[24] Adapted from the Prevent Communicable Diseases Action Plan of the NYS Prevention Agenda, available at https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/comm.htm#FA5.

Washington County

The immunization rate for children ages 19 – 35 months with the recommended 4:3:1:3:3:1:4 immunization series (76.2%) is lower than the Prevention Agenda benchmark (80.0%) and the percentage of females 13 to 17 with three dose HPV vaccine (42.9%) is lower than the Prevention Agenda benchmark of 50.0%. The rate of Pertussis cases in Washington County (1.1) is significantly lower than the ARHN region (11.7), Upstate New York (5.9) and New York State (5.1). The rate of pneumonia/flu hospitalizations for those 65 years of age or older per 10,000 is lower in Washington County (82.9) than in ARHN region (93.3), Upstate New York (93.7), and the state as a whole (87.3).

Saratoga County

The immunization rate for children ages 19 – 35 months with the recommended 4:3:1:3:3:1:4 immunization series (78.4%) is lower than the Prevention Agenda benchmark (80.0%) and the percentage of females 13 to 17 with three dose HPV vaccine (47.2%) is lower than the Prevention Agenda benchmark of 50.0%. The rate of Pertussis cases in Saratoga County (3.1) is significantly lower than the ARHN region (11.7), Upstate New York (5.9) and New York State (5.1). The rate of pneumonia/flu hospitalizations for those 65 years of age or older per 10,000 is similar in Saratoga County (93.7) to that of the ARHN region (93.3) and Upstate New York (93.7), but higher than the state as a whole (87.3). The Rate of Community Onset, Healthcare Facility Associated Clostridium difficile infections (CDIs) per 10,000 Patient Days (2.7) is higher than the NYS Prevention Agenda benchmark of 2.05.

Health Disparities

Improving health status in the five priority areas and reducing racial, ethnic, socioeconomic and other health disparities including those among persons with disabilities is an overarching goal of the NYS Prevention Agenda. The National Institutes of Health defines health disparities as the differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific population groups in the United States. Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), or sexual orientation. Health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources. Health disparities result from multiple factors, including poverty, environmental threats, inadequate access to health care, individual and behavioral factors, and educational inequalities. [25]

Warren, Washington and Saratoga counties are predominately White and do not face the traditional racial or ethnic disparities typically found in more urban or populated areas. Instead, populations in upstate New York face a unique combination of factors that create health disparities, which are often rooted in the social determinants of health. The social determinants of health are the circumstances in

[25] Adapted from the Centers for Disease Control and Prevention, Adolescent and School Health, Health Disparities website, https://www.cdc.gov/healthyyouth/disparities/index.htm.

which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness.[26] These factors are often associated with many different types of barriers to care.

Economic factors, cultural and social differences, educational shortcomings, and the isolation of living in a rural area all conspire to repress our population in their struggle to lead a healthy life. Many sections of the GFH service area face significant distance and transportation barriers to accessing community resources, service opportunities, and health care. These communities are traditionally underserved by most assistance programs; thereby creating health disparities among the people living and working in this area.

Limited data publicly exists to demonstrate non-racial or non-ethnic related health disparities in Warren, Washington and northern Saratoga counties. Household income and educational attainment highlight common health disparities within the GFH service area. In Warren and Washington counties, the mean household income is $76,756 and $65,798 respectively, compared to the NYS average of $93,443. Additionally, the percent of individuals living below the Federal Poverty Level is higher in Washington County (12.8%) as compared to Upstate NY (11.7%). Another notable factor is the relatively low level of achievement in higher education in both Warren and Washington Counties, where only 40.3% (Warren) and 30.5% (Washington) of the population age 25 and older has an Associate's, Bachelor's, or Graduate/Professional degree, compared to 44% of the NYS population. The relationship between socioeconomic status and better health outcomes is well established, leaving this geographic region at a disadvantage.

Additional barriers to care that result in health disparities can be attributed to health care provider shortages in the area – Warren County has six HPSA shortage areas, 3 primary care, 1 dental care, 2 mental health, while Washington County has four, 1 primary care, 1 dental care, and 2 mental health. Additional data shows the rate of primary care providers per 100,000 residents in both Washington County (66.4) and Saratoga County (87.5) to be substantially lower than both Upstate NY (102.8) and NYS as a whole (124.1).

Data from the NYS Prevention Agenda utilizes indicators related to premature death, preventable hospitalizations, insurance status and access to care (through % of adults with a regular health care provider) highlights additional items related to health disparities. The following table outlines the status of these indicators for Warren, Washington and Saratoga counties:

[26] Adapted from the Centers for Disease Control and Prevention, Social Determinants of Health website, http://www.cdc.gov/socialdeterminants/

Prevention Agenda Indicators: Disparities

	Warren	Washington	Saratoga	Comparison Regions/Data			
				ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark
1. Percentage of Overall Premature Deaths (before age 65 years), 2016	21.5%	23.7%	22.3%	22.8%	22.4%	24.0%	**21.8%**
2. Ratio of Black, Non-Hispanic Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16	2.21+	2.97+	1.80	1.69	2.05	1.95	**1.87**
3. Ratio of Hispanic/Latino Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16	1.6+	1.36+	1.70	2.12	2.16	1.87	**1.86**
4. Rate of Adult Age-Adjusted Preventable Hospitalizations per 10,000 Population (Ages 18 Plus), 2016	156.6	153.2	115.3	N/A	116.80	124.00	**122.0**
5. Ratio of Black, Non-Hispanic Adult Preventable Age-Adjusted Hospitalizations to White, Non-Hispanic, 2016	0.84+	0.55+	0.99	N/A	2.04	2.07	**1.85**
6. Ratio of Hispanic/Latino Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, 2016	0.72+	0.66+	0.44+	N/A	1.27	1.28	**1.38**
7. Percentage of Adults (Ages 18 - 64) with Health Insurance, 2016	94.1%	93.5%	94.9%	N/A	N/A	91.4%	**100.0%**
8. Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2016	82.9%	94.2%	88.0%	N/A	84.4%	82.6%	**90.8%**
N/A = insufficient data is available to report on this indicator							

Indicators for Warren, Washington and Saratoga counties reveal limited health disparities as defined by the NYS Prevention Agenda. As demonstrated above, often times there is insufficient data to report on racial and ethnic disparities. With respect to the benchmarks, the areas where there is room for improvement within the GFH service area include overall premature death in Saratoga and Washington counties, the rate of black, non-Hispanic premature deaths to white, non-Hispanic premature deaths in Warren and Washington counties and the rate of age-adjusted preventable hospitalizations per 10,000 population among those 18 years of age and older in Warren and Washington counties. Opportunities to improve these statistics may lie within the number of adults with a regular health care provider, as all both Warren and Saratoga counties fall below the Prevention Agenda benchmark. Lastly, all three counties are below the benchmark for health insurance coverage. These indicators can provide initial information about potential problems in a community that may require further, more in-depth analysis.

Cancer Burden and Disparities in Warren, Washington and Saratoga Counties

Data demonstrating many of the health behaviors that reduce the risk of cancer is described throughout this report. However, certain populations are disproportionately affected by the burden of cancer, and these populations are faced with many of the same challenges described above. These challenges often result in lower screening rates, and higher rates of cancer incidence and mortality.

The sociodemographic makeup of Warren, Washington and Saratoga counties more closely resembles that of NYS excluding NYC, than that of NYS. However, the lack of racial and ethnic diversity, as well as the low prevalence of foreign nativity, distinguishes the counties from NYS excluding NYC. In general, there are very limited racial or ethnic disparities in the region. In Warren, Washington and Saratoga counties, cancer-related disparities exist based on geography, gender, income status and access/transportation.

Geographic disparities are most notable when comparing incidence rates in each of the counties for certain types of cancers. In general, based on data from 2012-2016, Warren County has the highest rates of cancer across the region, and many times, compared to all counties in New York State. In Warren County, the rate for colorectal cancer is 40.2 per 100,000 in for both males and females, compared with 33.0 per 100,000 cases in Washington and 39.4 per 100,000 in Saratoga County. The rates in both Warren and Saratoga counties are higher than the New York State rate for colorectal cancer, which is 38.9 per 100,000. Similarly, the rate for lung and bronchus cancer in Warren County is 81.2 per 100,000 for both males and females, compared with 74.6 per 100,000 for Washington County and 72.2 per 100,000 for Saratoga County. All three counties have a higher rate than New York State, which is 58.9 per 100,000 for males and females. For all invasive malignant tumors, Warren County has the highest incidence rate at 55.4 per 100,00 for males and females, and the highest mortality rate of 179.9 per 100,000 for males and females. This compares to the New York State incidence rate of 482.9 per 100,000 for males and females, and 148.8 per 100,000 for mortality.27 For many of these types of cancer, screening can prevent the disease, or help find cancers at an early stage, when they are more easily cured or treated.

With respect to gender-related disparities, numerous differences between cancer incidence rates among men compared to women have been highlighted above. Income-related disparities are often most visible when understanding access to care. Access to care and transportation in our highly rural service area is also an issue for many residents. In looking at GFH's C.R. Wood Cancer Center data for the period 2007-2016, more than half (51%) of patients diagnosed traveled more than 10 miles for service and 24% of those traveled more than 25 miles. At the same time, the availability of public transportation in the region is limited, coupled with difficult driving conditions in the long winter months in Upstate New York.

[27] New York State Department of Health, New York State Cancer Registry. Cancer Incidence and Mortality by County and Gender, 2012 - 2016

There is a strong link between tobacco use and cancer, and smoking rates are higher in Warren (23.2%), Washington (22.3%) and Saratoga counties (16.5%), as well as most upstate NY counties, than the New York State rate of 14.2%. Current smoking rates in NYS vary by county from 7.0% to 29.0%.[28] While there has been a decline in the rate of tobacco use among both children and adults in NYS (and equally across all ethnic groups), smoking rates have not declined for the poor and less educated, which are significant issues in the GFH service area. This highlights the crucial need for prevention and cessation of tobacco use in these counties, especially for vulnerable populations in this area.

Regional Community Stakeholder Survey Results

As mentioned previously, as a part of the regional work facilitated by the ARHN, the 2019 Community Stakeholder Survey was drafted by the Ad Hoc Data Sub-Committee, with the final version approved by the full CHA Committee at the December 7, 2018 meeting. ARHN surveyed stakeholders in the seven-county service area, to provide the CHA Committee with input on regional health care needs and priorities. Stakeholders included professionals from health care, social services, educational, and governmental institutions as well as community members.

The survey was developed through SurveyMonkey and included 14 community health questions as well as several demographic questions. The CHA Committee provided a list of health care, social service, education, government, and service providers (hereafter referred to as community stakeholders) by county to be surveyed. The collected distribution list totaled 807 community stakeholders.

An initial email was sent to the community stakeholders in early January 2019 by the CHA Committee partners, introducing and providing a web-based link to the survey. A follow-up email was sent by ARHN staff approximately two weeks later after the initial reach out. CHA Committee members were provided the names of all non-respondents for additional follow-up, at partner discretion.

The survey requested that community stakeholders identify the top two priority areas from a list of five which they believe need to be addressed within their county. Community stakeholders also gave insight on what they felt were the top health concerns and what contributing factors were most influential for those specific health concerns.

A total of 409 responses (including 92 from Warren County and 150 from Washington County) were received through February 8, 2019, for a total response rate of 50.68%. Respondents were asked to indicate in which counties they provided services and could choose coverage of multiple counties, as appropriate. It took respondents an average of 22 minutes to complete the survey, with a median response time of approximately 17 minutes.

The survey results report provides a regional look at the results through a wide-angle lens, focusing on the ARHN service area. It provides individual analyses of Clinton, Essex, Franklin, Fulton, Hamilton,

[28] Bureau of Tobacco Control, StatShot, Prevalence of Current Smoking Among Adults, in New York by County, NYS BRFSS 2016, available at https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume11/n4_current_adult_smoking_by_county.pdf

Warren and Washington counties. Below are highlights from the analyses of Warren and Washington Counties:

- Respondents identified Promote Well-Being and Prevent Mental and Substance Use Disorders and Promote a Healthy and Safe Environment as the top two priority areas. *(As survey participants were not provided focus areas or goals associated with each priority area, it can be assumed that the answers for these priority areas were slightly swayed due to what partners believe the priority areas seek to address).*
- Respondents noted mental health conditions, substance abuse, and Alzheimer's disease within their top five health concerns facing the counties. Warren County also identified overweight/obesity and adverse childhood experiences, while Washington County identified opioid use and cancers.
- Top contributors to the health conditions noted above included age of residents, lack of mental health services, changing family structures, and poverty.
- Across the entire region, including Warren and Washington counties, individuals living at or near the federal poverty level is a subpopulation that respondents overwhelming believe experience the poorest health outcomes with individuals with mental health issues being the next subpopulation that experience the poorest health outcomes.
- Respondents were asked to choose three goals within each NYS Prevention Agenda Priority Area that their organization could assist in achieving in their counties. The tables below summarize those responses by county:

	Top Three NYS Prevention Agenda Goals Identified for Warren County		
NYS Prevention Agenda Priority Areas	**Goal #1**	**Goal #2**	**Goal #3**
Prevent Chronic Disease	Improve self-management skills for individuals with chronic disease	Increase skills and knowledge to support healthy food and beverage choices	Promote the use of evidence-based care to manage chronic diseases
Promote Healthy Women, Infants and Children	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Promote a Healthy and Safe Environment	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change

Promote Well-Being and Prevent Mental and Substance Use Disorders	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences
Prevent Communicable Disease	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use

	Top Three NYS Prevention Agenda Goals Identified for Washington County		
NYS Prevention Agenda Priority Areas	**Goal #1**	**Goal #2**	**Goal #3**
Prevent Chronic Disease	Improve self-management skills for individuals with chronic disease	Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	Increase skills and knowledge to support healthy food and beverage choices
Promote Healthy Women, Infants and Children	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Promote a Healthy and Safe Environment	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
Promote Well-Being and Prevent Mental and Substance Use Disorders	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Prevent Communicable Disease	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use

This stakeholder survey was conducted to gather information from a variety of fields and perspectives to provide valuable insight into the community's needs. The results enable us to guide strategic planning throughout the Adirondack region, for partners who serve individual counties, and those whose footprint covers multiple counties. For the full analyses of the Survey Results, see Appendix F.

County Health Rankings

To further support the information collected through the county health indicator data and the regional community stakeholder survey, County Health Rankings were used to understand how the health of Warren, Washington and Saratoga counties rank compared to each other and other counties in NYS. In total, there are 62 counties in NYS. Those having high ranks, e.g. 1 or 2, are considered to be the "healthiest."

Health outcomes demonstrate the current health status of the population and are based on two types of measures: how long people live and how healthy people feel while alive. Health factors are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors.

County Health Rankings - 2019

	Warren	Washington	Saratoga
Health Outcomes	**21**	**35**	**4**
Length of Life	**28**	**32**	**6**
Quality of Life	**9**	**29**	**4**
Health Factors	**10**	**42**	**2**
Health Behaviors	**20**	**43**	**11**
Clinical Care	**2**	**42**	**7**
Social & Economic Factors	**15**	**27**	**1**
Physical Environment	**15**	**50**	**49**

Source: County Health Rankings and Roadmaps, Building a Culture of Health, County by County, Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute – 2019, see http://www.countyhealthrankings.org/

For almost all of the ranking categories, Saratoga County ranked the highest (closest to 1), while Washington County ranked the lowest (closest to 62). Warren County was typically in the middle for all eight ranking scores, except for clinical care, where it was higher than most as the #2 county in all of New York State. This is most likely because of the physical presence of GFH in Warren County and the volume of services and providers available to the population. The extreme difference in ranking between Washington and Saratoga counties is striking. It is also important to note that the populations in the southern and northern most points of Saratoga County are extremely diverse. While the County Health Rankings only represent whole counties, typically, the health outcomes and health factors for the population in northern Saratoga County inside the GFH service area align more closely with Warren and Washington counties. The entirety of the data that was used to inform the rankings can be found in Appendix J.

Comments from Public

The Community Service Plan is available on the Glens Falls Hospital website, or by hard copy upon request. To date, Glens Falls Hospital has not received any comments from the public on either document. In 2019, Glens Falls Hospital added information on the website to proactively solicit comments, by advising individuals to use our 'Contact Us' form on the website to provide feedback.

When promoting availability in other reports, Glens Falls Hospital will also proactively solicit comments on the documents.

Gaps in Information

While the information collected through the community health assessment process was extremely comprehensive, there are a variety of gaps in information. First, there is limited data available by zip code, and much of the data is often at least 2 to 3 years old. Second, data sources are extremely limited to quantify the challenges and needs associated with the social determinates of health. Metrics are not available to wholly understand issues such as child care, housing, transportation, food insecurity, and other social barriers facing our populations. Similarly, while racial and ethnic disparities are often easily identified in other parts of New York State, disparities in this region are difficult to measure or quantify.

Prioritized Significant Health Needs

Through the ARHN collaborative, GFH coordinated with Warren and Washington counties to conduct a CHNA in each county. Saratoga County conducted a separate, yet similar process to determine their community's heath needs. The process was mainly coordinated by Saratoga Hospital and Saratoga County Public Health and facilitated by a different regional planning group. GFH representatives were members of the prioritization planning group and actively contributed to the process.

Utilizing the results of the indicator analysis, regional survey and the other county-specific community assessment resources listed previously, each county prioritized the most significant health needs for their residents. Each counties' CHA provides the rationale behind the prioritization of significant health needs. The following table outlines the most significant health needs identified in each county within the GFH service area.

	Warren County	**Washington County**	**Saratoga County / Saratoga Hospital**
Prevention Agenda Priority and/or Focus Area	Prevent Chronic Diseases • Tobacco Prevention • Chronic Disease Preventive Care and Management Promote Well-Being and Prevent Mental and Substance Use Disorders • Promote Well-Being • Mental and Substance Use Disorders Prevention	Prevent Chronic Diseases • Tobacco Prevention Promote Well-Being and Prevent Mental and Substance Use Disorders • Mental and Substance Use Disorders Prevention	Prevent Chronic Diseases • Obesity Prevention (Healthy Eating and Food Security & Physical Activity) Promote Well-Being and Prevent Mental and Substance Use Disorders • Substance Use Disorder Prevention

In addition to evaluating the priorities and county level data indicators for our local county health departments, GFH considered our expertise, capacity, funding, and potential impact. To that end, GFH has identified the following as the most significant health needs for the population served by GFH.

These needs will be the major focus of GFH's community health strategies for 2019 – 2021:

Priority Area: Prevent Chronic Disease

- **Focus Area 1 - Healthy Eating and Food Security**
- **Focus Area 2 - Physical Activity**
- **Focus Area 3 - Tobacco Prevention**
- **Focus Area 4 - Chronic Disease Preventive Care and Management**

Priority Area: Prevent Communicable Diseases

- **Focus Area 5 - Antibiotic Resistance and Healthcare-Associated Infections**

It is important to note that GFH chose similar chronic disease related priorities during both our 2013-15 and our 2016-18 Community Service Plan process. Continuing to focus on these areas will improve, strengthen and sustain the impact of our interventions. Emphasis will be placed on interventions that impact disparate and underserved populations in the service area, especially low-income populations and those with limited access to healthcare and other community resources. Additionally, in this Community Service Plan process, GFH is expanding the scope of work to include the priority area of Prevent Communicable Diseases, with a specific focus on antibiotic resistance and healthcare-associated infections.

Regional Priority

In addition to GFH choosing the four focus areas under the Prevent Chronic Diseases priority area, as part of the community health planning and assessment process, the CHA Committee identified and selected Prevent Chronic Diseases as one of the regional priorities in support of the NYS Prevention Agenda 2019-2024. The CHA Committee also selected a second priority, Promote Well-Being and Prevent Mental and Substance Use Disorders. CHA partners will work in tandem with the ARHN in a variety of ways to both support strategies to address and raise awareness about chronic disease prevention and mental and substance use disorder prevention.

Strategies being explored and formulated on how to best support regional priorities of Prevent Chronic Disease include:

- Identifying professional development/training opportunities for the region.
- Implementing a media campaign.
- Creating Prevention Agenda projects.

- Using social media outlets and websites to raise awareness of initiatives and programs currently in place from partners and others in our region.

Community Health Needs not Addressed in the Action Plan

Additional analysis revealed an increasing demand and need for mental health and substance abuse services throughout the three-county region. GFH recognizes this trend and the need for quality services and program, however, has not historically formalized strategies into the plan due to lack of resources and capacity. Currently, Glens Falls Hospital is the contracted behavioral health provider for Warren and Washington counties. The need will only increase, and we are working to proactively ensure patients have access to the care they need. Most recently, Glens Falls Hospital is working with Warren and Washington Counties to conduct a thoughtful and deliberate partnership exploration process for outpatient behavioral health and substance use services. We are working with the Counties to identify potential partners who can help us better serve patients, with a goal to expand access to much needed specialized behavioral health services in our community. Simultaneously, GFH will continue to work through initiatives such as Health Home and DSRIP to work with all providers on integrated care models and population health strategies.

Additional community health needs, such as housing, transportation, and other social determinants of health, are not addressed in the action plan due to lack of resources, expertise and/or quantitative data to support a proper assessment and plan.

Action Plan Development

After thorough data review and discussions with Senior Leadership, GFH identified evidence-based initiatives to address the prioritized community health needs related to our chosen priority areas. Throughout this process, GFH built on existing initiatives and community assets and identified new initiatives to complement and further enhance these existing programs. As a result, this Community Service Plan is a comprehensive, aligned plan with evidence-based strategies that will have significant impact on the health and well-being of the people and communities in the region.

GFH developed common terminology throughout the various departments within the institution to ensure consistent communication about goals, objectives, performance measures and activities. For each initiative, a Manager or Director participated in the development of a three-year action plan. GFH coordinated with Warren, Washington and Saratoga County Public Health throughout the process, and included other existing and new partners to ensure a collaborative and coordinated approach. Where applicable, GFH provided input into each county plan to ensure coordination and alignment with the hospital plan. Once finalized, the action plan was reviewed by Senior Leadership and presented to the Board of Governors for approval.

Priority Populations

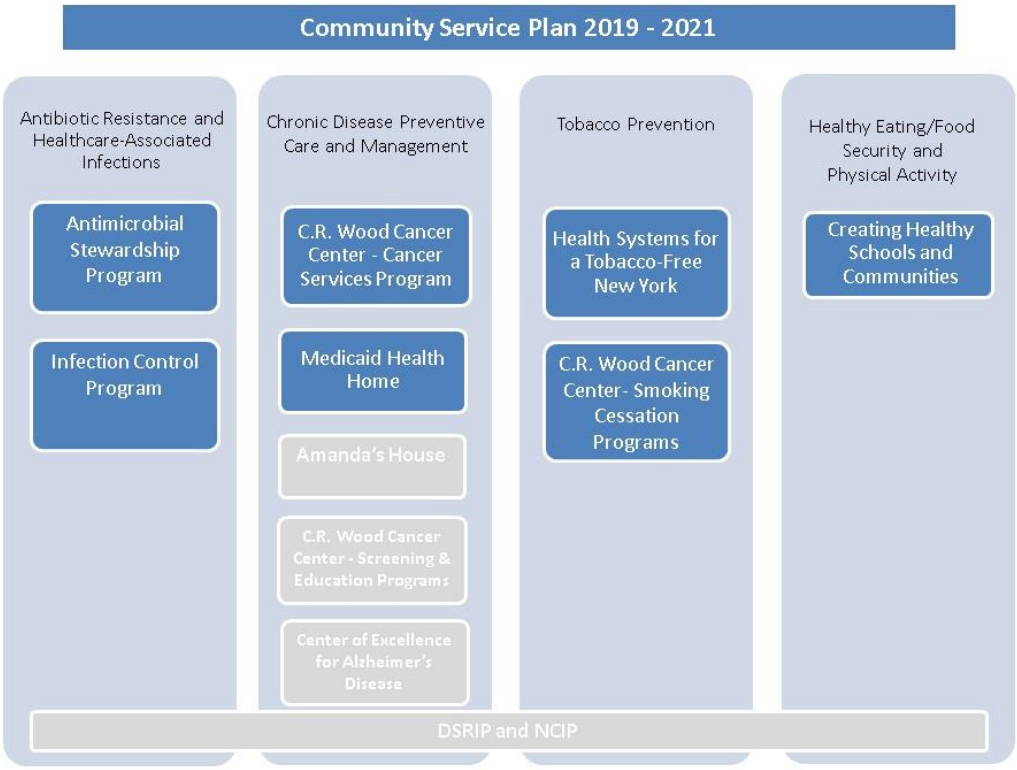
Emphasis throughout the action plan is placed on interventions that impact disparate and underserved populations in the service area, especially low-income populations and those with limited access to healthcare and other community supports and resources. As described earlier in this plan, Warren, Washington and Saratoga counties do not face the traditional racial or ethnic disparities typically found in more urban or populated areas. Instead, populations falling within our service area in upstate New York face a unique combination of factors that create health disparities, which are often rooted in the social determinants of health. Economic factors, cultural and social differences, educational shortcomings, and the isolation of living in a rural area all combine to create barriers for this population in their effort to lead a healthy life. Many sections of the region face significant distance and transportation barriers to accessing community resources, service opportunities, and health care. These communities are traditionally underserved by most assistance programs; thereby creating health disparities among the people living and working in this area. Throughout the action plan, priority populations for each specific initiative are noted within the section highlighting the health disparities addressed.

Action Plan for 2019-2021

The visual below outlines the evidence-based interventions led by GFH to address the prioritized community health needs. It includes initiatives to address the four focus areas under the Prevent Chronic Disease priority area and the one focus area under the Prevent Communicable Diseases priority area of the NYS Prevention Agenda. Many of the initiatives impact more than one focus area and some influence all focus areas.

The interventions were selected by GFH by aligning with the Prevention Agenda goals, building on existing initiatives and community assets, and identifying new initiatives to complement and further enhance these existing programs. Capacity, funding, and potential impact were also major considerations. The inventions in blue are the selected strategies that are included in the formal DOH required Community Service Plan. The interventions in gray are included here to be comprehensive, as they are part of the IRS-required Implementation Strategy, but are not included in the DOH required Community Service Plan as they do not neatly align with Prevention Agenda goals and/or the required workplan format.

In the corresponding action plan, each initiative includes a brief description, health disparities addressed, goal, SMART objective(s) and corresponding performance measure(s), key activities for the improvement strategy, and a list of partners who collaborate on the initiative and their roles. GFH continues to be actively involved in the counties' and other partner-led initiatives.



Glens Falls Hospital Initiatives

Please see the DOH-required workplan table, which outlines the action plan for each initiative.

Delivery System Reform Incentive Payment Program (DSRIP)

It is important to note that while DSRIP is included as a strategy, there is not a corresponding workplan within this Community Service Plan specific to define the many DSRIP initiatives in which GFH was involved. Most of the workplans have concluded with the pending DSRIP end-date of March 2020. We have, however, chosen to include DSRIP as a strategy with the knowledge that NYS has applied to CMS for a one-year extension of the current waiver program and a subsequent three-year renewal to allow the State to build upon the transformation started in the current waiver and continue on the road to value-based care. Assuming the DSRIP extension and renewal is granted and a workplan is developed, opportunities for alignment will be identified and integrated into the initiatives outlined herein.

North Country Innovation Pilot (NCIP)

It is important to note that while NCIP is included as a strategy, there is not a corresponding workplan within this Community Service Plan. The detailed design of the initiative is still under development, however, we have chosen to include NCIP as a strategy as the overall goals of the initiative align themselves with the population health initiatives identified herein. As the NCIP framework and focus is developed, opportunities for alignment will be identified and integrated into the identified initiatives.

Additional Community Benefit

In addition to the services and programs listed herein, GFH delivers numerous educational programs and screening events on a wide array of topics throughout the service area on an ad hoc basis to best meet the needs of our community members. These programs aim to increase awareness that will strengthen the community's knowledge and skills to improve their ability to better prevent and manage complex health conditions and navigate a complicated health care system. Because these programs are delivered on an as needed basis to meet current trends within the community, they do not lend themselves to fitting into the structure of an on-going action plan with quantifiable, long-term metrics. Rather, GFH tracks these programs as they present themselves as a means to ensure we are meeting the needs of the community through the regular provision of these services. These programs are tracked and noted as community benefit programs and are quantified for inclusion into our Schedule H, as applicable, using staff time, materials, administration and other programmatic supports.

Evaluation Plan

To ensure efficacy of the proposed interventions, GFH will work with Warren, Washington and Saratoga Public Health Departments to monitor and track progress using process and, where applicable, outcome evaluation. GFH will ensure these efforts align with and compliment the evaluation plans developed by each county. Process evaluation will demonstrate if the activities were implemented, if the appropriate populations were reached, and how external factors influenced the implementation. Progress will be tracked through discussion with internal and external partners responsible for each initiative. Through these discussions, mid-course corrections may be made to the plan to ensure goals and objectives are met. Outcome evaluation will demonstrate the impact of the activities, where data is available, and the ability to meet the objectives outlined in the action plan. This information will be used to provide regular updates to the NYS DOH and the IRS, as requested or required. In addition, this information will be used to share successes and challenges, and inform broader communications with the community and key partners.

Glens Falls Hospital Resources to Address Community Health Needs

GFH will dedicate the necessary resources and assets to meet the identified health needs of our community members and in support of the interventions, initiatives, strategies and activities defined within this Community Service Plan. These resources include but are not limited to the provision of traditional resources such as staff time, office space, meeting and community-use space, program supplies, educational and promotional materials, as well as, infrastructure assistance including clinical supports, IT support, financial and administrative support, public relations, media development and marketing expertise. Additional resources will be provided through fostering partnerships and broad-based, multi-sector engagement, and support that will enhance, promote and sustain the work identified herein to maximize impact and increase outcomes.

Partner Engagement

GFH will continue to partner with Warren, Washington and Saratoga county Public Health departments to implement the strategies in this action plan. GFH has a long-standing history of partnerships with these and other community-based organizations and agencies to support implementation of community health initiatives. These include a wide array of disciplines, such as schools, workplaces, providers, housing and transportation authorities, Offices on Aging, county health departments, local economic opportunity councils, Chambers of Commerce and local decision makers. Many of these partners participated in the various county health assessments and planning processes and therefore are well versed in the need for these interventions and are poised to provide the support necessary to ensure the attainment of the proposed goals.

Many of these partnerships will be further enhanced through ongoing participation in the Adirondack Rural Health Network, Population Health Improvement Program, Delivery System Reform Incentive Payment Program, Adirondacks ACO, Health Home and the North Country Innovation Pilot. In addition, community engagement is integral to the success of improving health in our region. GFH will solicit the guidance and expertise of relevant content experts to ensure a coordinated approach and to best meet the needs of the population we serve. In addition, any feedback received from the public at large will also be considered in the planning and implementation. A list of partners and corresponding roles for each intervention is included in the required workplan table.

Community Assets to Meet Needs

Many community assets have been described throughout this Community Service Plan, including those described within the Infrastructure and Services, Health Care Facilities, and Educational System sections.

Countless additional potential partners exist throughout the three-county area, many of which GFH has a long-standing relationship with already[29]. These include, but are not limited to:

- Business sector
- Community-based organizations
- Municipalities, such as those where targeted interventions are planned
- Mental health service providers
- Healthcare providers
- Service providers for individuals with disabilities; and
- Cancer-specific community organizations

Additional community assets that are available to everyone, and will help to address the identified priorities, include the following:

- Glens Falls Hospital services and facilities (see http://glensfallshospital.org/services for a full listing)

[29] The most comprehensive listing of businesses in the region can be found at the GlensFallsRegion.com website, https://www.glensfalls.com/.

- Community gardens
- Farmers markets and community supported agriculture (CSAs)
- Gyms and other wellness facilities
- Parks and Recreation
- Walking trails and bicycle routes
- Grocery stores and convenience stores
- Faith-based organizations

Lastly, there are many community resources and supports that are specific to certain population groups. These include employer-sponsored wellness programs and services, insurer-sponsored wellness and health promotion benefits, other neighborhood or community-specific services or events, school district-specific resources or activities as well as health care provider-specific resources. The Tri-County United Way also offers 2-1-1, which helps people assess their needs and links them directly to the resources that will help.

C.R. Wood Cancer Center Resources

The C.R. Wood Cancer Center has many available resources on site for patients after a diagnosis of cancers. These resources and services include an oncology health psychologist and mental health counselor to assist with psychosocial services; including one on one counseling, retreats, camps and support groups. An oncology social worker to assist with transitions in care, oncology nurse navigators who assess any barriers to care and arrange for interventions included but not limited to: transportation assistance through local community vendors and through paid contracts with local cab companies through donated funds. A financial navigator assesses every patient for out of pocket expenses for all cancer-related medications and helps find foundation funds, co-pay assistance programs and free or replacement drugs for those whom qualify.

Gaps in the Availability of Resources

The most significant gap in the availability of resources is related to housing assistance for patient while undergoing treatment. There has been an increase in the number of patients that are homeless or are in jeopardy of losing their housing while going through treatment. While Glens Falls Hospital is able to offer patients and families temporary housing through Amanda's House, the long-term, permanent needs for families seeking housing options are growing, with limited affordable, permanent housing options in the region. Transportation also continues to be a significant issue in our rural areas.

GFH will continue to use this listing of community assets to determine the most effective group of core partners to address the three prioritized needs identified above. Additional organizations, assets and resources will be identified to respond to emerging issues.

Impact of Previous Community Service Plan

As a result of 2016-2018 Community Service Plan process, GFH chose the following health needs as priorities.

- Increase access to high quality chronic disease preventative care and management in both clinical and community settings
- Reduce obesity in children and adults
- Reduce illness, disability and death related to tobacco use and secondhand smoke exposure

Through many of the health care transformation projects described herein, in addition to strong community partnerships and community-based interventions focused on policy and environmental changes, GFH has made great strides in improving the health of community members. The following is a list of notable accomplishments from 2016 - 2018.

- Provided **Health Home care coordination** services to adults and children enrolled in Medicaid, for a total of 3551 encounters in 2016, 4108 encounters in 2017 and 3455 encounters in 2018. A ´Health Home´ is a group of health care and service providers working together to make sure Medicaid members get the care and services they need to stay healthy.
- Partnered with 5 strategic local human service agencies to refer eligible individuals for **free cancer screenings.** The rates of comprehensive screenings for breast, cervical, colorectal cancer improved to 61%.
- Continued to conduct **smoking cessation program**s for community members that resulted in approximately 20% of individuals successfully reducing consumption of nicotine products. Approximately 5% quit for a short time and are working on reducing their consumption.
- Organized **Cindy's Retreat, a weekend getaway** for women living with and beyond cancer, in partnership with the Silver Bay YMCA Resort and Conference Center. The retreats were held twice a year between 2016 and 2018, for a total of six women's retreats with a total of 56 attendees. A men's retreat was also piloted reaching 10 attendees. All participants evaluated stated that the program helped them with tools for coping after their diagnosis and 100% stated that they felt better connected to services and others with similar diagnosis.
- Provided **wigs and head coverings** free of charge to patients undergoing chemotherapy at the C.R. Wood Cancer Center, through the Uniquely You Boutique and Salon. Nearly 900 patients used the salon between 2016 and 2018, and over 375 wigs were provided free of charge.
- Conducted 5 **Comfort Camps** between 2016 and 2018, a weekend overnight camp for children and teens who have experienced the death of a family member, in partnership with the Double H Hole in the Woods camp. Over 100 individuals participated and evaluation of the program showed that 100% of the families found the education and support helpful in reconnecting their families during the stressful treatment timeframe.
- Conducted **free skin cancer screening** once per year, for a total of three screenings between 2016 and 2018, which are free and open to the community. Nearly 430 individuals participated and each year, 75% of participants stated they had spots that needed to be checked and would not have otherwise seen a provider.

- Provided free accommodations through 1,300 room nights and over 2,000 guest nights, between 2016 and 2018, through **Amanda's House, a home away from home** for Glens Falls Hospital patients and their families who have traveled a distance for health care. The house accommodated guests from as close as an hour away to states as far as Florida and California and countries and territories as far as Canada, Venezuela, Puerto Rico, and Columbia. Family members of patients in the ICU and other units were able to remain close to the hospital to make decisions about their care and in some cases be there when they passed away. Patients who may not otherwise have had access to care were treated at the C.R. Wood Cancer Center, the Wound Center, the Sleep Lab and/or received procedures on almost every unit of the hospital.
- Conducted 12 **support groups** and 6 **diabetes education classes** between 2016 and 2018.
- Achieved NCQA recognition for all 8 primary care practices operated by Glens Falls Hospital under the **2017 Patient-Centered Medical Home (PCMH)** standards. These practices are now enrolled in the annual sustainability model. This model ensures continuous work in meeting quality metrics including patient engagement, access and continuity of care, patient satisfaction, and risk stratification of patients to identify those that would benefit from care management.
- Established all GFH primary care medical centers as **Comprehensive Primary Care Plus** (CPC+) sites.
- Piloted **primary care and behavioral health integration**, developed a solid step up and step down algorithm whereas patients received a warm hand off within the office and then triaged to the appropriate setting and clinician. Due to recruitment and retention challenges, the model is evolving and we are working to explore the use of telehealth.
- Established new services, including a NYS designated **Stroke Center** and a **Center of Excellence for Alzheimer's Disease**.
- Participated in regional care delivery transformation through the **DSRIP program**:
    - Renovated 4 medical centers to create a physical space conducive to integrating behavioral health services into primary care. Through these projects, two of the medical centers also increased their footprint to expand primary care capacity.
    - Established a new Crisis Care Center to expand services of the Emergency Department.
    - Accessed DSRIP workforce and training support to send staff to 30 trainings/conferences for professional development that would not have otherwise been possible. This includes a hospital-wide initiative to address crisis prevention and behavioral safety.
    - Established the Glens Falls Medical Group, a provider engagement and alignment initiative which established a physician-driven governance structure; created a data driven strategic plan that outlined goals around quality improvement, financial stability and patient satisfaction; and improved communication and referrals amongst providers through a newly established meeting framework, newsletters, education and training, data dashboards and a provider directory.
    - Formed new or enhanced existing collaborations with community partners to reach and serve our most vulnerable patients.

- Continued to **advance tobacco prevention and control efforts** across the region:
    - Provided training to over 30 agencies to **increase implementation of evidence-based intervention** and care for tobacco dependence.
    - Established 15 **new tobacco or smoke-free policies** throughout Warren, Washington, and Saratoga Counties by community partners in areas such as parks, worksites, and multi-unit housing complexes. Partners included the Double H Ranch, Skidmore College, and the Saratoga Springs Housing Authority, which resulted in 330 smoke-free homes. Another housing policy resulted in the creation of over 200 new smoke-free homes.
    - Supported 10 **public housing authorities to provide tobacco cessation opportunities** for residents as they develop tobacco free living spaces as per new federal housing law.
    - Sponsored a **Certified Tobacco Treatment Specialist training** resulting in 40 new tobacco treatment professionals throughout the region.
    - Collaborated with the **Medical Society of the State of New York** to train 50 clinicians from Glens Falls Hospital, Hudson Headwaters Health Network, Irongate, Adirondack Health, CVPH, Alice Hyde and others, in contemporary and evidenced-based protocols for Tobacco Dependence Treatment.
    - Partnered with 13 medical and 17 behavioral health system partners to **enhance interventions, policies and workflow protocols** to address tobacco dependence with patients.
- Continued to advance policy and environmental changes to **promote physical activity and nutrition:**
    - Partnered with local agencies to deliver a **Mobile Fresh Produce Pantry** that has provided 2,429 households with 17,557 pounds of fresh produce over two years.
    - Assisted 4 local school districts in improving their **Local Wellness Policies** to provide students with increased opportunities for physical activity and nutrition.
    - Provided local school districts with **hydration stations, healthy food items** for taste testing events, **cafeteria equipment** and equipment to support a **hydroponic vegetable garden** for use in school foods, in addition to **equipment for increased physical activity** during recess, breaks and PE class and after school programs.
    - Hosted **Math and Movement Family Nights** in the Granville Central School District and the Hadley-Luzerne Central School District to bring families together to improve students' math skills while being physically active. The events hosted approximately 120 students and their families.
    - Provided 8 schools in Hudson Falls, Fort Ann, Whitehall, Granville and Lake Luzerne with nearly $15,000 of **equipment and supplies to increase physical activity** during the school day and recess.
    - Created **safer streets for pedestrians and bicyclists** by providing over $35,000 in Complete Streets support (such as speedbumps, signage, and speed feedback detectors) to Hadley, Kingsbury, Hudson Falls and Whitehall.

The complete 2016-2018 IS and corresponding CSP can be found on the GFH website at http://www.glensfallshospital.org/services/community-service/health-promotion-center.

Dissemination

The GFH Community Service Plan and Executive Summary, along with the CHNA and corresponding IS, are available at http://www.glensfallshospital.org/services/community-service/health-promotion-center.

The previous two most recent CSPs, CHNAs, and Implementation Strategies are also available on the site. GFH will use various mailings, newsletters and reports to ensure the availability of the CSP Executive Summary and the full plans are widely publicized. Hard copies will be made available at no-cost to anyone who requests one.

Approval

The Director of Research and Planning worked with Senior Leadership to develop the plans, which were presented to the Board of Governors for approval. The Board was provided with an executive summary of the CHNA and IS in advance and a brief presentation was conducted during a regular monthly meeting to communicate highlights and answer questions. The CHNA and IS were approved on December 19, 2019. Elements from those documents were combined to create this Community Service Plan, for submission to the NYS DOH.