ALBANY MED Health System

GLENS FALLS HOSPITAL

Implementation Strategy

2022 - 2024

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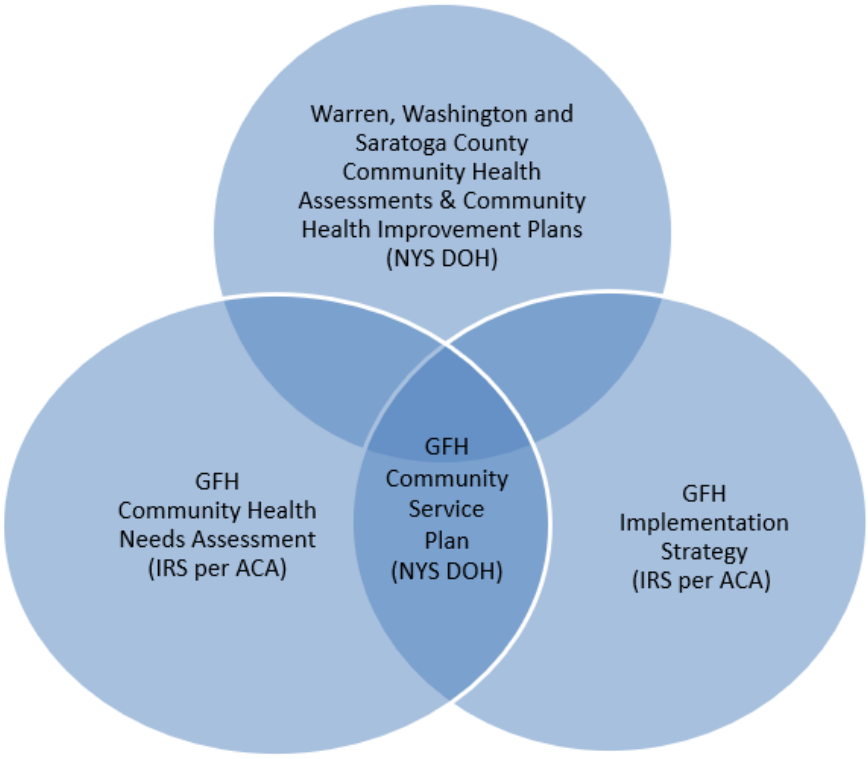
Introduction

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 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 the largest employer in New York's Adirondack region, with over 2,300 employees and a medical staff of over 550 providers (see Appendix A).

On July 1, 2020, Glens Falls Hospital became an affiliate of the Albany Med Health System which includes Albany Medical Center, Columbia Memorial Hospital, Glens Falls Hospital, and Saratoga Hospital. Together, our four-hospital system is enhancing the quality of care for more than three million people in our region. A region is a collection of its communities, and each community has its own characteristics. The hospitals, physician practice offices and urgent care centers of the Albany Med Health System retain their own unique identities for the communities they serve. Each hospital maintains its own name, leadership, employees, board and fundraising team.

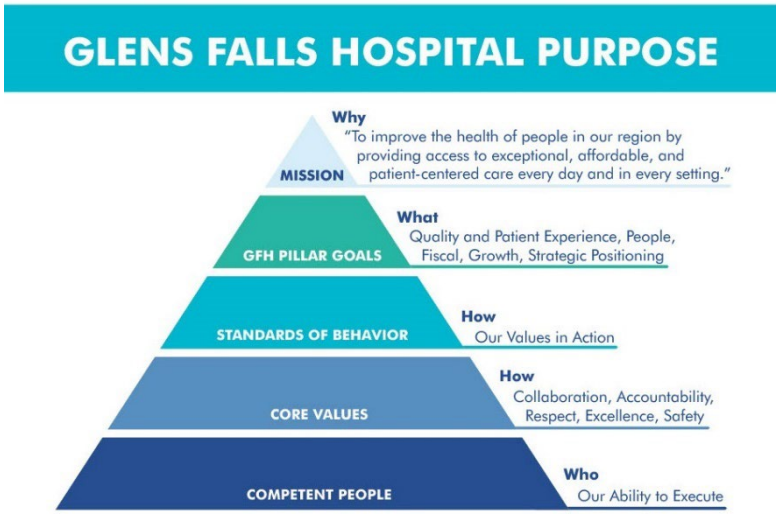
The primary and secondary service areas for GFH include Warren, Washington, and northern Saratoga counties, covering over 2,000 square miles. However, patients often travel from as far away as Essex and Hamilton counties to obtain services within the GFH system. With an extended service area that stretches 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 120 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 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

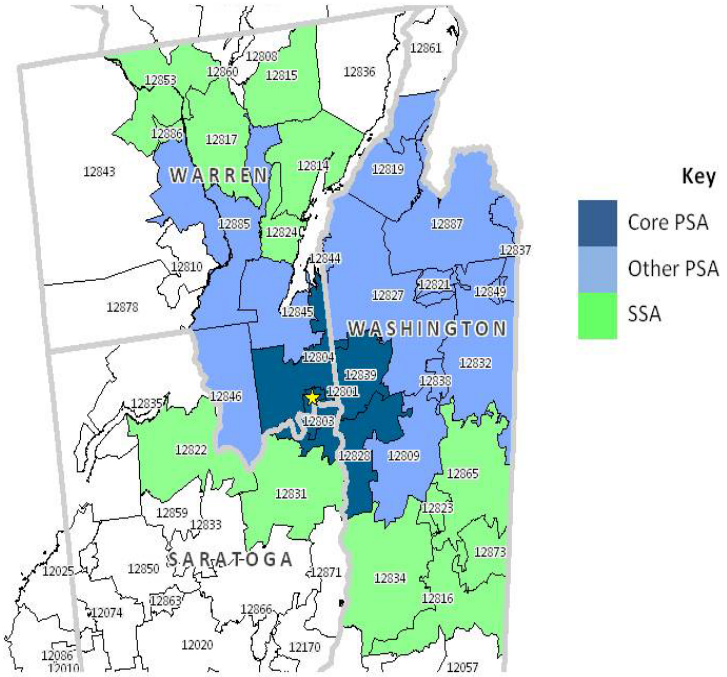
affordable and patient-centered care every day and in every setting. Our fundamental values are: **C**ollaboration, **A**ccountability, **R**espect, **E**xcellence and **S**afety. The GFH Purpose combines our Mission - WHY we exist as an organization, our Pillar Goals -WHAT we need to accomplish in order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



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.

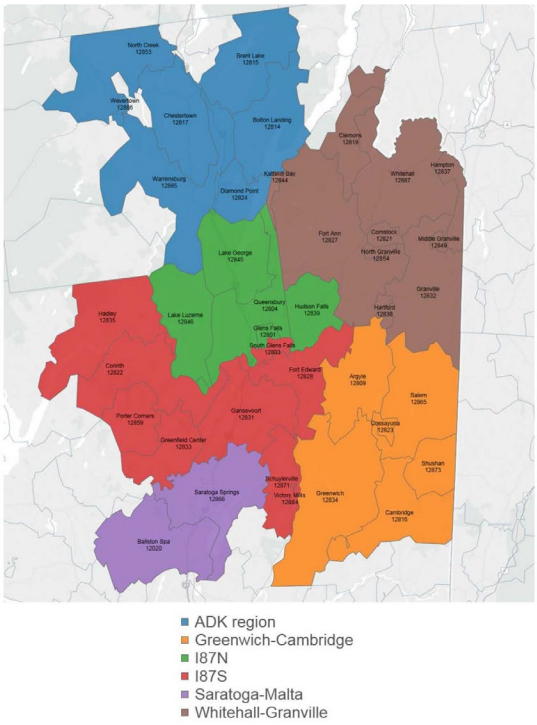
The GFH inpatient service area is defined by a Core Primary Service Area (PSA), Other Primary Service Area (Other PSA) and a Secondary Service Area (SSA). The Core PSA represents the ZIP codes immediately contiguous to the hospital. The SSA reflects more outlying areas where GFH has either a strong market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



GFH Inpatient Service Area

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.



GFH Ambulatory Service Area

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.

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

[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).

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 coordinated with Warren, Washington and Saratoga counties as well as Saratoga Hospital 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, provides education and training to further the NYS DOH Prevention Agenda, and offers other resources that support the development of the regional health care system. 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 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 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 from health care and other service providing agencies including representatives of medically underserved, low income and/or vulnerable populations. 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 Hospital, primarily serving Saratoga County residents, conducted a separate, yet similar process to determine their community's needs and GFH representatives were members of the prioritization planning group and contributed to the process. GFH remains in contact with Saratoga County Public Health to coordinate as appropriate and review opportunities for collaboration on an ongoing basis. Preliminary data gathered by Saratoga County Public Health suggests alignment in at least one priority area across the region.

Utilizing the results of the indicator analysis, regional survey and the other county-specific community assessment resources listed previously, each organization prioritized the most significant health needs for their residents. Each organizations' 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 • 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 • Tobacco Prevention • Chronic Disease Preventive Care and Self-Management Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Diseases • Heart Disease Promote Well-Being and Prevent Mental and Substance Use Disorders • 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. 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 2022-2024:

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. It is widely believed that the long-term collective trauma of the pandemic will be a global issue impacting the public's health. Demand for mental health and well-being services and supports is at an all-time high, exasperating an already limited supply of services. Currently, Glens Falls Hospital 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 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, Glens Falls Hospital 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 this 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 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 as well as Saratoga Hospital 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

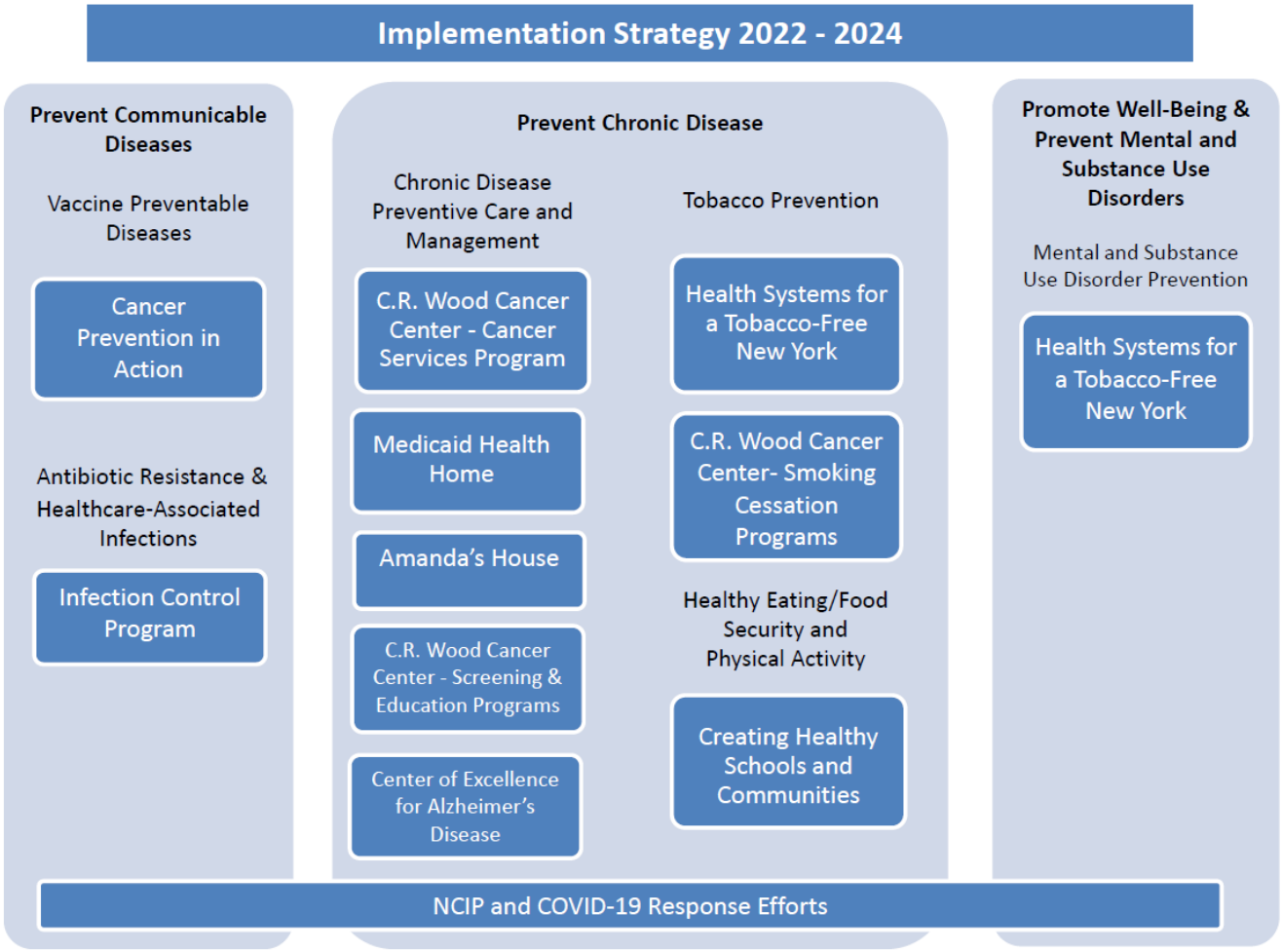
Emphasis throughout the IS is placed on interventions that impact disparate and underserved populations in the service area, especially low-income populations and those with limited access to healthcare and other community supports and resources. As described in the CHNA, Warren, Washington and Saratoga 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 2022-2024

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, the one focus area under Promote Well-Being and Prevent Mental and Substance Use Disorders, and the two focus areas 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.



Glens Falls Hospital Initiatives

GFH Initiative/Improvement Strategy: Cancer Prevention in Action
Brief Description/background: The focus of the Cancer Prevention in Action (CPiA) initiative is to increase awareness about skin cancer as well as HPV related cancers while also assisting with policy change and providing community organizations the resources they need to help prevent and reduce cancer in our community. CPiA works to raise awareness of HPV vaccine among adolescents and educate their parents and guardians about the cancer prevention benefits of the HPV vaccine. This initiative looks to partner with healthcare providers such as pediatrician offices to promote the HPV vaccine as cancer prevention.

<table>
<tr><td colspan="2">Disparities Addressed: Children and families with limited access to health care and preventive services</td></tr>
<tr><td colspan="2">Goal: Improve vaccine rates</td></tr>
<tr><td>SMART Objective(s)</td><td>Performance Measure(s)</td></tr>
<tr><td rowspan="4">By April 2024, increase by at least 25 the number of community education interventions for adolescents, health care providers and parents to support an increase in HPV vaccination</td><td># of earned media attempts developed and submitted (press releases, letters to the editors, print and broadcast stories)</td></tr>
<tr><td># of target audiences engaged and educated such as dentists, parent teacher associations and pediatricians on the importance of HPV vaccines</td></tr>
<tr><td># of vaccination seminars developed and presented geared toward middle and high school students</td></tr>
<tr><td># of governmental decisionmakers met with and educated about the importance of the HPV vaccine as cancer prevention</td></tr>
<tr><td colspan="2">Activities</td></tr>
<tr><td colspan="2">Provide educational resources and presentations to local school districts, dentists, pediatric offices and other relevant healthcare offices.</td></tr>
<tr><td colspan="2">Partner with FQHC to provide CME accredited presentations about the importance of the HPV vaccine as cancer prevention and best practice for increasing vaccine uptake within their clinics. Offer and make available the presentations to other healthcare provider networks and pediatric offices in the area.</td></tr>
<tr><td colspan="2">Engage local legislators to educate about cancer prevention efforts</td></tr>
<tr><td colspan="2">Partners/roles:
NYS HPV Coalition
The NYS HPV coalition offers many resources and collaborative efforts with statewide agencies to increase vaccination rates statewide. This includes members of the American Cancer Society, SUNY Upstate medical professors, pediatricians and other healthcare workers.
Hudson Headwaters Health Network
Hudson Headwaters will be utilizing our educational resources to hand out to patients to increase access to information among their population served. We will also be partnering to increase their providers current knowledge of the HPV vaccine and best practice for increasing vaccine uptake.
Warren, Washington, and Saratoga County Public Health Departments
The County Public Health departments will assist with engaging and educating communities by mobilizing their health educators to increase awareness of our resources to their connections within the community.</td></tr>
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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

<table>
<tr><td colspan="2">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.</td></tr>
<tr><td colspan="2">Goal: Reduce infections caused by multidrug resistant organisms</td></tr>
<tr><td>SMART Objective(s)</td><td>Performance Measure(s)</td></tr>
<tr><td>By December 2024, facilitate antimicrobial resistance data evaluation using a standardized approach to provide local practitioners with an improved awareness of a variety of antimicrobial resistance problems to aid in clinical decision making and prioritize transmission prevention efforts.</td><td># of quarterly data sets provided to prescribers as compared to regional data</td></tr>
<tr><td>By December 2024, facilitate antimicrobial resistance data evaluation using a standardized approach to provide facility-specific measures in context of a regional and national perspective (Specifically, benchmarking) that can inform decisions to accelerate transmission prevention efforts and reverse propagation of emerging or established resistant pathogens.</td><td># of presentations to key stakeholders including Infection Prevention Committee, Antimicrobial Stewardship Committee, Pharmacy & Therapeutics, and Medical Staff Committees.</td></tr>
<tr><td rowspan="2">By December 2024, allow regional and national assessment of antimicrobial resistant organisms of public health importance, including ecologic and infection burden assessment.</td><td># of benchmarks compared based on validated data</td></tr>
<tr><td># of opportunities identified and change management model cycle (PDSA) conducted with a 30% reduction in usage</td></tr>
<tr><td colspan="2">Activities</td></tr>
<tr><td colspan="2">The National Health and Safety Network offers the Antimicrobial Use and Antimicrobial resistance modules as optional participation to provide a mechanism to report, analyze, benchmark and improve on both unnecessary usages, and to slow the potential resistance demonstrated on a facility, regional and national level. Glens Falls Hospital has purchased this module for testing in 2022 Q4 and implementation with validation in January 2023.</td></tr>
<tr><td colspan="2">Partners/roles:
Antimicrobial Stewardship Pharmacist- Change Agent, validation studies
Infection Preventionist- NHSN administrator/submission data
Quality Management Director-implementation & change support
Medical Staff- Change actors
Committees; IP, ABX, P&T, Med Exec- rapid cycle change approval
Administration- support
IT- Electronic module integration</td></tr>
</table>

<table>
<tr><td>GFH Initiative/Improvement Strategy: C.R. Wood Cancer Center- Cancer Services Program</td></tr>
<tr><td>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</td></tr>
</table>

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 2024, conduct cancer screenings in priority populations to ensure: • 20% of clients screened are women who are rarely or never screened • 20% of clients screened are male clients • 20% of clients screened are those needing comprehensive screenings (breast, cervical and colorectal)	% of clients screened
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: Strategic Partners are those who assist the program by referring patients / clients to the Cancer Services Program. Those include but are not limited to: Glens Falls Hospital Medical group, Hudson Headwaters Health Network, and Irongate Family Practice.	

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 2024, maintain above 75% completion of HCBS assessments	% completion of HCBS assessments
By December 2024, 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: • 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 2024, 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 2024**,** 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 2024, provide 2 semi-annual retreats for women with a maximum of 12 women per retreat.	# of events held # of attendees
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.	
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)**
By December 2024, 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
By December 2024, 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. Health Promotion Center of Glens Falls Hospital provides educational resources on skin cancer prevention.	

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: it is a Neurology program which incorporates Social Work. After a thorough clinical assessment, patients and families are parled to community-based services for support and provided information on clinical research opportunities. The program also serves as a leader to educate health professionals in assessing and managing cognitive affective conditions. The workforce development priority is vital to meet the growing need of healthcare professionals trained to diagnose and management dementia as cases swell with the aging Baby Boomers population.	
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 2024, perform 1000 patient assessments.	# of Assessments Performed
By December 2024, make 5000 patient referrals to community resources annually.	# of referrals to community resources
By December 2024, create 20 public outreach events/announcements to educate the programmatic goals of the CEAD.	# of public outreach events/announcements
By December 2024, on an annual basis provide 10 education and training programs to 65 Primary Care Physicians and 25 Specialty Care Physicians; provide education and training programs to 300 non-physician health care providers; and 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	
Pursue Level-2 designation of the Institute for Health Improvement's Age Friendly Health System 4M Framework.	
Participate in the Institute for Health Improvement's 4Ms/Age-Friendly cohort sponsored by HANYS.	
Collaborate with the Warren Washington Association for Mental Health, on the *Age-Friendly Task Force*, which includes Adirondack Health Institute and other health organizations regionally to build greater capacity for dementia regionally	
Collaborate with the Hudson Mohawk Area Health Education Center and SUNY Adirondack on both professional development opportunities and workforce development programs	
Partners/roles: • Diagnostic services and education ○ Hospitals, Physician Practices, FQHC, Public Health Offices, The Akwesasne Nation • Care Management and Patient Management	

- Residential and Assisted Living Communities/Skilled Nursing Communities, Home Health Organizations, Adirondack Mercy Care, The Alzheimer's Association, The Alzheimer's Disease Caregiver Support Initiative,
- Community Engagement and Public Awareness
  - The Rotary Organization and the YMCA, Academic Institutions, The NYS Legislature, The office of the 21st Congressional District and the local chapters of MSSNY.

GFH Initiative/Improvement Strategy: Health Systems for a Tobacco Free New York	
Brief Description/background: The Health Systems for a Tobacco-Free New York (HSTFNY) program provides resources and consultation to health care providers to help increase the delivery of comprehensive, evidence-based treatment for nicotine addiction. works collaboratively with health care systems to develop and support the consistent and effective identification and treatment of tobacco users. HSTFNY 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, Herkimer, Montgomery, St. Lawrence, Warren and Washington counties.	
Disparities Addressed: Special consideration is given, but not limited to, those that serve disparate populations with low-income and low-educational attainment. 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 2024, 50% of target medical health care organizations will adopt PHS Guideline concordant comprehensive policies that improve tobacco dependence delivery.	# of inventory and assessment of medical health systems serving disparate populations. # of medical system targets educated on the tobacco burden and importance of evidence-based treatment. # of active targets engaged in at least one performance improvement project # 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 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 health systems.	
Engage these targeted medical health systems to ascertain the current state of each system's tobacco use and dependence interventions.	
Partners/roles: This initiative partners with Medical 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.	

Glens Falls Hospital – Will form a committee that will work towards policy development within the hospital.
HHHN – Will work together towards a potential partnership to discuss education regarding the burden of tobacco and the importance of comprehensive policy.
Irongate - Will work together towards a potential partnership to discuss education regarding the burden of tobacco and the importance of comprehensive policy.
Specifically in Washington County we will be partnering with the following Community Based organizations:
Comfort Foods – Potentially train staff to be CTTS to serve people in Washington County
LEAP - Potentially train staff to be CTTS to serve people in Washington County

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 who are currently being treated for cancer or blood disorders. Each patient is assessed by the provider regarding motivation for smoking cessation and one on one counseling will be provided as needed.	
Disparities Addressed: Individuals at high-risk for poor health outcomes	
Goal: Promote Tobacco Cessation	
SMART Objective(s)	**Performance Measure(s)**
By December 2024, individuals receiving smoking cessation supports will demonstrate a 20% decrease in the number of cigarettes smoked	# patients served per year % average decrease of cigarettes smoked by program participants
Activities	
Provide one on one counseling and follow up of all patients referred to the smoking cessation program.	
Partners/roles: Health Promotion Center of Glens Falls Hospital provides printed workbooks and other printed handouts to the cancer center staff to work with each individual.	

GFH Initiative/Improvement Strategy: Creating Healthy Schools and Communities
Brief Description/background: The Creating Healthy Schools and Communities initiative works with communities and the school districts, Early Childcare Centers, worksites, and community organizations within those entities. The initiative implements sustainable policy, systems, and environmental changes within the communities. Projects focus 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 funded by the NYS DOH. This initiative is implemented in communities located in Warren and Washington counties.
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.	
Goals: Improve the health of people in the GFH region through prevention of obesity and related chronic conditions and more specifically: • 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	
SMART Objective(s)	**Performance Measure(s)**
By December 2024, increase the number of worksites and community settings that implement food service guidelines by 15.	# of worksites and community settings recruited, assessed, and applying behavioral design strategies
By December 2024, increase the number of childcare providers that improve policies, practices, and environments for physical activity and nutrition by 18.	# of childcare providers that improve policies, practices, and environments for physical activity and nutrition
By December 2024, increase the number of municipalities that adopt and implement community planning and active transportation interventions to increase safe and accessible physical activity by 13.	# of municipalities identified, assessed, and receive training, technical assistance, and resources.
By December 2024, increase the number of school districts that improve policies, practices, and environments for physical activity and nutrition by 10.	# of school districts with established wellness committees and implemented Wellness Policies and Comprehensive School Physical Activity Programs.
Activities	
Support worksites and community settings in multiple venues to improve the availability of healthy foods and beverages through the implementation of Food Service Guidelines that align with the Dietary Guidelines for Americans 2020-2025 and behavioral design practices.	
Increase worksite-based physical activity policies, programs, and best practices through a combination of multi-component worksite physical activity programs; environmental supports, prompts to encourage physical activity, and structured walking-based programs.	
Increase physical activity and nutrition policies, practices, and environments at Early Childcare Centers, Home Daycares, and Pre-kindergarten programs through trainings, technical assistance and needed resources.	
Increase policies and practices that support community planning and active transportation interventions in municipalities to increase safe and accessible physical activity by creating safe, activity-friendly routes that are connected to everyday destinations.	
Increase access to healthy, affordable foods through implementing policies that increase a school districts ability to meet Healthy Hunger-Free Kids Act provisions standards relevant to foods sold and served outside the school meal programs. Efforts will include assistance to establish and implement a Farm to School program.	
Support the creation and implementation of Comprehensive School Physical Activity Programs.	
Promote student wellness through the assessment, development, improvement, and implementation of local School Wellness Policies.	
Partners/roles:	

Early Childcare Centers, Home Daycares and Preschools

- We will work the directors, owners, and employees to write policies and implement strategies in relation to nutrition and physical activity.

Child Care Resource and Referral Network

- Southern Adirondack Childcare Council will connect HPC to the Early Childcare Centers, Home Daycares and Preschools in the specifics townships and cities and provided resources for HPC to connect them back to in relations to nutrition and physical activity practices and trainings.

Governmental Elected Officials of Municipalities

- We will work the governing bodies of the municipalities to draft, approve and implement polices related to safe walking and biking and active-friendly routes to destinations.

Community Organizations

- Organizations in the community that work with active transportation such as but not limited to Promote Fort Edward, Feeder Canal Trail Alliance, Champlain Canal Trail Alliance, Bike Glens Falls, Adirondack Glens Falls Transportation Council, Washington and Warren County Planning Departments, Warren County Bikeway, Safe Routes to Schools, East End Action Committee, Adirondack Cycling Group, Food pantries, local farm to library programs,

Worksites

- Worksites that have vending, cafeterias or similar food locations for their staff.

PreK-12 School Districts and Buildings

- Within the districts we will work with Food service directors, teachers, administrators, school wellness committee to update and implement policies related to nutrition and physical activity.
- County Public Health Departments- Provides sustainable programs to support school districts
- County Cornell Cooperative Extensions Provides sustainable programs to support school district
- Comfort Food Communities- Supporting Farm to School efforts and local food pantries
- Food for Thought- Organization that supplies local schools with snacks for during the school day snack time

GFH Initiative/Improvement Strategy: Health Systems for a Tobacco Free New York

Brief Description/background: The Health Systems for a Tobacco-Free New York (HSTFNY) program provides resources and consultation to health care providers to help increase the delivery of comprehensive, evidence-based treatment for nicotine addiction. works collaboratively with health care systems to develop and support the consistent and effective identification and treatment of tobacco users. HSTFNY 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, Herkimer, Montgomery, St. Lawrence, Warren and Washington counties.

Disparities Addressed: Special consideration is given, but not limited to, those that serve disparate populations with behavioral health care needs. This specific population is prioritized because of their disproportionate use of tobacco products in comparison to the general population.

Goal: Reduce the mortality gap between those living with serious mental illness and the general population	
SMART Objective(s)	**Performance Measure(s)**
By December 2024, 50% of target behavioral health care organizations will adopt PHS Guideline concordant comprehensive policies that improve tobacco dependence delivery.	# of inventory and assessment of behavioral health systems serving disparate populations. # of behavioral system targets educated on the tobacco burden and importance of evidence-based treatment. # of active targets engaged in at least one performance improvement project # 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 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 behavioral health systems.	
Engage these targeted behavioral health systems to ascertain the current state of each system's tobacco use and dependence interventions.	
Partners/roles: This initiative partners with 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.	

North Country Innovation Project

It is important to note that while North Country Innovation Project (NCIP), a coalition of North Country providers, is included as a strategy, there is not a corresponding workplan within this IS. We have, however, chosen to include NCIP as a strategy with the knowledge that NYS has applied to the Centers for Medicare and Medicaid Services (CMS) to fund a new Medicaid 1115 Waiver that incorporates lessons learned from its DSRIP Program experience to address the inextricably linked health disparities and systemic health care delivery issues that have been both highlighted and intensified by the COVID-19 pandemic. Because the approval of the initiative is still under review and not yet finalized, we have chosen to include NCIP as a strategy as the overall goals of the coalition align themselves with the population health initiatives identified herein. Should a new Medicaid 1115 waiver be approved for implementation in New York State, opportunities for alignment will be identified and integrated into the identified initiatives.

COVID-19 Response Efforts

It is important to note that while COVID-19 response efforts is included as a strategy, there is not a corresponding workplan within this IS. With the unpredictability of COVID-19 surges and variants and subsequent impact on hospital operations and the surrounding community, developing a structured

workplan with detailed strategies and desired outcomes would be futile. COVID-19 response has evolved over time and will likely continue to change as we settle into our new normal. GFH continues to take all necessary precautions per State and Federal guidelines to safeguard our patients and community throughout the implementation of all programs outlined herein. In addition, GFH will continue to be a leader in promoting science-based precautions to keep our communities safe, including COVID-19 vaccination. GFH will continue to offer COVID-19 vaccine to employees of the hospital and to inpatients as appropriate. As COVID-19 related needs evolve overtime, GFH will continue to be a responsive and engaged partner of our State and Local Health Departments as we together keep our communities safe.

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 County 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 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

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**.**

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.

Dissemination

The GFH CHNA, along with the corresponding IS, is available at http://www.glensfallshospital.org/services/community-service/health-promotion-center.

The previous three 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 with opportunity to provide comments and feedback. Hard copies will be made available at no-cost to anyone who requests one.

Approval

The Assistant Vice President of Planning worked with Senior Leadership to develop the content of the CHNA and this corresponding IS which was presented on November 17, 2022 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.