



Glens Falls Hospital

Implementation Strategy

2019-2021

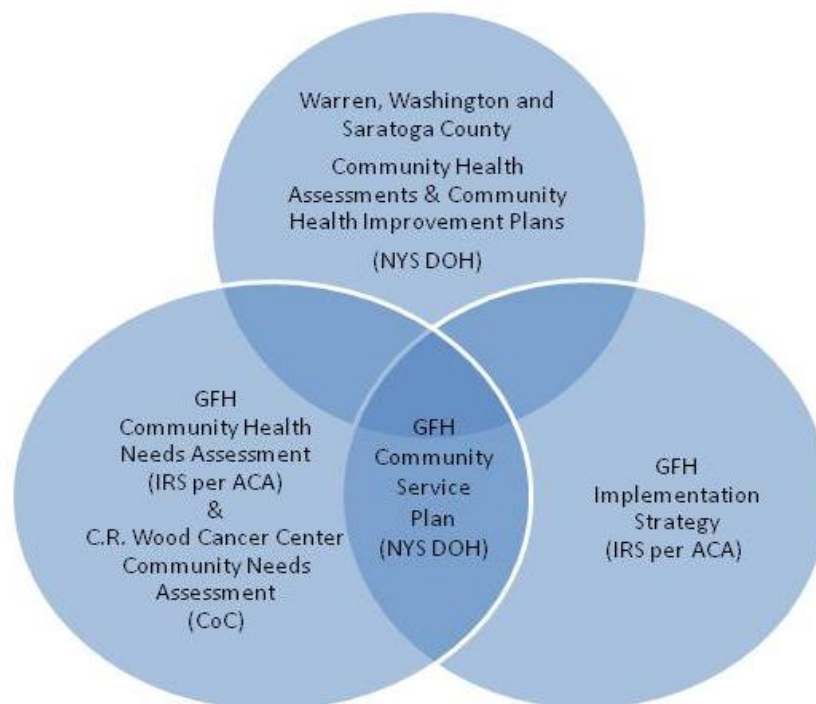
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Introduction

Glens Falls Hospital (GFH) developed this Implementation Strategy (IS) to address the prioritized community health needs of the patients and communities within the GFH service area. It is a three-year plan of action including goals, objectives, improvement strategies and performance measures with measurable and time-framed targets. Strategies are evidence-based and align with the New York State (NYS) Prevention Agenda 2019-2024. The prioritized community health needs were identified in the corresponding Community Health Needs Assessment (CHNA).

The CHNA and IS will address the requirements set forth by the Internal Revenue Service (IRS) through the Affordable Care Act (ACA). 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 IS to meet the significant health needs of the communities they serve, at least once every three years. The GFH CHNA also addresses the American College of Surgeons (ACoS) Commission on Cancer (CoC) requirements to complete a community needs assessment. The NYS Department of Health (NYS DOH) requires hospitals to work with local health departments to complete a Community Service Plan (CSP) that mirrors the CHNA and IS per the ACA. Consequently, this IS will be combined with the CHNA to develop the CSP. County health departments in NYS have separate yet similar state requirements to conduct a Community Health Assessment (CHA) and a corresponding Community Health Improvement Plan (CHIP). Aligning and combining these requirements 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. 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

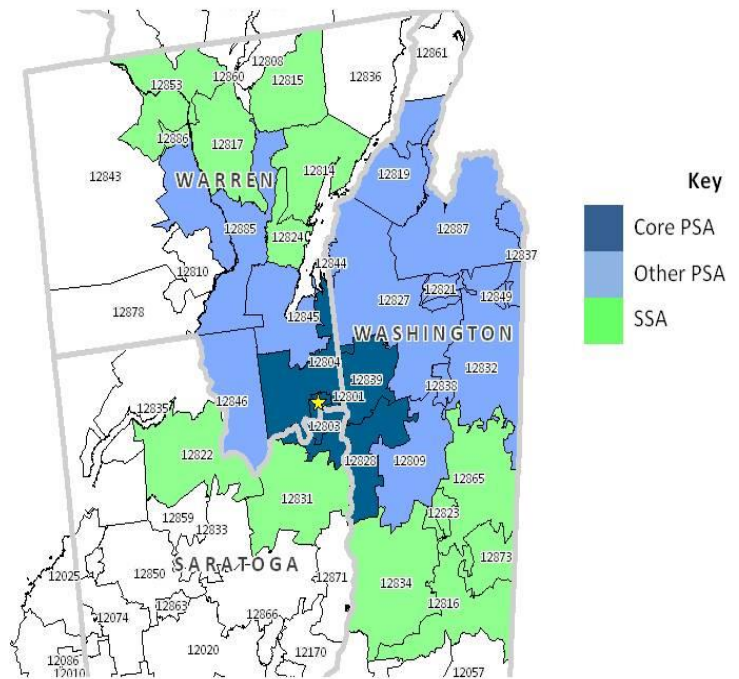
The mission of GFH is to improve the health of people in our region by providing access to exceptional, affordable and patient-centered care every day and in every setting. Our fundamental values are: **Collaboration, Accountability, Respect, Excellence and Safety.** The GFH Purpose combines our Mission - 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.



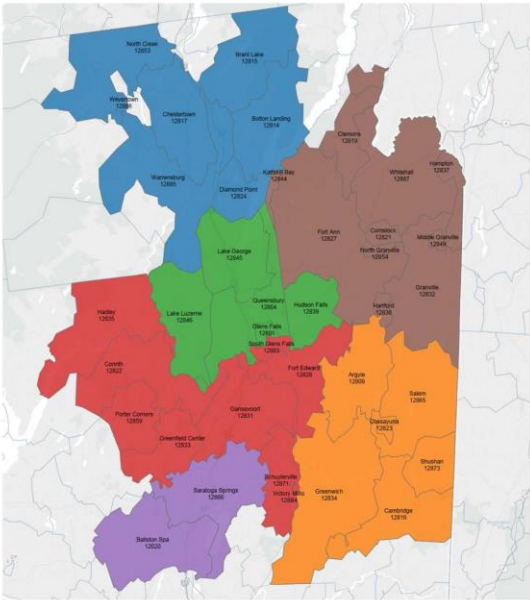
Glens Falls Hospital Service Area

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- 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.



GFH Inpatient Service Area



GFH Ambulatory Service Area

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).¹ 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 currently underway in our service area. Detailed information on these ventures are outlined in our corresponding CHNA.

¹ 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).

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

More information on the Prevention Agenda can be found at https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/index.htm.

Glens Falls Hospital Prioritization of Significant Health Needs

GFH and Warren, Washington and Saratoga County Public Health collaborated in the development of our CHNA. 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 the Adirondack Rural Health Network (ARHN).

ARHN is a regional multi-stakeholder coalition that conducts community health assessment and planning activities. Collaboration is an essential element for improving population health and working together reduced duplication and facilitated an effective and efficient approach.

GFH serves a multi-county area, which encouraged a strategic approach to ensure alignment with each county assessment and planning process. After careful consideration and extensive internal and external discussions, 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' CHA processes and 2) utilize the results of each of the county assessments to inform a coordinated and complementary regional CHNA for the GFH service area. A detailed description of each county CHA process is included in the corresponding GFH CHNA.

The CHNA report provides a regional profile (geography, infrastructure and services, healthcare facilities, educational system) for Warren, Washington and Saratoga counties in addition to a detailed analysis of population and demographic data. The NYS Prevention Agenda is used as a framework to present county-level data regarding the community health needs for the region. The CHNA also includes results from supporting surveys that collected input from residents and key stakeholders representing health care and other service providing agencies. Lastly, a specific section was devoted to health disparities and barriers to care for patients and communities, along with an overview of the County Health Rankings for Warren, Washington and Saratoga counties. Extensive details and information is available in the GFH CHNA.

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 health 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 county's 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 <ul style="list-style-type: none"> • Tobacco Prevention • Chronic Disease Preventive Care and Management Promote Well-Being and Prevent Mental and Substance Use Disorders <ul style="list-style-type: none"> • Promote Well-Being • Mental and Substance Use Disorders Prevention 	Prevent Chronic Diseases <ul style="list-style-type: none"> • Tobacco Prevention Promote Well-Being and Prevent Mental and Substance Use Disorders <ul style="list-style-type: none"> • Mental and Substance Use Disorders Prevention 	Prevent Chronic Diseases <ul style="list-style-type: none"> • Obesity Prevention (Healthy Eating and Food Security & Physical Activity) Promote Well-Being and Prevent Mental and Substance Use Disorders <ul style="list-style-type: none"> • 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 CHNA 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 CHNA 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.

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.

Implementation Strategy Development

GFH utilized the results of the corresponding CHNA to develop this IS. 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 IS 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 IS was reviewed by Senior Leadership and presented to the Board of Governors for approval.

Priority Populations

Emphasis throughout the IS 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 in the CHNA, 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 below, priority populations for each specific initiative are noted within the section highlighting the health disparities addressed.

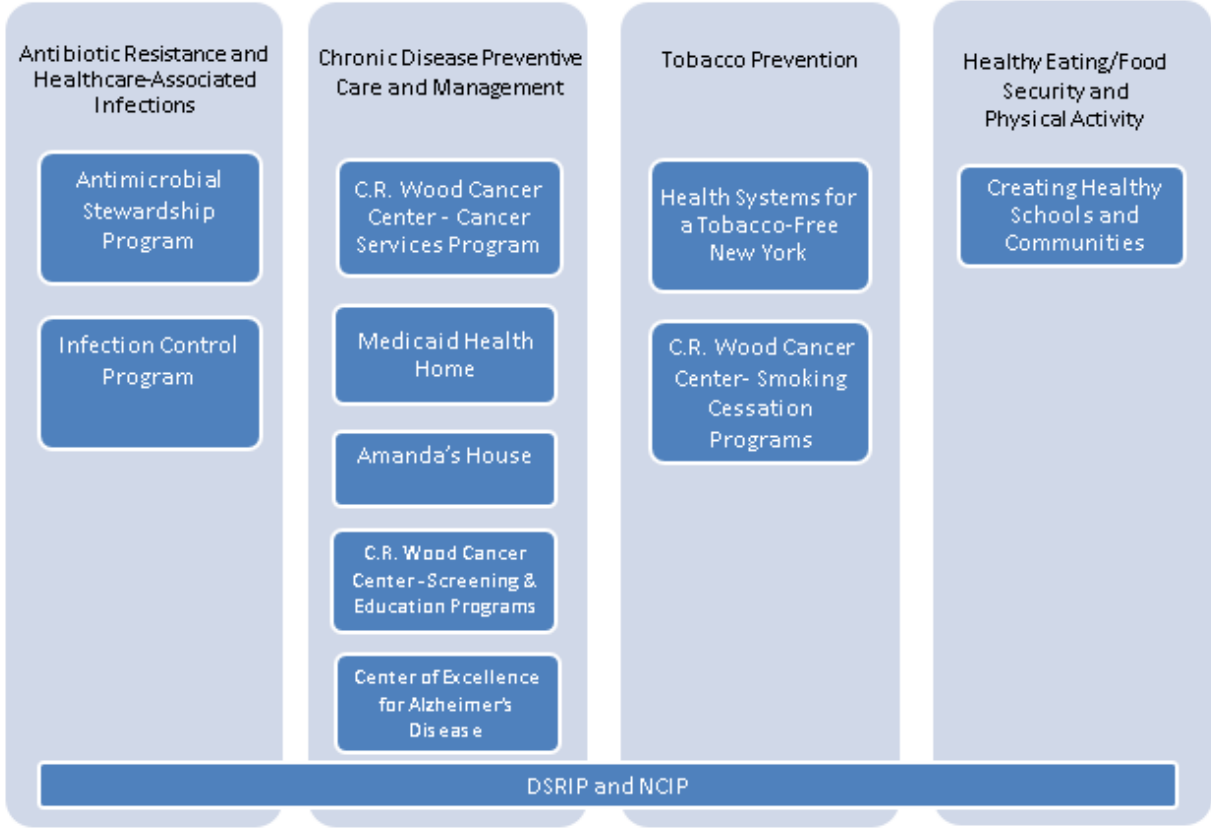
Action Plan for 2019-2021

The following three-year action plan includes initiatives 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.

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.

The following table outlines the reach of each program that will be conducted by GFH to meet the needs of our community members.

Implementation Strategy 2019 - 2021



Glens Falls Hospital Initiatives

GFH Initiative/Improvement Strategy: Antimicrobial Stewardship Program	
Brief Description/background: Antibiotic resistance occurs when antibiotics no longer work against bacteria that cause infections. Antibiotics can be lifesaving, but bacteria are becoming more resistant to treatment. Antibiotic resistance is part of a broader threat called antimicrobial resistance (AR), which is resistance to medicines used to treat all types of infections, including those caused by bacteria, parasites, and fungi. Two important preventable causes of AR are inappropriate antibiotic prescribing (antibiotic prescribing when not necessary such as for viral infections) and inappropriate antibiotic usage (antibiotic use without a healthcare provider's guidance). To reduce inappropriate antibiotic use, Glens Falls Hospital is focusing on reductions in length of therapy based upon current literature, reductions in treatment of Asymptomatic Bacteriuria (ASB) and treatment of infections in a guideline consistent manner including management of community acquired pneumonia.	
Disparities Addressed: AR disproportionately affects those with significant healthcare exposure, often impacting patients over age 65 years.	
Goal: Reduce Inappropriate antibiotic use	
SMART Objective(s)	Performance Measure(s)

By December 2021, Glens Falls Hospital will (continue to) meet the standards set forth by the CDC for Antimicrobial Stewardship Programs (ASPs).	# of Core Elements met
By December 2021, length of therapy for management of Community Acquired Pneumonia (CAP) will be reduced to 5-7 days total length of therapy, as appropriate, for the majority of GFH patients with CAP.	# days total length of therapy
By December 2021, reduce use of ceftriaxone (an antibiotic used to treat many kinds of bacterial infections) by 20%.	% reduced
Activities	
Initiation of Urinalysis with Reflex to Culture: urinalysis for patients without localizing signs of infection will not be automatically cultured, thus providers are not faced with a result they may feel compelled to treat.	
New Provider PowerPlans are being developed to help guide providers to guideline consistent selection of agent and duration. Plans for Sepsis are also being updated.	
Partners/roles:	
<ul style="list-style-type: none"> • Physician Leadership including President of Medical Staff, Associate Chief Medical Officer and Chief Medical Officer – roles vary dependent upon the clinical initiative. • Supervisor, Lab Operations and Lab Lead, Microbiology - implementation of advanced diagnostics and fine tuning of current procedures. • Manager, Infection Prevention and Control -coordinates approach to reviewing Surgical Site infections, hospital Acquired infections as well as other subjects which identify themselves. • IT Solution Architect- Provides IT support in development of EMR based tools/ Plans. 	

GFH Initiative/Improvement Strategy: Infection Control Program	
Brief Description/background: Glens Falls Hospital Infection Prevention & Control uses a coordinated approach based on established epidemiological principles, statistical methodologies, surveillance and evidence-based information to minimize, reduce, or ultimately eliminate the risk of infection. The program is based on the underlying principle of continuous quality improvement.	
Disparities Addressed: The program faces challenges found consistently across healthcare including low health literacy, barriers to direct physical access to care in our rural service area, and comprehensive infection control practices while admitted in the hospital for care, attending an outpatient appointment or visiting a patient receiving care in the hospital. Cultural challenges faced by the Infection Prevention Control Program include preferences that relate to seeking, complying with and following up on medical care and advice.	
Goal: Reduce Infections caused by multidrug resistant organisms and C. Difficile	
SMART Objective(s)	Performance Measure(s)
MDRO's: By December 2021, reduce hospital acquired multidrug resistant organisms (MDRO's) year over year by 30%. Each year's objective is measured against the last year's actual results. For those organisms reaching zero infections, the objective is to sustain zero.	% reduction from prior year or # of infections if maintaining at zero
CDI: By December 2021, reduce hospital onset Clostridioides <i>difficile</i> infections (CDI's) year over year by 30%. Each year's objective is measured against the last year's actual results. For	% reduction from prior year or # of infections if maintaining at zero

those organisms reaching zero infections, the objective is to sustain zero.	
Activities	
MDRO: Focus on Surgical Site Infections based on 2018 data. Ensure bundle elements are adhered to including: antimicrobial prophylaxis (right antibiotic, for the right site at the right time before the surgery), maintain glycemic control, normothermia, appropriate skin preparatory agent, and environmental cleanliness to include the microbial burden of the room. Introduce a pre-surgical body decolonization process with nasal decolonizing povidone iodine solution, and a six-wipe chlorhexidine gluconate body antiseptic agent for all cases with a dermal incision below the neck.	
CDI: Apply diagnostic stewardship by implementing the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Disease Society of America (IDSA) two-step testing guidelines set forth. These guidelines provide a clinically significant algorithm to distinguish between colonization and active infectious processes that require treatment and transmission-based precautions.	
MDRO: Focus on hospital acquired bacteremia (bacteria in the bloodstream) by bringing together a multidisciplinary workgroup to address peripheral intravenous line best practice for insertion and maintenance. Obtain a baseline bacteremia rate from retrospective data 2016-2019 for future benchmarking. Preparedness for novel strain organisms including educating frontline staff members on proper environmental cleaning, transmission-based precautions, hand hygiene, and develop an exposure plan algorithm.	
CDI: Obtain baseline from 2019 data, continue 30% reduction objective with focus on antimicrobial usage and environmental decontamination.	
Partners/roles:	
<ul style="list-style-type: none"> • Microbiology supervisor- CDI two-step testing, microbiological identification and resistance patterns • Infection Prevention & Control Medical Director- Provider support and education • Vascular access educator- bacteremia nurse champion • Environmental Services Director- environmental cleanliness • Day surgery & PACU manager- SSI reduction nurse champion • Antibiotic Stewardship Pharmacist- CDI reduction, SSI antimicrobials, annual antibiogram 	

GFH Initiative/Improvement Strategy: Creating Healthy Schools and Communities
Brief Description/background: The Creating Healthy Schools and Communities initiative works with school districts to implement sustainable policy, systems and environmental changes in high needs school districts and the communities where the students and their families live. Work focuses on increasing access to healthy, affordable foods and beverages and expanded opportunities to be physically active. Creating Healthy Schools and Communities is a program of the Health Promotion Center of Glens Falls Hospital and is partially funded by the NYS DOH. This initiative is implemented in school districts and communities located in Warren and Washington counties.

<p>Disparities Addressed: Low socio-economic status populations as demonstrated by schools and communities with the 1) highest percent of district population living in poverty; 2) highest percent of the population with less than a high school education; 3) highest percent of students qualifying for free/reduced lunch; 4) highest percent of children living in poverty; and 5) highest percent of students who are obese.</p>	
<p>Goals: Improve the health of people in the GFH region through prevention of obesity and related chronic conditions and more specifically:</p> <ul style="list-style-type: none"> • Increase access to healthy and affordable foods and beverages • Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities • Promote school, child care and worksite environments that increase physical activity 	
<p>SMART Objective(s)</p>	<p>Performance Measure(s)</p>
<p>By December 2021, improve school environments to support and promote healthful eating and increased opportunities for physical activity, before, during and after the school day for all students in grades K-12 by implementing environmental and board approved policy changes across 14 identified schools.</p>	<p># of schools implementing environmental and/or policy changes.</p>
<p>By December 2021, enhance opportunities for improved nutrition and physical activity by implementing policy or environmental changes across 5 identified communities.</p>	<p># of communities (including worksites) implementing environmental and/or policy changes.</p>
<p>Activities</p>	
<p>Increase access to healthy, affordable foods through implementing policies that increases a school districts ability to meet Healthy Hunger-Free Kids Act provisions.</p>	
<p>Support implementation of Comprehensive School Physical Activity Programs.</p>	
<p>Promote student wellness through the assessment, development, improvement and implementation of local School Wellness Policies.</p>	
<p>Increase access to healthy, affordable foods through the implementation of zoning regulations, cooperative buying groups and creating or enhancing food hubs.</p>	
<p>Increase adoption and use of food standards and procurement policies in municipalities, community-based organizations, worksites and hospitals.</p>	
<p>Adopt and implement Complete Streets policies, plans and practices.</p>	
<p>Partners/roles:</p> <ul style="list-style-type: none"> • k-12 Schools- Food service directors, teachers, administrators, school wellness committee, community based organizations are involved with policy or environmental change development, approval and implementation. • Community partners- Businesses/worksites, libraries, food pantries, recreation centers, municipalities, elected officials, highway superintendents, community-based organizations are involved with policy or environmental change development, approval and implementation. 	

GFH Initiative/Improvement Strategy: Health Systems for a Tobacco Free New York	
Brief Description/background: Health Systems for a Tobacco-Free NY works with health system administrations to integrate policies and practices that ensure the consistent delivery of aggressive tobacco dependence treatment in accordance with the Public Health Service’s Clinical Practice Guidelines for Tobacco Use and Dependence. Health Systems for a Tobacco-Free NY is a program of the Health Promotion Center of GFH and is partially funded by the NYS DOH. This initiative is implemented in Clinton, Essex, Franklin, Fulton, Hamilton, Montgomery, Saratoga, Warren and Washington counties.	
Disparities Addressed: Individuals with low income, low educational attainment and individuals diagnosed with mental health issues. These specific populations are prioritized because of their disproportionate use of tobacco products in comparison to the general population.	
Goal: Promote Tobacco Use Cessation	
SMART Objective(s)	Performance Measure(s)
By December 2021, Health Systems for a Tobacco-Free NY will partner with and educate decision makers of 7 medical health systems within the nine county service area to support the development of comprehensive, guideline concordant and evidenced-based policies that address tobacco dependence within their patient population.	# of educational touches to decision makers at each of the identified medical health system targets. # of adopted comprehensive policies that complete systems level change to address tobacco dependence as directed by the Public Health System’s 2008 Clinical Guidelines for Treating Tobacco Use and Dependence .
By December 2021, Health Systems for a Tobacco-Free NY will partner with and educate decision makers of 7 behavioral health systems within the nine county service area to support the development of comprehensive, guideline concordant and evidenced-based policies that address tobacco dependence within their patient population.	# of educational touches to decision makers at each of the identified behavioral health system targets. # of adopted comprehensive policies that complete systems level change to address tobacco dependence as directed by the Public Health System’s 2008 Clinical Guidelines for Treating Tobacco Use and Dependence .
Activities	
Engage or re-engage significant medical and behavioral health care systems and their key administrators within the nine county area to approach with the health improvement initiative.	
Enlist influential local and regional organizations and members in activities that support and advance advocacy with decision makers of the targeted medical and behavioral health systems.	
Engage these targeted medical and behavioral health systems to ascertain the current state of each system’s tobacco use and dependence interventions.	
Partner with the targeted medical and behavioral health systems to establish and integrate system-level policies and procedures that meet the Public Health Service Clinical Guidelines for Tobacco Use and Dependence.	
Lead target health systems to measure the implementation of the evidence-based policy in order to enhance the protocols where needed, and to impact the sustainability of the initiative.	
Partners/roles: This initiative partners with Medical and Behavioral Health Systems and specifically looks to engage providers and administrators or other key decision makers of those systems. This could include hospital systems, Federally Qualified Health Centers and/or private practices.	

GFH Initiative/Improvement Strategy: C.R. Wood Cancer Center- Smoking Cessation Programs	
Brief Description/background: The C.R. Wood Cancer Center offers smoking cessation programs for patients and community members. The 4-week program is currently offered four times a year, led by Oncology Nurse Navigators at the Cancer Center.	
Disparities Addressed: Individuals at high-risk for poor health outcomes	
Goal: Promote Tobacco Cessation	
SMART Objective(s)	Performance Measure(s)
By December 2021, individuals attending the smoking cessation programs will demonstrate a 20% decrease in the number of cigarettes smoked	% average decrease of cigarettes smoked by program participants
Activities	
Provide quarterly smoking cessation programs	
Offer individual smoking cessation counseling to patients whom have been diagnosed with any type of cancer	
Provide pre-post program evaluations for effectiveness of the program	
Provide timely follow-up to ensure and reinforce knowledge base.	
Partners/roles:	
<ul style="list-style-type: none"> • Health Promotion center at Glens Falls Hospital provides the printed work books and other printed handouts to the class. • Providers, local health departments and other community-based organizations advertise the classes for their patient population. 	

GFH Initiative/Improvement Strategy: C.R. Wood Cancer Center- Cancer Services Program	
Brief Description/background: The Integrated Breast, Cervical and Colorectal Cancer Screening Program provides comprehensive screening for uninsured residents. Cancer Services Program (CSP) partners with close to 50 local health care providers for screening services. Outreach and education practices are in place with strong relationships cultivated with community partners. The CSP partners are key community leaders, public health departments, elected officials, the Chamber of Commerce and the local libraries. The CSP is a program of C.R. Wood Cancer Center of GFH and is partially funded by the NYS DOH.	
Disparities Addressed: Low socio-economic status populations and uninsured individuals with limited access to screening services.	
Goal: Increase Cancer Screening Rates	
SMART Objective(s)	Performance Measure(s)
By December 2021, conduct cancer screenings in priority populations to ensure: <ul style="list-style-type: none"> • 20% of clients screened are women who are rarely or never 	% of clients screened

<p>screened</p> <ul style="list-style-type: none"> • 20% of clients screened are male clients • 20% of clients screened are those needing comprehensive screenings (breast, cervical and colorectal) 	
Activities	
Develop and implement advertising campaigns during breast, cervical and colorectal cancer awareness months. (October, January & March).	
Broaden inreach efforts within GFH to include the ED and Behavioral Health Services to identify uninsured and age-eligible people for cancer screenings.	
Utilize the CSP centralized intake system to ensure comprehensive screenings have been completed.	
Establish and maintain relationships with community-based organizations and providers who are referral sources for clients.	
Partners/roles:	
Glens Falls Hospital Medical group, Hudson Headwaters Health Network, and Irongate Family Practice as well as other strategic community partners- refer patients /clients to the Cancer Services Program.	

GFH Initiative/Improvement Strategy: Medicaid Health Home	
Brief Description/background: 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. 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. A HARP is a managed care product that manages physical health, mental health, and substance use services in an integrated way for adults with significant behavioral health needs (mental health or substance use). Individuals identified as HARP eligible must be offered care management through a Health Home. HARPs manage the Medicaid services for people who need them, manage an enhanced benefit package of HCBS and provide enhanced care management for members to help them coordinate all their physical health, behavioral health and non-Medicaid support needs. GFH is a care management agency of the Adirondack Health Institute's (AHI) Health Home.	
Disparities Addressed: This patient population presents with multiple social determinants of health and compliance issues.	
Goal: Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	
SMART Objective(s)	Performance Measure(s)
By December 2021, maintain above 75% completion of HCBS assessments	% completion of HCBS assessments
By December 2021, increase enrollment of the HARP population by 5% annually (baseline to be set in 2019)	% increase in enrollment of HARP patients
Activities	

Complete all trainings for the HH CC regarding HCBS services, HARP requirements & mandatory assessments.
Increase in HCBS service availability, increase HCBS assessment completion and increase in HARP enrollment.
Partners/roles: <ul style="list-style-type: none"> • AHI Lead health Home Training, Tracking and reporting back to the CMA • HCBS service Provider- Training and making sure the Lead HH & CMA's are aware of their services, staffing and availability • Patients- engaging in the programs

GFH Initiative/Improvement Strategy: Amanda's House	
Brief Description/background: Amanda's House provides complimentary accommodations for patients and families of patients receiving care from Glens Falls Hospital. Many hospitality houses exist as separate non-profit organizations, Amanda's House is one of the rare hospital-owned hospitality houses.	
Disparities Addressed: Social determinates of health that disproportionately affect access to care.	
Goal: Improve access to care by giving complimentary accommodations to patients and their families who seek services and treatment through Glens Falls Hospital.	
SMART Objective(s)	Performance Measure(s)
By December 2021, provide complimentary accommodations of over 1000 guest nights to patients and families.	# of guest nights provided
Activities	
Maintain accommodations that address patient and family needs based on the patient population of Glens Falls Hospital.	
Continue to increase community awareness to maximize the potential to serve as many guests as possible and continue to maintain accommodations that address patient and family needs based on the patient population of Glens Falls Hospital.	
Partners/roles: Many Glens Falls Hospital Departments and staff and many local nonprofits assist us in raising awareness and providing guests with as much support as possible.	

GFH Initiative/Improvement Strategy: C.R. Wood Cancer Center -Screening and Education Programs: Uniquely You Boutique and Salon
Brief Description/background: This boutique and salon is offered free of charge to patients of the C.R. Wood Cancer Center who are undergoing treatment for their diagnosis of cancer that may cause them to lose their hair. Weekly beautician services are available, as well as wigs, hats, and head coverings.

Disparities Addressed: Patients with body image issues related to hair loss during treatment for a diagnosis of cancer, especially those with low socio-economic status and/or limited access to other clinical/community supports.	
Goal: Provide free wigs and hair care services to patients of the C.R. Wood Cancer Center.	
SMART Objective(s)	Performance Measure(s)
By December 2021, provide boutique and salon services annually to a minimum of 300 patients of the C.R. Wood Cancer Center.	# of people served
Activities	
Provide weekly beautician services	
provide free wigs and head coverings	
provide free skin care education and products	
Partners/roles: GFH Foundation Donors- Supplies are purchased through donated funds	

GFH Initiative/Improvement Strategy: C.R. Wood Cancer Center -Screening and Education Programs: Cindy's Retreat – Weekend Cancer Survivor Retreat	
Brief Description/background: Weekend retreat for community members who have had a cancer diagnosis.	
Disparities Addressed: Emotional support after a diagnosis of cancer especially those with limited access to other clinical/community supports.	
Goal: Provide a weekend retreat for patients to share concerns, fears, and worries and to gain support, education and tools to live with and beyond a diagnosis of cancer, especially those with limited access to other clinical/community supports.	
SMART Objective(s)	Performance Measure(s)
By December 2021, provide 2 semi-annual retreats for women with a maximum of 12 women per retreat.	# of events held # of attendees
By December 2021, provide 1 annual retreat for couples with a maximum of 10 couples (beginning in Spring 2020 and moving forward)	# of couples in attendance
Activities	
Provide emotional support to women after a diagnosis of cancer through a weekend retreat and provide tools for living with and beyond a diagnosis of cancer.	
Provide emotional support and communication skills to couples after one partner has been diagnosed with cancer and provide tools for coping as a couple	
Partners/roles: This retreat is Held at Silver Bay YMCA and Conference center that is paid for through community donated funds.	

GFH Initiative/Improvement Strategy: C.R. Wood Cancer Center -Screening and Education Programs: Cindy's Comfort Camp	
Brief Description/background: A free weekend camp for children who have experienced the death of an immediate family member, and 1 weekend each year for families dealing with a diagnosis of cancer.	
Disparities Addressed: Cancer and emotional distress, especially those with limited access to other clinical/community supports.	
Goal: Provide emotional support and coping mechanisms for children and families.	
SMART Objective(s)	Performance Measure(s)
Provide an annual camp for children who have experienced the death of an immediate family member. Minimum of 15 children in attendance and maximum of 30 children in attendance.	# of attendees
Provide an annual camp for families dealing with the emotional distress of having one parent with a diagnosis of cancer.	# of attendees
Activities	
Provide one-on-one support with trained big buddies for each child/ family in attendance.	
Provide group discussion / support to age appropriate groups at each camp.	
Partners/roles: This camp is held at the Double H Hole in the Woods Ranch in Lake Luzerne, Fees are covered by community donations. Double H volunteers are also used during these camps.	

GFH Initiative/Improvement Strategy: C.R. Wood Cancer Center -Screening and Education Programs: Skin Cancer Screening Event	
Brief Description/background: The C.R. Wood Cancer Center offers a free Skin Cancer screening clinic for patients and community members. This head to toe skin check is held annually in collaboration with Gateway Dermatology, Irongate Family Practice and Hudson Headwaters Health Network (HHHN) and held at the C.R. Wood Cancer Center at Glens Falls Hospital.	
Disparities Addressed: Low socio-economic status populations especially those that are underinsured or uninsured with limited access to screening services.	
Goal: Increase the rate of skin cancer screenings to improve the health of people in the greater Glens Falls region.	
SMART Objective(s)	Performance Measure(s)
The C.R. Wood Cancer Center will hold a free skin cancer screening event annually and serve a minimum of 100 patients.	# of people attending the free screening clinic
Activities	
Host a one-day screening event to members of the community. Have free head to toe skin assessments by volunteer providers, provide referral resources for anyone who needs a follow-up.	
Partners/roles: Volunteer providers from gateway Dermatology, Irongate Family Practice, Hudson Headwaters Health Network and Glens Falls Hospital Medical group are in attendance to perform the skin assessment. American Academy of Dermatology provide the resources and materials needed to complete the program.	

GFH Initiative/Improvement Strategy: Center of Excellence for Alzheimer’s Disease (CEAD)	
Brief Description/background: The Center of Excellence for Alzheimer’s Disease program offers diagnostic expertise for Alzheimer’s Disease and Other Dementias with an interdisciplinary team approach, which links community-based Social Work support to the patient and caregiver. The program also provides disease-focused education to health systems, patients and caregivers across six counties of Northeastern New York. Collaboration with community partners and civic leaders is integral to the program as it strives to combat the challenges associated with the condition that Dr. David Satcher called, “The most under-recognized threat to public health in the 21 st century.”	
Disparities Addressed: The population within the six-county Adirondack region is: 1) aging and at a progressively higher risk of experiencing Alzheimer’s Disease/Other Dementias, 2) limited in the availability of relevant medical specialists, 3) lacking a treatment or mechanism to improve or slow the worsening symptoms of a chronic, neurodegenerative disease; 4) experiencing a decline in school enrollment and corresponding pipeline of home health aides 5) limited in institutional resources available to manage the cases as the disease worsens and the aging population swells.	
Goal: Promote earlier diagnosis and management of Alzheimer’s Disease and related dementias for community members, while supporting patients and caregivers, acting as a conduit to community resources, and serving as a leader in education for providers, patients and families.	
SMART Objective(s)	Performance Measure(s)
By December 2021, perform 1100 patient assessments.	# of Assessments Performed
By December 2021, make 4800 patient referrals to community resources annually.	# of referrals to community resources
By December 2021, enroll 25 patients in clinical trials annually.	# of patients enrolled in clinical trials
By December 2021, on an annual basis provide 10 education and training programs to 65 Primary Care Physicians and 25 Specialty Care Physicians; provide 8 education and training programs to 200 non-physician health care providers; and 3 education and training initiatives to 15 Medical Students and 60 Health Professions Students.	# of education programs deployed by the type of audience reached and the # of attendees of each program
Activities	
Partner with Adirondack Health to implement the Institute for Health Improvement’s Age Friendly Health System 4M Framework, focusing on the “Mentation” component of the framework, which seeks to prevent, identify, treat and manage dementia, depression and delirium across settings of care.	
Provide training on the cognitive assessment code and the way to connect patients to community supports such as the Alzheimer’s Disease Caregiver Support Initiative and Alzheimer’s Association.	
Utilize biomarkers to a greater extent in the assessment process of the diagnostic pathway to identify changes years before noticeable cognitive decline becomes evident in order to increase the number of patients who meet eligibility criteria for clinical trials.	
Extend the 4Ms initiative to other Health Systems in the six county geography.	
Deploy education campaigns across the region on the neurodegenerative nature of disease, and recommendations from The Healthy Brain Initiative: The Public Health Road Map for the State and National Partnership.	
Engage Acute Care Advisory Coalitions regionally with education relating to the impact of dementia on across the healthcare continuum.	

Develop operational plans to identify dementia and or delirium, create systems for care plans for discharge and transfers and establish and monitor metrics for improvement.
Extend diagnostic education to payers and policy makers.
Coordinate efforts with ACOs and insurers in methods to reach the un-diagnosed earlier in the progression of disease, ways to enroll in research and opportunities to use community resources to help manage patients' and caregivers' needs.
Leverage evidence from the Acute Care Advisory work to illuminate opportunities for effective policy change.
Partners/roles: Regional Health Systems-Hospitals, Physician Practices, Residential and Assisted Living Communities/Skilled Nursing Communities, Home Health Organizations, Public Health Offices, Adirondack Mercy Care, The Akwesasne Nation, The Alzheimer's Association, The Alzheimer's Disease Caregiver Support Initiative, The Rotary Organization and the YMCA, Academic Institutions, The NYS Legislature, The office of the 21 st Congressional District and the local chapters of MSSNY.

Delivery Service Reform Incentive Program (DSRIP)

It is important to note that while DSRIP is included as a strategy, there is not a corresponding workplan within this IS 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 IS. 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 as outlined in the GFH CHNA and in support of the interventions, initiatives, strategies and activities defined within this IS. 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. 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.

Impact of Previous Community Health Needs Assessment

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

1. Increase access to high quality chronic disease preventative care and management in both clinical and community settings
2. Reduce obesity in children and adults
3. 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 programs** 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**, a **Center of Excellence for Alzheimer's Disease** and a new **Crisis Care Center** within the Emergency Department.
- 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.
 - Renovated a section of the emergency department to establish a Crisis Care Center.
 - 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 CHNA, along with the corresponding IS, is available at <http://www.glensfallshospital.org/services/community-service/health-promotion-center>.

The previous two most recent CHNAs are also available on the site. GFH will also use various mailings, newsletters and reports to ensure the availability of the CHNA and IS is 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 content of this CHNA which was presented on December 19, 2019 to the Board of Governors for approval. The Board was provided with an executive summary in advance and a brief presentation was conducted during a regular monthly meeting to communicate highlights and answer questions. This Implementation Strategy has been reviewed and approved by the Glens Falls Hospital Board of Governors. A signed copy is available upon request.