Glens Falls Hospital

Implementation Strategy

2016-2018

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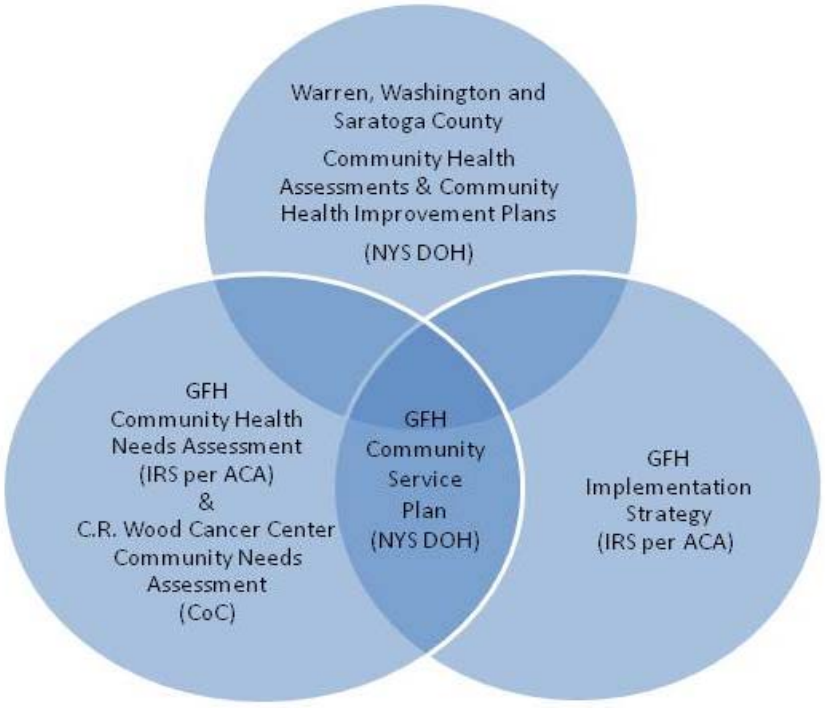
Introduction

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 2013-2018. The prioritized community health needs were identified in the corresponding Community Health Needs Assessment (CHNA).

The CHNA and IS will address the requirements set forth by the Internal Revenue Service (IRS) through the Affordable Care Act (ACA). The community health needs assessment provision of the ACA (Section 9007) links hospitals' tax exempt status to the development of a needs assessment and adoption of an IS to meet the significant health needs of the communities they serve, at least once every three years. The GFH CHNA also addresses the American College of Surgeons (ACoS) Commission on Cancer (CoC) requirements to complete a community needs assessment. The NYS Department of Health (NYS DOH) requires hospitals to work with local health departments to complete a Community Service Plan (CSP) that mirrors the CHNA and IS per the ACA. Consequently, this IS will be combined with the CHNA to develop the CSP. County health departments in NYS have separate yet similar state requirements to conduct a Community Health Assessment (CHA) and a corresponding Community Health Improvement Plan (CHIP). Aligning and combining these requirements ensures the most efficient use of hospital resources and supports a comprehensive approach to community health and population health management in the region.



Glens Falls Hospital

GFH is the largest and most diverse health care provider in the area and provides a comprehensive safety net of health care services to a rural, economically-challenged region in upstate New York. The not-for-profit health system includes the sole acute care hospital located in this region – a 410-bed comprehensive community hospital in Warren County, approximately 50 miles north of Albany. GFH is the largest hospital between Albany and Montreal and is the largest employer in the region.

GFH serves as the hub of a regional system of health care providers and offers a vast array of health care services including general medical/surgical and acute care, emergency care, intensive care, coronary care, obstetrics, gynecology, a comprehensive cancer center, renal center, occupational health, inpatient and outpatient rehabilitation, behavioral health care, primary care and chronic disease management, including a chronic wound healing center. In addition to the main acute care hospital campus, GFH operates 24 regional health care facilities, including 11 neighborhood primary care health centers and physician practices, five outpatient behavioral health clinics, numerous outpatient rehabilitation sites, eight specialty practices, two occupational health clinics and a rural school-based health center. (see Appendix A)

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

As the largest employer in the region, GFH is staffed by more than 2700 employees, including over 150 physicians, physician assistants and nurse practitioners. Staffing also includes more than 300 affiliated medical staff and approximately 100 adjunct allied health staff, ranging from primary care practitioners to surgical subspecialists. Our physicians are board-certified in more than 25 specialties and provide services that combine advanced medical technology with compassionate, patient-centered care. The primary and secondary service areas for GFH include Warren, Washington and northern Saratoga counties, covering over 2,000 square miles. However, patients often travel from as far away as Essex and Hamilton counties to obtain services within the health system. With an extended service area that stretches across five, primarily rural counties and over 6,000 square miles, GFH is responsible for the well-being of an extremely diverse, broad population and region.

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

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

GFH has worked to create healthier communities since its founding in 1897, and is actively implementing numerous care transformation initiatives to support the Institute for Healthcare Improvement's Triple Aim of better health, better care and lower costs. These initiatives are further described in the CHNA.

Glens Falls Hospital Mission

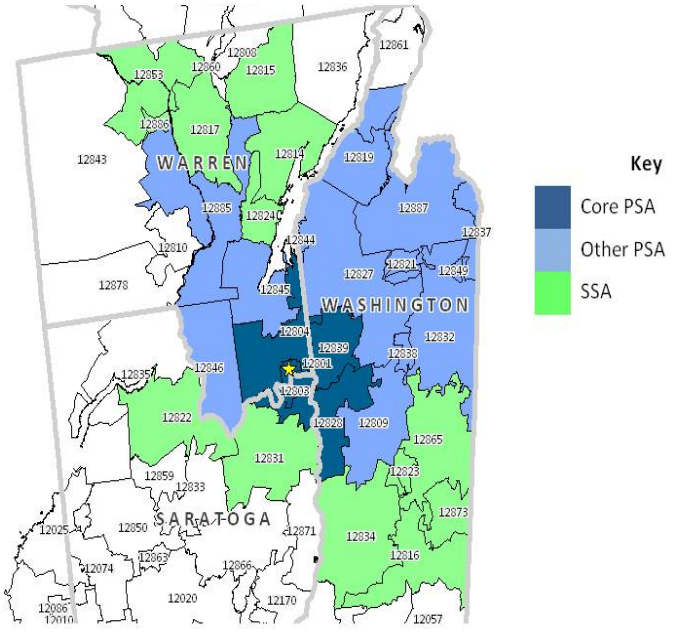
The mission of GFH is to improve the health of people in our region by providing access to exceptional, affordable and patient-centered care every day and in every setting. Our fundamental values are: **C**ollaboration, **A**ccountability, **R**espect, **E**xcellence and **S**afety. The GFH Purpose combines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

Glens Falls Hospital Service Area

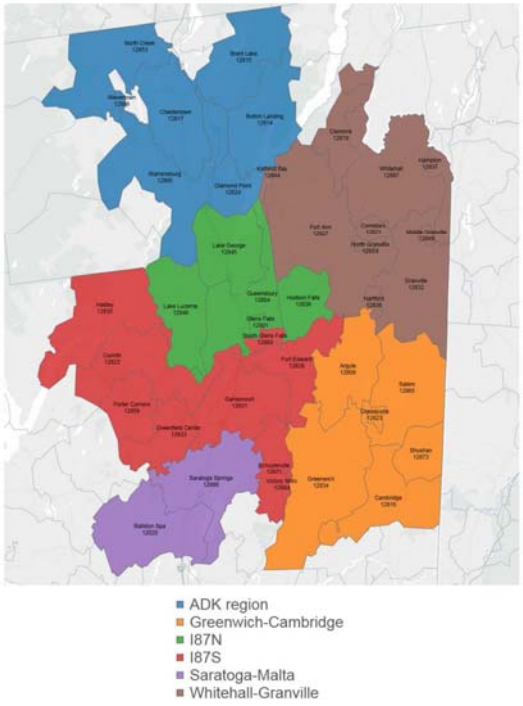
Although GFH draws from neighboring communities to the North and West, our primary service area is defined by ZIP codes in Warren, Washington and northern Saratoga counties. This definition results from an analysis of patient origin, market share (which reflects how important GFH is to a particular community),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

The data that follows further defines the GFH service area and utilizes data derived from a 2012 patient origin analysis and market share analysis based on 2015 discharges.

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).



GFH Inpatient Service Area



GFH Ambulatory Service Area

The Core PSA represents the ZIP codes immediately contiguous to the hospital. Statistics for these ZIP codes have a combined patient origin of 51% and a market share of 78.5%. The Other PSA rings the Core PSA and includes ZIP codes with a combined patient origin of 20% and GFH market share of 73.8%. Combined, the Core PSA and Other PSA have a patient origin of 71% and GFH market share of 77.1%. 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. These ZIP codes have a combined patient origin of 13% and GFH market share of 40.2%. The Core PSA, Other PSA and SSA combined represent the residence of 84% of patients that are served by GFH.

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]

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 underway in our service area. Detailed information on these ventures are fully outlined in our corresponding CHNA.

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

New York State Prevention Agenda 2013 – 2018*

The Prevention Agenda 2013-2018 is a blueprint for local, regional, and state entities to improve the health of New Yorkers in five priority areas with a focus on reducing health disparities for racial, ethnic, disability, and low socioeconomic groups, as well as other populations who experience them. 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, CHNAs and an IS per the ACA requirements.

The Prevention Agenda establishes focus areas and goals for each priority area and defines indicators to measure progress toward achieving these goals, including reductions in health disparities among racial, ethnic, and socioeconomic 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-Reduce Obesity in Children and Adults
    - Focus Area 2-Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure
    - Focus Area 3-Increase Access to High-Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings
- Promote Healthy and Safe Environments
    - Focus Area 1-Outdoor Air Quality
    - Focus Area 2-Water Quality
    - Focus Area 3-Built Environment
    - Focus Area 4-Injuries, Violence and Occupational Health
- Promote Healthy Women, Infants and Children
    - Focus Area 1-Maternal and Infant Health
    - Focus Area 2-Child Health
    - Focus Area 3-Reproductive, Preconception and Inter-Conception Health
- Promote Mental Health and Prevent Substance Abuse
    - Focus Area 1-Promote Mental, Emotional and Behavioral Well-Being in Communities
    - Focus Area 2 - Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
    - Focus Area 3 - Strengthen Infrastructure across Systems
- Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Health Care-Associated Infections
    - Focus Area 1-Prevent HIV and STDs
    - Focus Area 2-Prevent Vaccine-Preventable Diseases
    - Focus Area 3-Prevent Health Care-Associated Infections

More information about the Prevention Agenda can be found at
http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

*The Prevention Agenda was originally a five year plan (2013-2017), it was extended to 2018 to align its timeline with other state and federal health care reform initiatives.

Glens Falls Hospital Prioritization of Significant Health Needs

GFH and Warren, Washington and Saratoga County Public Health collaborated in the development of our CHNA. Additionally, GFH coordinated with Fulton, Essex, Hamilton, Franklin and Clinton County Public Health, in addition to several other hospitals in the region, through the regional health assessment and planning efforts coordinated by the Adirondack Rural Health Network (ARHN).

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

GFH serves a multi-county area, which encouraged a strategic approach to ensure alignment with each county assessment and planning process. After careful consideration and extensive internal and external discussions, GFH determined that the most effective strategy would be twofold: 1) ensure the hospital coordinated with and/or participated in each of the public health departments' CHA processes and 2) utilize the results of each of the county assessments to inform a coordinated and complementary regional CHNA for the GFH service area. A detailed description of each county CHA process is included in the corresponding GFH CHNA.

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

Through the ARHN collaboration, GFH coordinated with Warren and Washington counties to conduct a CHNA in each county. Saratoga County conducted a separate, yet similar process to determine their community's heath needs in which GFH representatives were members of their Health Priority Workgroup.

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 Areas	Prevent Chronic Disease Promote Mental Health Prevent Substance Abuse	Reduce obesity in children and adults Reduce illness, disability and death related to tobacco use and secondhand smoke exposure Prevent substance abuse and other mental, emotional and behavioral health disorders	Promote Mental Health Prevent Substance Abuse

In addition to evaluating the priorities and county level data indicators for our local county health departments, GFH considered our expertise, capacity, funding, and potential impact. To that end, GFH has identified the following as the most significant health needs for the population served by GFH. These needs will be the major focus of GFH's community health strategies for 2016 – 2018.

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

It is important to note that GFH chose the same priorities during our 2013-15 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.

Regional Priority

In addition to GFH choosing the three focus areas under the Chronic Disease priority area, as part of the community health planning and assessment process, the ARHN workgroup identified and selected Chronic Disease Prevention as a regional priority in support of the NYS Prevention Agenda 2013-2018. ARHN 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.

Community Health Needs not Addressed in the Action Plan

Additional analysis revealed an increasing demand and need for mental health and substance abuse services throughout the three county region. GFH recognizes this trend and the need for quality services and programs, however, we have chosen not to formalize the current efforts within this CSP. GFH will continue to focus on this priority as we recruit providers, build capacity and develop innovative care models to meet the needs of the region. Through initiatives such as DSRIP and Health Home, GFH

continues to evolve and develop integrated care models and population health strategies that focus on expanding access to behavioral health services. Additionally, GFH is working closely with county health departments and community partners to discuss how we can best meet the needs of the community and provide clinical and community linkages.

Present efforts to increase our ability to meet the behavioral health needs of the communities we serve will focus on four main components. Two components will address increasing capacity and sustainability 1) recruiting and retaining qualified staff and 2) developing a Crisis Care Center. In addition, two components will directly impact our population 3) continuing to support the implementation of co-locating behavioral health services and primary care and 4) continuing to implement a Medicaid Health Home program. Additional efforts will concentrate on exploring opportunities to expand our services through the development and implementation of emerging and innovative care models to address the rising needs of these services.

Staffing

The need for qualified mental health professionals is well documented in health literature. This nationwide trend continues to be problematic for GFH and is often times amplified in the very rural region of upstate NY that is served by GFH. Efforts to recruit and retain quality behavioral health professionals continues to be a priority for both GFH and the entire North Country region. As such, GFH continues to explore innovative and emerging models of care to meet this need for our population.

Crisis Care Center

Through funding from NYS Capital Restructuring Financing Program (CFRP), together with DSRIP funds, GFH is in the planning stages of constructing a crisis stabilization unit within our existing hospital structure. The Crisis Care Center at GFH (the Center) will provide readily accessible behavioral health crisis services to adults and adolescents, supporting a rapid de-escalation of the crisis facilitated by the appropriate level of service and providers. The Center will be staffed by a multidisciplinary care team consisting of Social Workers, Psychiatric RNs and Behavioral Health Technicians with expertise and training in crisis de-escalation.

Integrating Behavioral Health and Primary Care

GFH is working to advance health care through the integration of behavioral health care into the primary care health centers. Physical and mental health treatment and services will be internally integrated and coordinated with the wider health care network in order to promote and support health, wellness and recovery.

Medicaid Health Home

A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that a patient's needs are addressed in a complete and comprehensive manner. This is done primarily through a "care manager" who oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared among providers

so that services are not duplicated or neglected. Health Home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual "Health Home." Health Home focuses on people who have complex medical, behavioral, and long term care needs thus needing help navigating multiple systems of care. GFH is a care management agency of the Adirondack Health Institute's (AHI) Health Home.

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 also identified new initiatives to complement and further enhance these existing programs. As a result, this IS is a comprehensive, aligned plan with evidence-based strategies that will have significant impact on the health and well-being of the people and communities in the region.

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

Priority Populations

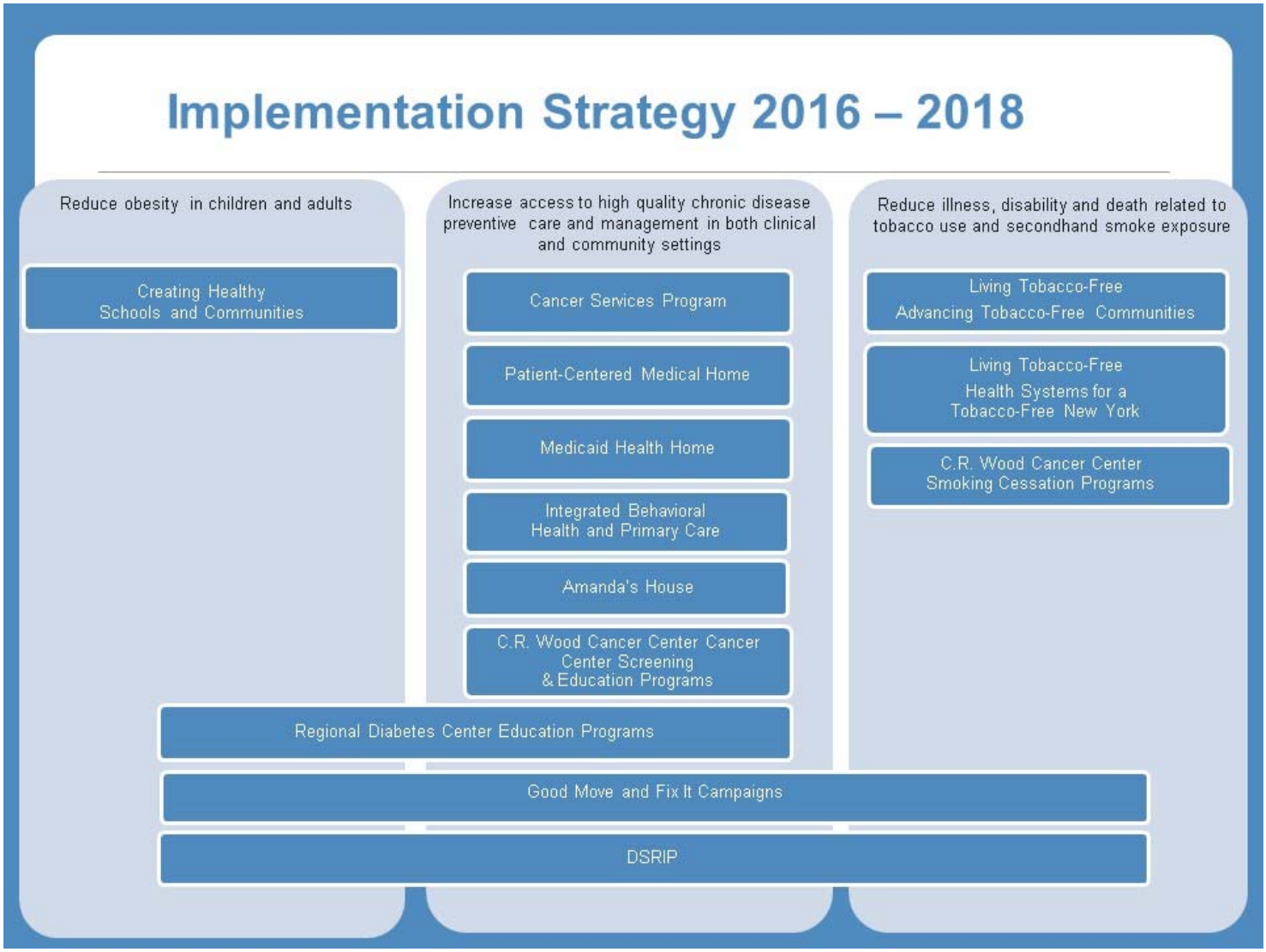
Emphasis throughout the IS is placed on interventions that impact disparate and underserved populations in the service area, especially low-income populations and those with limited access to healthcare and other community supports and resources. As described in the CHNA, Warren, Washington and Saratoga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

Action Plan for 2016-2018

The following three-year action plan includes initiatives led by GFH to address the prioritized community health needs. It includes initiatives to address the focus areas under the Prevent Chronic Disease priority area of the NYS Prevention Agenda. Many of the initiatives impact more than one focus area and some influence all three focus areas.

Each initiative includes a brief description, health disparities addressed, goal, SMART objective(s) and corresponding performance measure(s), and key activities for the improvement strategy. 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.



GFH Initiative/Improvement Strategy: Creating Healthy Schools and Communities	
Initiative – Brief Description/Background: The Creating Healthy Schools and Communities initiative works with school districts to implement sustainable policy, systems and environmental changes in high needs school districts and the communities where the students and their families live. Work focuses on increasing access to healthy, affordable foods and beverages and expanded opportunities to be physically active. Creating Healthy Schools and Communities is a program of the Health Promotion Center of GFH and is partially funded by the NYS DOH. This initiative is implemented in school districts and communities located in Warren, Washington and Saratoga counties.	
Health 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.	
GFH Goal: Improve the health of people in the GFH region through prevention of obesity and related chronic conditions**.**	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2018, improve school environments to support and promote healthful eating and increased opportunities for physical activity, before, during and after the school day for all students in grades K-12 by implementing 33 environmental and 4 board approved policy changes in identified schools.	# of schools implementing environmental changes. # of board approved policy changes.
By December 2018, enhance opportunities for improved nutrition and physical activity by implementing 37 policy or environmental changes in identified communities.	# of communities implementing environmental and/or policy changes.
Activities	
Increase access to healthy, affordable foods through establishing policy that increases a school districts ability to meet Healthy Hunger-Free Kids Act provisions.	
Establish Comprehensive School Physical Activity Programs.	
Promote student wellness through the assessment, development, improvement and implementation of local School Wellness Policies.	
Increase access to healthy, affordable foods through the establishment of zoning regulations, cooperative buying groups and creating or enhancing food hubs.	
Increase adoption and use of food standards and procurement policies in municipalities, community-based organizations, worksites and hospitals.	
Adopt and implement Complete Streets policies, plans and practices.	

GFH Initiative/Improvement Strategy: Living Tobacco-Free: Health Systems for a Tobacco-Free NY	
Initiative – Brief Description/Background: Health Systems for a Tobacco-Free NY works with health system administrations to integrate policies and practices that ensure the consistent delivery of aggressive tobacco dependence treatment in accordance with the Public Health Service's Clinical Practice Guidelines for Tobacco Use and Dependence. Health Systems for a Tobacco-Free NY is a program of the Health Promotion Center of GFH and is partially funded by the NYS DOH. This initiative is implemented in Clinton, Essex, Franklin, Fulton, Hamilton, Montgomery, Saratoga, Warren and Washington counties.	
Health Disparities Addressed: Individuals with low income, low educational attainment and individuals diagnosed with mental health issues. These specific populations are prioritized because of their disproportionate use of tobacco products in comparison to the general population.	
GFH Goal(s): To reduce the morbidity, mortality and economic burden attributed to tobacco use in Clinton, Essex, Franklin, Fulton, Hamilton, Montgomery, Saratoga, Warren and Washington counties.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2018, Health Systems for a Tobacco-Free NY will partner with 7 medical health systems within the nine county service area to develop comprehensive, guideline concordant and evidenced-based policies that address tobacco dependence within their patient population.	# of medical health providers signing an MOU that complete systems level change to address tobacco dependence as directed by the Public Health System's 2008 Clinical Guidelines for Treating Tobacco Use and Dependence.
By December 2018, Health Systems for a Tobacco-Free NY will partner with 7 behavioral health systems in the nine county service area to develop comprehensive, guideline concordant and evidenced-based policies that address tobacco dependence within their client population.	# of behavioral health providers signing an MOU 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	
Identify significant medical and behavioral health care systems and their key administrators within the nine county area to approach with the health improvement initiative.	
Enlist influential local and regional organizations and members in activities that support and advance advocacy with decision makers of the targeted medical and behavioral health systems.	
Engage these targeted medical and behavioral health systems to ascertain the current state of each system's tobacco use and dependence interventions.	
Partner with the targeted medical and behavioral health systems to establish and integrate system-level policies and procedures that meet the Public Health Service Clinical Guidelines for Tobacco Use and Dependence.	
Lead target health systems to measure the implementation of the evidence-based policy in order to enhance the protocols where needed, and to impact the sustainability of the initiative.	

GFH Initiative/Improvement Strategy: Living Tobacco-Free: Advancing Tobacco-Free Communities	
Initiative – Brief Description/Background: Advancing Tobacco-Free Communities fosters environments supportive of policies that reinforce the tobacco-free norm in communities throughout NYS. This approach to chronic disease prevention utilizes a community-based strategy, which includes community education, community mobilization, government policy maker education and advocacy with organizational decision makers in order to create local environments that are supportive of tobacco-related policy change. Advancing Tobacco-Free Communities, a program of the Health Promotion Center of GFH and is partially funded by the NYS DOH and serves Saratoga, Warren and Washington counties.	
Health Disparities Addressed: Youth and low socioeconomic populations at high risk for tobacco use, or exposure to secondhand smoke.	
GFH Goal(s): Improve the health of people in the GFH region through education, mobilization and the execution of policies that reduce tobacco use.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2018, create a local environment that successfully supports the development and/or passage of at least 10 tobacco-related policies across four different initiatives: point of sale, tobacco-free outdoors, smoke-free housing, and/or smoke-free media.	# of total tobacco-related policies in development or completion for point of sale, tobacco-free outdoors, smoke-free housing, and/or smoke-free media.
Activities	
Establish and maintain relationships with local community organizations, youth, key stakeholders, and decision makers.	
Garner earned media for initiatives and tobacco-related holidays.	
Educate community members about the benefits of tobacco-free environments and policy solutions.	
Mobilize community partners to advocate for tobacco-free communities and policy change.	
Support community partners in adopting tobacco-related policies.	

GFH Initiative/Improvement Strategy: Good Move/Fix it! Campaign	
Initiative – Brief Description/Background: *Good Move* and *Fix it!* is a campaign to encourage individuals and families to take steps toward good health in the community, in the workplace, and in the school. The campaign promotes being active, eating healthy foods, tobacco cessation and making use of preventative care. Good Move/Fix it! is a program of the Health Promotion Center of GFH and is partially funded by the NYS DOH through Creating Healthy Schools and Communities, Living Tobacco-Free: Advancing Tobacco-Free Communities and Health Systems for a Tobacco-Free NY.	
Health Disparities Addressed: Low socio-economic status populations with limited access to community resources with increased risk for chronic disease	
GFH Goal: Improve the health of people in the GFH region by enhancing access to clinical and community preventive services through coordinated health-related messaging.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2018, coordinate chronic disease messaging by establishing 40 distribution sites for a campaign to promote awareness of preventative health measures; including increased physical activity, access to quality nutrition, tobacco-free environments and preventive care services.	# of community organizations, partners and/or sites distributing and promoting Good Move/Fix it campaign materials.
Activities	
Expand our communication and outreach plan to support a coordinated and integrated network of partners such as healthcare providers, schools, worksites and community-based organizations or municipalities.	
Work with partners to determine setting-specific messaging and placement of materials.	
Monitor campaign efficacy and reach through partner and community feedback.	

GFH Initiative/Improvement Strategy: C.R. Wood Cancer Center Smoking Cessation Programs	
Initiative – Brief Description/Background: The C.R. Wood Cancer Center offers smoking cessation programs for patients and community members. The 4-week program is currently offered four times a year, led by Oncology Nurse Navigators at the Cancer Center.	
Health Disparities Addressed: Individuals at high-risk for poor health outcomes	
GFH Goal(s): Improve the health of people in the GFH region through the promotion of tobacco use cessation and the elimination of exposure to secondhand smoke.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2018, individuals attending the smoking cessation programs will demonstrate a 20% decrease in the amount of cigarettes smoked.	% average decrease of cigarettes smoked by program participants
Activities	
Provide quarterly smoking cessation classes.	
Offer individual smoking cessation counseling to high risk individuals who have been screened through the high risk lung screening clinic.	
Provide pre- and post-evaluations to qualify the cessation program effectiveness.	
Provide timely follow-up to ensure and reinforce knowledge base.	

GFH Initiative/Improvement Strategy: C.R. Wood Cancer Center Screening and Education Programs: Uniquely You Boutique and Salon	
Initiative – 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.	
Health Disparities Addressed: Patients with body image issues related to hair loss during treatment for a diagnosis of cancer, especially those with low SES and/or limited access to other clinical/community supports.	
GFH Goal(s): Provide free wigs and hair care services to patients of the C.R. Wood Cancer Center	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2018, 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 wig and head coverings	
Provide skin care education	

GFH Initiative/Improvement Strategy: C.R. Wood Cancer Center Screening and Education Programs: Cindy's Retreat – Weekend Cancer Survivor Retreat	
Initiative – Brief Description/Background: Weekend retreat for patients after a diagnosis of cancer.	
Health Disparities Addressed: Emotional support after a diagnosis of cancer especially those with limited access to other clinical/community supports.	
GFH Goal(s): 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.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2018, provide 2 semi-annual retreats for women. Maximum of 16 people per retreat.	# of events held # of people in attendance
By December 2018, provide 1 annual retreat for men. Maximum of 10 people in attendance.	# in attendance
Activities	
Provide emotional support to women and men after a diagnosis of cancer through a weekend retreat.	
Provide tools for living with and beyond a diagnosis of cancer.	

GFH Initiative/Improvement Strategy: C.R. Wood Cancer Center Screening and Education Programs: Cindy's Camp Comfort	
Initiative – Brief Description/Background: A free weekend camp for children who are either living with someone with a serious illness or whom have experienced the death of an immediate family member.	
Health Disparities Addressed: Cancer and emotional distress especially those with limited access to other clinical/community supports.	
GFH Goal(s): Provide emotional support and coping mechanisms for children	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2018, provide an annual camp for children whom are living with an immediate family member with a chronic illness. Minimum of 10 children in attendance.	# of attendees
By December 2018, provide an annual camp for children whom have experienced the death of an immediate family member. Minimum of 15 children in attendance.	# of attendees
Activities	
Provide one-on-one support with trained "Big Buddies" for each child in attendance.	
Provide group discussion / support to age appropriate groups at each camp.	

GFH Initiative/Improvement Strategy: C.R. Wood Cancer Center Screening and Education Programs: Skin Cancer Screening Clinic	
Initiative – 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 GFH's C.R. Wood Cancer Center.	
Health Disparities Addressed: Low socio-economic status populations especially those that are underinsured or uninsured with limited access to screening services.	
GFH Goal(s): Improve the health of people in the GFH region through screening of early skin cancers	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2018, 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	
Partner with Gateway Dermatology, Irongate Family Practice and HHHN for volunteer practitioners to perform the screening service	
Partner with nurses and support staff at the C.R. Wood Cancer Center to organize and facilitate the clinic and educate the community on the importance of skin safety.	

GFH Initiative/Improvement Strategy: Cancer Services Program	
Initiative – Brief Description/Background: The Integrated Breast, Cervical and Colorectal Cancer Screening Program provides comprehensive screening for uninsured residents. Cancer Services Program (CSP) partners with close to 50 local health care providers for screening services. Outreach and education practices are in place with strong relationships cultivated with community partners. The CSP partners are key community leaders, public health departments, elected officials, the Chamber of Commerce and the local libraries. The CSP is a program of C.R. Wood Cancer Center of GFH and is partially funded by the NYS DOH.	
Health Disparities Addressed: Low socio-economic status populations and uninsured individuals with limited access to screening services	
GFH Goal(s): Improve the health of the people in the GFH region by increasing screening rates for breast/cervical/colorectal cancer.	
GFH SMART Objective(s) By December 2018, 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) • Increase and promote policies for paid time off or flex time for cancer screening with at least 4 municipalities and/or businesses.	**Performance Measure(s)** NYSDOH Cancer Services Program Monthly Performance Measures; PM#2 PM#4 PM#7 Workplan performance measure
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.	
Collaborate and actively engage organizations and individuals throughout the service area to assist in implementing required activities to meet or exceed program performance measures.	
Work with municipalities and local businesses to expand or implement new paid time off or flex time policies for cancer screenings.	

GFH Initiative/Improvement Strategy: Patient-Centered Medical Home	
Initiative – Brief Description/Background: Within our 11 health centers, GFH is working to transform the model of primary care delivery through advancement of patient-centered medical homes. This transformation will strengthen the physician-patient relationship with a special focus to ensure high needs populations have access to high quality of care, including integration of primary, specialty, behavioral and social care services.	
Health Disparities Addressed: Individuals living in rural areas with limited access to comprehensive**,** coordinated care.	
GFH Goal: Improve the health of people in the GFH region by increasing access to high quality, evidence based preventive care and chronic disease management.	
GFH SMART Objective(s):	**Performance Measure(s)**
By December 2018, expand the use of the patient-centered medical home model in 11 GFH health centers.	# of health centers receiving NCQA 2014 PCMH Level 3 recognition
Activities	
Adapt and use certified electronic health records to support clinical decision making, population health management, improvement in clinical quality measures, and coordination of care.	
Implement Best Practice Advisories (BPA). These BPAs alert the care team to services that are due, overdue or about to be due. These include those items identified as high risk population (depression, diabetes, Medicaid Health Home participants), as well as those health maintenance items that are distinct and similar to those required by our Medicare Shared Savings Accountable Care Organization. These included items such as mammograms, colorectal screening, influenza, pneumococcal, tobacco cessation, BMI, fall risk, depression screening, Coronary Artery Disease (CAD), and Ischemic Vascular Disease (IVD).	
Perform population health management by actively using electronic medical records (EMR) and other IT platforms, including use of targeted patient registries.	
Implement preventive care screening protocols including behavioral health screenings (PHQ9) for all patients to identify unmet needs. Develop a process for assuring referral to appropriate care in a timely manner.	
Identify care coordinators at each primary care practice site that are responsible for care connectivity, internally, as well as connectivity to care managers at other primary care practices.	
Implement open access scheduling in all participating primary care practices.	

GFH Initiative/Improvement Strategy: Integrated Behavioral Health and Primary Care	
Initiative – Brief Description/Background: GFH is working to advance health care through the integration of behavioral health care into the primary care health centers. Physical and mental health treatment and services will be internally integrated and coordinated with the wider health care network in order to promote and support health, wellness and recovery.	
Health Disparities Addressed: Individuals with limited access to behavioral health services	
GFH Goal(s): Improve the health of people in the GFH region through the use of evidence-based, integrated care to prevent and manage chronic disease.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2018, advance health care for adult patients through the integration of primary and behavioral health care at three health centers.	# of GFH health centers with a psychiatric provider and/or social worker available to provide onsite assessment and treatment services
Activities	
Identify health centers with the capacity and need for integrated primary and behavioral health care.	
Leverage best practices from current model, including clinical integration strategies.	
Complete facility renovations at target sites to support expanded staffing and clinical workflows.	
Recruit and hire psychiatric nurse practitioners and/or licensed clinical social workers.	
Provide staff education and training relative to rolls for existing office staff and providers.	
Ensure appropriate orientation and training for newly hired NPPs and LCSWs.	
Coordinate the availability and schedules of behavioral health services and providers to ensure adequate coverage within practices for the expected volume of patients and hours of service required.	
Launch primary care /behavioral health adult referral protocol designed to establish criteria for the referral of adults and older adults from the primary care setting to the behavioral health setting and vice versa.	

GFH Initiative/Improvement Strategy: Medicaid Health Home	
Initiative – 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. This is done primarily through a "care manager" who oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared among providers so that services are not duplicated or neglected. Health Home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual "Health Home." Health Home focuses on people who have complex medical, behavioral, and long term care needs thus needing help navigating multiple systems of care. GFH is a care management agency of the Adirondack Health Institute's (AHI) Health Home.	
Health Disparities Addressed: Low socio-economic status populations on Medicaid disproportionately affected by complex chronic conditions.	
GFH Goal(s): Improve the health of people in the GFH region by promoting coordinated care to prevent and manage chronic disease.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2018, increase by 5 the number of Care Coordinators within our primary care centers (PCC) to assist with the management of chronic disease and behavioral health integration.	# of Care Coordinators recruited and working in primary care centers (PCC)
Activities	
Convene an internal care coordination workgroup to begin to identify current capacity, gaps and needs.	
Utilize Cerner EMR system, including the disease registries, to identify potential Health Home members.	
Partner with local behavioral health organizations to ensure access to comprehensive services.	
Expand utilization of the patient portal and My Chart to increase patient engagement.	
Expand care coordination capacity through the identification of new downstream providers.	
Conduct outreach to existing PCPs to assess capacity for additional patients.	

GFH Initiative/Improvement Strategy: Regional Diabetes Center Education Programs	
Initiative – Brief Description/Background: As a component of GFH's Nutrition Services, the Regional Diabetes Center provides patients and community members with education, resources, counseling and disease management support.	
Health Disparities Addressed: Populations disproportionately affected by complex chronic conditions due to low-SES, access to care and services and related social determinants of health.	
GFH Goal(s): Improve the health of people in the GFH service area by providing social and clinical support to increase health outcomes for those with health concerns and nutritional questions.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2018, conduct 4 support groups annually to patients and community members with a diabetes diagnosis.	# of support groups conducted
By December 2018, conduct 5 educational programs annually on topics related to the prevention, control and management of diabetes and other health related conditions.	# of education programs provided
Activities	
Plan, promote and present comprehensive educational programs.	
Publicize and facilitate on-going support group services for people living with diabetes.	

GFH Initiative/Improvement Strategy: Amanda's House	
Initiative – Brief Description/Background: Amanda's House provides complimentary accommodations for patients and families of patients receiving care from GFH. Many hospitality houses exist as separate non-profit organizations, Amanda's House is one of the rare hospital-owned hospitality houses.	
Health Disparities Addressed: Social determinates of health that disproportionately affect access to care.	
GFH Goal(s): Improve access to care by giving complementary accommodations to people who seek services and treatment through GFH.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2018, provide complimentary accommodations of 2500 guest nights to patients and families.	# of guest nights offered
Activities	
Provide free toiletries and other personal items to patients and families staying on premises.	
Provide free access to coffee, pantry, and kitchen during stay.	

Delivery Service Reform Incentive Program (DSRIP)

It is important to note that while DSRIP is included as a strategy, there is not a corresponding workplan within this IS specific to the many DSRIP initiatives in which GFH is involved. Many of these workplans are still under development as the projects continue to evolve. We have, however, chosen to include DSRIP as a strategy as the overall goals of the program, especially those projects within Domain 4, align themselves with the population health initiatives identified herein. As each DSRIP workplan is developed, opportunities for alignment will be identified and integrated into the initiatives outlined herein.

Additional Community Benefit

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

Evaluation Plan

To ensure efficacy of the proposed interventions, GFH will work with Warren, Washington and Saratoga Public Health Departments on comprehensive evaluation plans that include both process and outcome evaluation. GFH will ensure these plans 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 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 2013-15 CHNA process, GFH chose the following health needs as priorities.

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

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

- Working with 15 local school districts to increase opportunities for quality physical activity and nutrition through implementing policy and creating supportive environments.
- Partnering with local municipalities to create 119 environmental and policy changes affecting recreation and pedestrian environments. These changes consisted of the procurement and placement of picnic tables, bike racks, benches, wayfinding signs and drinking fountains.
- Distributing promotional materials that stress the importance of healthful eating and physical activity to prevent chronic disease to over 130 partners in NYS.
- Delivering the National Diabetes Prevention Program (DPP) that connected 19 high-risk patients with pre-diabetes to the community-based lifestyle modification program. The average weight loss achieved by these participants who attended at least four core sessions of the DPP was 4.7% of body weight.
- Partnering with five strategic local human service agencies with the intent to refer eligible people for free cancer screenings. The rates of comprehensive screenings for breast, cervical, colorectal cancer improved to 51.2%.
- Collaborating with local worksites to implement wellness initiatives that resulted in increased employee access to produce through community supported agriculture (CSA) programs and farmers' markets at the worksites, adoption of lactation support policies, availability of

resources or programs to help employees increase their physical activity levels, and promotion of preventive health programs to reduce risk factors for chronic diseases.

- Providing training and consultation to over 175 health care provider organizations to help them develop and adopt health systems change to ensure all patients are screened and treated for tobacco dependence.
- Conducting smoking cessation programs for community members that resulted in approximately 5% of individuals successfully quitting smoking and continuing to be non-smokers. Approximately 10% quit for a short time and are working on reducing their consumption, and an estimated 20% stated a reduction in the amount of cigarettes consumed per day.
- Launching an integrated behavioral health model in the Greenwich Family Health Center. Through this and other alternative models for integrated care we have reached 615 distinct patients.
- Achieving NCQA recognition for all 11 health centers operated by GFH under the 2011 Patient-Centered Medical Home (PCMH) standards.
- Increasing outreach and enrollment in Health Home from 240 members in 2014 to nearly 540 individuals as of 2015.
- Developing a series of maps that outlined local level partnerships and the impact of our interventions in this region. In total, five maps were created and shared with local partners and decision makers.
- Creating local environments that successfully supported the passage of 8 tobacco-related policies through the community engagement and Reality Check components of the Living Tobacco-Free initiative.
- Obtaining 14 MOUs from physical and behavioral health administrators to implement systems change for tobacco dependent patients though the Health Systems component of the Living Tobacco-Free initiative.

The complete 2013-2015 IS and corresponding CSP updates can be found on the GFH website at http://www.glensfallshospital.org/services/community-service/health-promotion-center.

Dissemination

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

GFH will also use various mailings, newsletters and reports to ensure the availability of the CHNA and IS is widely publicized. Hard copies will be made available at no-cost to anyone who requests one.

Approval

The Manager of the Health Promotion Center worked with Senior Leadership to develop the content of this IS which was presented 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 IS has been reviewed and approved by the GFH Board of Governors. A signed copy is available upon request.