



ALBANY MED Health System

GLENS FALLS HOSPITAL

Community Health Needs Assessment and Implementation Strategy

2022- 2024

Executive Summary

Overview

The Community Health Needs Assessment (CHNA) and Implementation Strategy (IS) will address the requirements set forth by the Internal Revenue Service through the Affordable Care Act (ACA). Similarly, the New York State 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.

Community Health Needs Assessment

Glens Falls Hospital (GFH) conducted the CHNA to identify and prioritize the community health needs of the patients and communities within the GFH service area (Warren, Washington and Saratoga counties). The findings in this CHNA result from a year-long process of collecting and analyzing data and consulting with stakeholders throughout the community and the region. The CHNA can be used as a roadmap to guide service providers, especially public health, in their efforts to develop programs and services targeted to improve the overall health and well-being of people and communities in the region.

Working within the framework provided by the NYS Prevention Agenda, GFH collaborated with Warren, Washington and Saratoga Counties, as well as Saratoga Hospital, in the development of this 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. 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. At the time of the writing of this assessment, Saratoga County was still in process of conducting an independent analysis to determine the needs of their residents and will subsequently choose priorities based on the specific needs of the county. GFH and Saratoga County have agreed to continue to coordinate and collaborate where priorities align. Saratoga Hospital, primarily serving Saratoga County residents, conducted a similar analysis to determine priority areas for their CHNA. Due to overlapping service areas, Saratoga Hospital and Glens Falls Hospital will also coordinate where appropriate. Each organization's needs assessment process was similar and involved both data analysis and consultation with key members of the community.

A variety of data sources were used to inform the county and hospital assessments. 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. Each county and hospital, as well as GFH, used additional data sources

to supplement this information and inform the process based on their needs. Additional data sources used by GFH include the NYS Prevention Agenda Dashboard, County Health Rankings, the NYS Cancer Registry, the Governor’s Cancer Research Initiative – Warren County Cancer Incidence Report, and tobacco reports from the New York State Tobacco Control Program.

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 two to three 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 childcare, 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. Lastly, the direct and indirect impacts of the COVID-19 pandemic on health outcomes are not yet reflected in the data we have available today. Community health concerns and trends that were supported by data prior to the COVID-19 pandemic are likely to be amplified following the pandemic and/or may reveal potentially new or emerging health concerns. As data and trends are shared and better understood over the next three years, health systems and community/public health planners will likely need to adapt to the changing and emerging needs of communities served.

Because GFH serves a multi-county area, it 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’ CHNA processes and 2) utilize the available results of each of the county assessments to inform a coordinated and complementary regional CHNA for the GFH service area. 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"> • Increasing Physical Activity • Tobacco Prevention • Chronic Disease Preventive Care and Self-Management Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Diseases <ul style="list-style-type: none"> • Tobacco Prevention • Chronic Disease Preventive Care and Self-Management Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Diseases <ul style="list-style-type: none"> • Heart Disease Promote Well-Being and Prevent Mental and Substance Use Disorders <ul style="list-style-type: none"> • Pediatric Mental Health • Adult Mental Health Opioid and other substance misuse

In addition to evaluating the priorities and county level data indicators for our local county partners, GFH considered our expertise, capacity, funding, and potential impact. The following have been identified 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 2022 - 2024, and informed the development of a corresponding IS:

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: Promote Well-Being and Prevent Mental and Substance Use Disorders

- **Focus Area 2 – Mental and Substance Use Disorder Prevention**

Priority Area: Prevent Communicable Diseases

- **Focus Area 1 – Vaccine Preventable Diseases**
- **Focus Area 5 - Antibiotic Resistance and Healthcare-Associated Infections**

It is important to note that GFH chose similar chronic disease and communicable disease related priorities in the previous 2019-2021 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 Promote Well-Being and Prevent Mental and Substance Use Disorders as well as focusing on vaccine preventable diseases to include COVID-19.

Regional Priority

In addition to GFH choosing priority areas, as part of the community health planning and assessment process, the CHA Committee identified and selected Prevent Chronic Diseases and Promote Well-Being and Prevent Mental and Substance Use Disorders as regional priorities in support of the NYS Prevention Agenda 2019-2024. 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

GFH acknowledges the wide range of community health issues that emerged from the Community Health Needs Assessment process. GFH determined that it would place the most significant focus on those health needs which were deemed most pressing, within our ability to influence and would have long term benefit and impact on our community. Due to a lack of current available data reflecting the direct and indirect impacts of the COVID-19 pandemic on health outcomes, GFH understands that new or changing health concerns may emerge within the timeframe of the action plan. As our resources,

capacity and expertise allow, GFH remains positioned to pivot to address the unpredicted needs of the community.

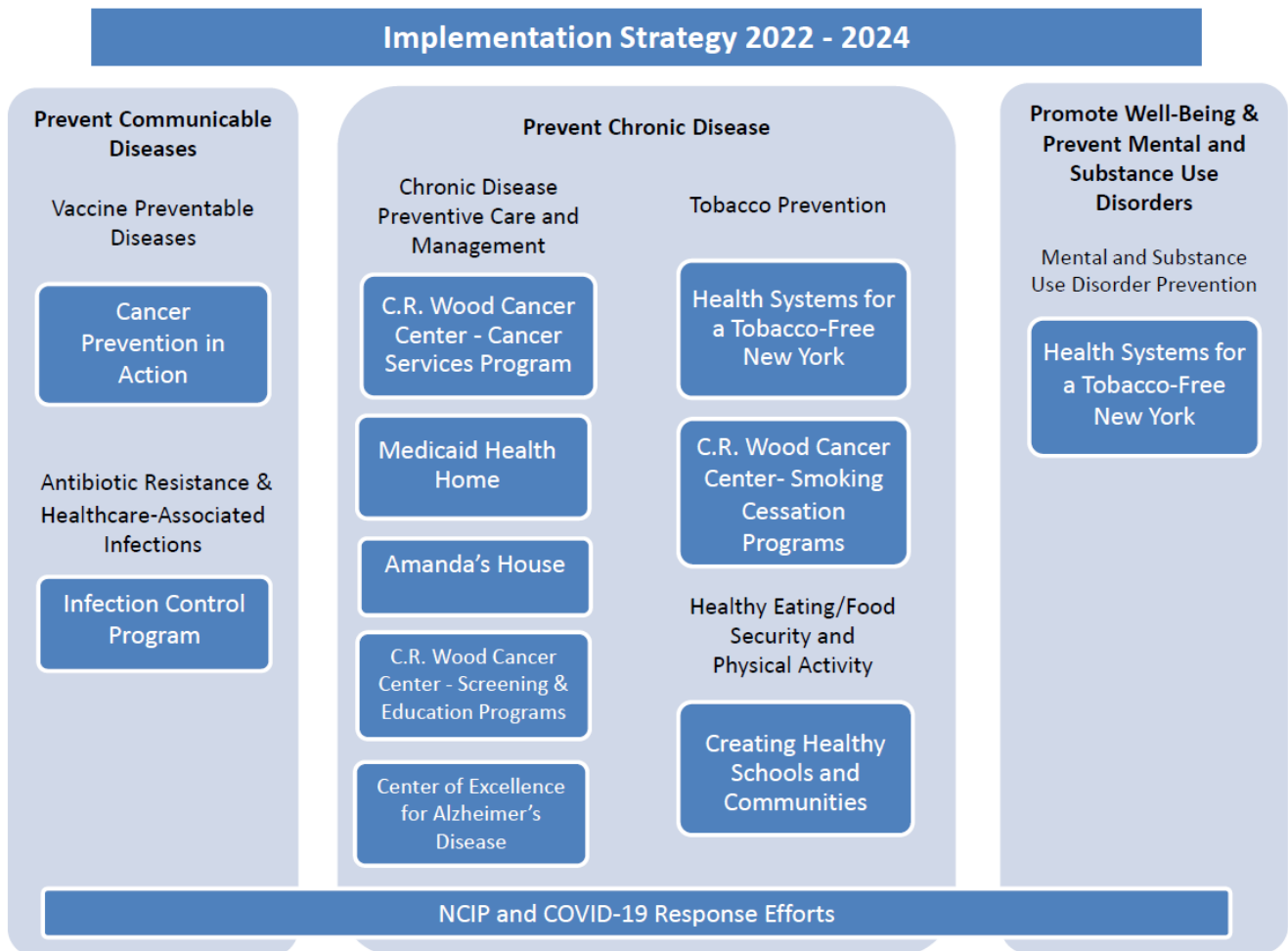
Additional analysis revealed an increasing demand and need for mental health and substance abuse services throughout the three-county region. Currently, GFH is including mental and substance use disorder prevention in the action plan through our Health Systems for a Tobacco Free New York program, which includes work to impact individuals with behavioral health diagnoses. GFH recognizes the trend and the need for quality behavioral health services and programs is far reaching and complex, however, has not historically formalized strategies into the plan due to lack of resources and capacity. While not included in the action plan, GFH is actively pursuing opportunities for collaboration regionally to address the community-wide capacity issues our region is facing together. The work is in its infancy and therefore GFH is not yet ready to formalize an action plan for the IS. In addition, GFH will continue to work through initiatives such as Health Home and NCIP 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. GFH recognizes a growing need to work collaboratively across the region to address social drivers of health and remains actively engaged with community partners working to address these issues.

Implementation Strategy

GFH developed the 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 for initiatives led by GFH, that includes goals, objectives, activities, partners and performance measures. Strategies are evidence-based and align with the NYS Prevention Agenda 2019-2024, addressing four focus areas under the Prevent Chronic Disease priority area, one focus area under Promote Well-Being and Prevent Mental and Substance Use Disorders, and two focus areas under the Prevent Communicable Diseases priority area. Certain initiatives, including the Medicaid Health Home, Amanda's House, Cancer Center education programs, the Center of Excellence for Alzheimer's Disease, the North Country Innovation Project (NCIP), and COVID-19 Response Efforts do not directly align with the Prevention Agenda strategies, but are included as additional community benefit.

GFH utilized the results of the corresponding CHNA to develop the 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, resources, capacity and community assets. As a result, the IS is a comprehensive, aligned plan with strategies that will have significant impact on the health and well-being of the people and communities in the region. 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 resources.



GFH will use various mailings and other methods to ensure the availability of the CHNA and IS is widely publicized. Once approved by the GFH Board of Directors, both documents will be posted to the GFH website, along with the NYS DOH-required CSP.

Impact of Previous Community Health Needs Assessment

As a result of 2019-2021 CHNA process, GFH chose the following health needs as priorities.

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

The complete 2019-2021 CHNA and corresponding IS can be found on the GFH website at <http://www.glensfallshospital.org/services/community-service/health-promotion-center>.

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 2019 - 2021.

Communicable Disease Prevention and COVID-19 Response:

- Developed and implemented weekly **institutional COVID-19 educational videos** covering guidance changes, proper disinfection, personal protective equipment, patient placement, testing protocols, vaccination information, and local, state, national and international trends. Infection Control Team also completed numerous news station interviews to disseminate information as it became available and **recorded community education videos** available on the GFH website.
- Hosted, staffed, and maintained regular **outpatient COVID-19 vaccination clinics** from December 2020 - September 2021 and eligible inpatient vaccination continues. We administered our first **monoclonal antibody therapy treatment** on 12/15/2020, administering a total of 1,217 treatments for outpatients during 2021, this number does not capture the inpatient population served with the same therapies.
- Reduced hospital onset Clostridioides difficile infections (CDI's) by 50% from 2018-2019 with a Standardized Infection Ratio (SIR) dropping from 0.88 to 0.44. The beginning of the pandemic altered the focus slightly with a marginal increase of CDI from 0.44 in 2019 to 0.53 in 2020. Once again, in 2021 another significant reduction of 31% from 0.53 to 0.36. Despite a pandemic and continued staffing shortages, Glens Falls Hospital demonstrated **a total reduction of 59% from the baseline data in 2018 through 2021.**
- Implemented evidence-based interventions to address surgical site infections (SSIs) resulting in our ability to **maintain a 57% reduction in all SSIs in 2019 far exceeding the 30% goal** originally set forth.

Chronic Disease Prevention:

- Provided **Health Home care coordination** services to adults and children enrolled in Medicaid, for a total of 3433 encounters in 2019, 3776 encounters in 2020 and 3282 encounters in 2021. 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**. During Covid-19 many screening services were placed on hold, however the rates of comprehensive screenings for breast, cervical, colorectal cancer stayed steady compared to prior years at 60%.
- In 2019 4 **smoking cessation classes** for community members were held with a total of 14 attendees that resulted in 50% of individuals reducing consumption by 20% or more, 25% quit completely and 25% were not ready to quit. Classes were suspended during the COVID-19 pandemic from 2020 – 2021 due to COVID-19 precautions within the hospital.
- 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. In 2019 there were 2

retreats held with a total of 16 participants. 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. Due to COVID-19 precautions there were no retreats in 2020 or 2021.

- 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 800 patients used the salon between 2019 and 2021, and over 325 wigs were provided free of charge.
- Conducted 2 **Comfort Camps** in 2019, 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. Family camp had 35 individuals and children's camp had 29 campers and evaluation of the program showed that 100% of the families and campers found the education and support helpful in reconnecting their families during the stressful treatment timeframe. Due to COVID-19 precautions camps were not held in 2020 and 2021.
- Conducted **free skin cancer screening** once per year, for a total of three screenings between 2019 and 2021, which are free and open to the community. Due to COVID-19 precautions smaller scale screening events were held in 2020 and 2021. Approximately 280 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 949 room nights between 2019 and 2021, 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. Due to COVID-19 precautions occupancy was limited to serving one family at a time throughout 2020 and 2021. 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.
- Maintained NCQA recognition and enrollment in the annual sustainability model for all 7 primary care practices operated by Glens Falls Hospital under the **2017 Patient-Centered Medical Home (PCMH)** standards. 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.
- Transitioned all GFH primary care medical centers from Comprehensive Primary Care Plus (CPC+) sites to the **CMS Primary Care First (PCF) model**. This newly established 5-year program builds upon concepts of CPC+ by prioritizing the clinician-patient relationship, enhancing care for patients with complex chronic needs, and focusing on improved health outcomes.
- Established a partnership with aptihealth, the leader in intelligent integrated behavioral healthcare, to deliver **innovative teletherapy program to patients in our primary care practices**, addressing a critical community need that has been exacerbated by the COVID-19 pandemic. Patients can now access **integrated physical and behavioral care** through the aptihealth platform. This supportive care team model and patient-driven 90-day care program has been shown to decrease symptom severity by over 50%, resulting in improved health outcomes and

reduced care costs. This implementation awarded GFH the North Country Telehealth Partnership's 2021 Telehealth Innovator of the Year in recognition of outstanding achievements.

- Pivoted to the use of **telehealth in GFH practice sites** due to COVID-19, allowing patients to receive the services they needed in a virtual setting. In parallel, a strategy was approved and implemented for those patients that required in-person care. In addition, **a pathway to provide COVID-19 testing was initiated** whereas patients could receive testing locally all while providing the necessary precautions for staff.
- Continued to improve the standard of quality and access to care for the community through the Stroke Center:
 - Achieved **Primary Stroke Certification** through DNV in 2019.
 - Received the 2021 American Heart Association's **Gold Plus Get With The Guidelines®-Stroke Quality Achievement Award** for our commitment to ensuring stroke patients receive the most appropriate treatment according to nationally recognized, research-based guidelines.
 - Offered robust **community outreach and education** through multiple modalities including virtual events, Farmer's Markets, educational lectures, and social media posts contributing to a progressive decline of approximately 25% of ambulatory arrivals and increase of about 15% in EMS arrivals, a favorable trend as EMS activation is recommended for suspected stroke victims to expedite care.
 - Experienced a total stroke reoccurrence rate of 10.5% from 2019 through April 2022 for patients that presented to our organization compared to world-wide statistics indicating nearly 26% of patients have a second stroke within 5 years.
- Continue to offer an interdisciplinary approach to diagnosing and managing Alzheimer's Disease and related dementias through the **Center of Excellence for Alzheimer's Disease**:
 - Formalized an agreement with a regional Federally Qualified Health Center (FQHC) to collaborate on opportunities to improve the FQHC's diagnostic approach for **earlier detection, enhance data sharing** for greater understanding of process improvement opportunities with cognitive assessment, and **promote public health education** efforts.
 - Assessed the incidence of dementia and other neurocognitive affective diagnoses among GFH patients who present with aggression during a hospitalization and found 60% of patients who have a dementia diagnosis will develop aggressive symptoms. Strategies implemented to improve patient care and keep staff safe include two new algorithms for process improvement related to pharmacologic therapies, a new order set for non-pharmacologic interventions that can help with the sensory overload a dementia patient experiences in a hospital environment, and a training deployed to frontline staff to teach optimal verbal and non-verbal communication strategies when interacting with people with dementia.
 - Formalized a team to participate in the HANYS Age-Friendly Action Community which focused on the tenets of the Institute for Health Improvement's Age-Friendly 4Ms initiative. The team started its work in 2021, and by August 2022, Glens Falls Hospital had been recognized with **Level-1 Designation as an "Age-Friendly Health System"**.

- Participated in regional care delivery transformation through the **DSRIP program in 2019 – Q1 2020**:
 - Sustained the **Opioid Diversion Program**, a collaborative effort between Glens Falls Hospital’s Center for Recovery and the Council for Prevention, to provide individuals arrested for crimes related to their opioid addiction an alternative to incarceration allowing them to receive treatment and recovery services via Adventure Based Counseling. In 2019, 19 individuals participated in programming, 4 graduated the program in its entirety, many became employed full-time, 2 resumed college coursework, and 1 started their own business. 95% of participants were kept out of the inpatient behavioral health unit, crisis care center, and were not rearrested. 76% of participants reported improved mental health and improved access to health care. 100% of participants would recommend the program to others seeking treatment and reported that the program helped them achieve their goals in the areas of substance use, general physical health and social life/leisure.
 - Piloted a Vertical Integration model of care in partnership with Fort Hudson Health System to **enhance coordination of patients across service lines** through expanded Care Management function and purpose; purposeful sharing of data and clinical processes/outcomes; creation of preferred network of services; and expansion of best practice clinical pathways.
 - Contributed to the Adirondack Health Institute Performing Provider System’s (AHI PPS) performance in earning the **highest percentage of claims-based metrics** in measurement years 4 and 5 in New York State. The outcomes-based performance was based on 32 distinct population health metrics in the areas of potentially preventable readmissions, potentially preventable visits, primary care visits, and behavioral health services.
 - 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:
 - Formed a **regional task force** with a goal of passing local level Tobacco 21 legislation. Continued to facilitate the group and developed a presentation that was used for schools, rotaries, businesses, and local level governments to increase awareness of, and garner support for the legislation. **Regional support was a key factor in the statewide passing of Tobacco 21 legislation in November 2019.**
 - Supported the Gloversville Housing Authority to go Tobacco Free, impacting the residents of the **85 apartments**. Cessation materials and nicotine replacement therapies were distributed to residents to assist with implementation.
 - Partnered with Skidmore College to **plan, implement and sustain a 100% tobacco-free campus policy and adopt a comprehensive tobacco dependence treatment policy** within their campus health center **impacting more than 2,500 students, 1,000 staff and an additional 500 first-year students who join the campus community annually.**

- Training and cessation resources were provided to staff, while students were provided with education and access to quitting aids.
- Educated **5 school districts on the Vaping Epidemic** via community panel discussions to increase community awareness of the issue as well as educate the community on local level resources that are available.
 - Educated **4 Behavioral Health Care, 4 Medical Health Care and 2 dental practices** on the burden of tobacco on their patients, the steps they can take as a system to fortify their response, and the impact they have as providers on their patients' outcomes.
 - Formed the **North Country Tobacco Treatment Specialists group** which continues to meet monthly to idea share, receive training, and discuss implementing best practices at their respective health systems. The model for this group is now being replicated across New York State.
 - Staff attended, sponsored, and presented at numerous regional, statewide, and national conferences. Staff was able to educate providers of both medical and behavioral health systems, as well as providers at FQHCs on **the burden of tobacco use** and engage them in ways they can partner with the HSTFNY initiative **to fortify their institution's response to tobacco dependence**.
 - Developed a **new comprehensive assessment tool** for use at medical and behavioral health systems across the region which determines their baseline state for tobacco dependence treatment and sets goals towards the implementation of gold standard tobacco dependence treatment. This assessment tool is now being replicated and used as a template across New York State.
- Continued to advance policy and environmental changes to **promote physical activity and nutrition**:
 - Assisted 8 local school districts in improving their **Local Wellness Policies** to provide students with increased opportunities for physical activity and nutrition including sponsoring one school district administration's attendance to a **Leadership Conference** to increase child wellness in schools.
 - Provided 9 local schools with **materials for school cafeterias to promote healthy eating**. **Cafeteria equipment** was provided such as breakfast carts to **increase breakfast participation**, salad bars to **increase consumption of fruits and vegetables**, and equipment to support a **hydroponic vegetable garden** for use in school foods.
 - Provided local schools with equipment to **increase physical activity**. Physical Education teachers from 2 school districts received **Professional Development**. To increase physical activity during elementary recess and breaks 12 schools received specially crafted **Obstacle course bins** and **Hallway Sensory Paths, Gaga Ball pits**. Middle and high school students benefited from **flexible seating options** to stand and move in class and **outdoor recreations supplies** to use during lunch period.
 - Hosted **Math and Movement** training for 5 school districts and provided materials to implement the curriculum in 7 elementary and primary schools.

- Provided 5 districts in Hudson Falls, Fort Ann, Whitehall, Granville, Hadley, and Lake Luzerne with nearly \$68,0000 of **equipment, supplies, and training to increase physical activity and nutrition** throughout the school day.
- Increased access to **healthy food and drinks options in 9 locations** in Washington county, which included employees of the Washington County Municipal center and local food pantries.
- Increased physical activity at worksites and in the community providing **Washington County Municipal Center employees** with **stand-up workstations**, hosting a **Get out & Go Granville event**, providing materials for a **Story Board Walk**, and **treadmills and yoga mats** for teachers.