ALBANY MED Health System

GLENS FALLS HOSPITAL

Community Health Needs Assessment and Implementation Strategy

2025-2027

Executive Summary

Overview

The Community Health Needs Assessment (CHNA) and Implementation Strategy (IS) will address the requirements set forth by the Internal Revenue Service through the Affordable Care Act (ACA). Similarly, the New York State Department of Health (NYS DOH) requires hospitals to work with local health departments to complete a Community Service Plan (CSP) that mirrors the CHNA and IS per the ACA.

Community Health Needs Assessment

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

Working within the framework provided by the NYS Prevention Agenda, GFH collaborated with Warren, Washington and Saratoga Counties, as well as Saratoga Hospital, in the development of this CHNA. Additionally, GFH coordinated with Fulton, Essex, Hamilton, Franklin and Clinton County Public Health, in addition to several other hospitals in the region, through the regional health assessment and planning efforts coordinated by the Adirondack Rural Health Network ARHN. Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning in the region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of hospitals and county health departments working together to utilize a systematic approach to community health planning and assessment. At the time of the writing of this assessment, Saratoga County was still in process of conducting an independent analysis to determine the needs of their residents and will subsequently choose priorities based on the specific needs of the county. GFH and Saratoga County have agreed to continue to coordinate and collaborate where priorities align. Saratoga Hospital, primarily serving Saratoga County residents, conducted a similar analysis to determine priority areas for their CHNA. Due to overlapping service areas, Saratoga Hospital and Glens Falls Hospital will also coordinate where appropriate. Each organization's needs assessment process was similar and involved both data analysis and consultation with key members of the community.

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

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

While the information collected through the community health assessment process was extremely comprehensive, there are a variety of gaps in information. First, there is limited data available by zip code, and much of the data is often at least two to three years old. Second, data sources are extremely limited to quantify the challenges and needs associated with the social determinates of health. Metrics are not available to wholly understand issues such as childcare, housing, transportation, food insecurity, and other social barriers facing our populations. Similarly, while racial and ethnic disparities are often easily identified in other parts of New York State, disparities in this region are difficult to measure or quantify. As data and trends are shared and better understood over the next three years, health systems and community/public health planners will likely need to adapt to the changing and emerging needs of communities served.

Because GFH serves a multi-county area, it fostered the need for a strategic approach to ensure alignment with each county assessment and planning process. Consistent with previous years, GFH determined that the most effective strategy would be twofold: 1) ensure the hospital coordinated with and/or participated in each of the public health departments' CHNA processes and 2) utilize the available results of each of the county assessments to inform a coordinated and complementary regional CHNA for the GFH service area. The following table outlines the most significant health needs identified in each county within the GFH service area:

	Warren County	**Washington County**	**Saratoga County/Saratoga Hospital**

Prevention Agenda Domain and/or Focus Area	• **Domain: Social and Community Context:**
	  • Primary prevention, Substance misuse and overdose prevention
	  • Anxiety & Stress
	• **Domain: Healthcare Access and Quality:**
	  • Childhood Behavioral Health
	• **Domain: Economic Stability:**
	  • Housing Stability & Affordability
		• **Domain: Economic Stability:**
		  • Poverty
		• **Domain: Social and Community Context:**
		  • Tobacco/E-Cigarette Use
		• **Domain: Health Care Access and Quality:**
		  • Prevention Service for Chronic Disease Prevention and Control
			• **Domain: Economic Stability:**
			  • Food security
			• **Domain: Social and Community Context:**
			  • Reduced major depressive episodes
			• **Domain: Healthcare Access and Quality:**
			  • Increased A1C testing and cancer screening

In addition to evaluating the priorities and county level data indicators for our local county partners, GFH considered our expertise, capacity, funding, and potential impact. The following have been identified as the most significant health needs for the population served by GFH. These needs will be the major focus of GFH's community health strategies for 2025 - 2027, and informed the development of a corresponding IS:

Domain: Social and Community Context

- Priority: Mental Wellbeing and Substance Use
    - Tobacco/E-Cigarettes Use

Domain: Education Access and Quality

- Priority: PreK-12 Student Success and Educational Attainment
    - Health and Wellness Promoting Schools

Domain: Health Care Access and Quality

- Priority: Health Insurance Coverage and Access to Care
    - Preventative Services for Chronic Disease Prevention and Control
- Healthy Children
    - Preventative Services
        - Hearing Screening and Follow-up

It is important to note that GFH chose similar chronic disease and communicable disease related priorities in the previous 2022-2024 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 Domain areas, as part of the community health planning and assessment process, the CHA Committee identified and selected Social and Community Context, Healthcare Access and Quality and Economic Stability as regional priorities in support of the NYS Prevention Agenda 2025-2030. CHA partners will work in tandem with the ARHN in a variety of ways to both support strategies to address and raise awareness about chronic disease prevention and mental and substance use disorder prevention.

Strategies being explored and formulated on how to best support regional priorities of Social and Community Context, Healthcare Access and Quality and Economic Stability include:

- Identifying professional development/training opportunities for the region.
- Implementing a media campaign.
- Creating Prevention Agenda projects.
- Using social media outlets and websites to raise awareness of initiatives and programs currently in place from partners and others in our region.

Community Health Needs Not Addressed in the Action Plan

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. 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 support 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, it 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.

Additional community health needs, such as housing, transportation, and other social determinants of health, are not addressed in the action plan due to lack of resources, expertise and/or quantitative data to support a proper assessment and plan. GFH recognizes a growing need to work collaboratively across the region to address social drivers of health and remains actively engaged with community partners working to address these issues.

Implementation Strategy

GFH developed the Implementation Strategy to address the prioritized community health needs of the patients and communities within the GFH service area. It is a three-year plan of action for initiatives led by GFH, that includes goals, objectives, activities, partners and performance measures. Strategies are evidence-based and align with the NYS Prevention Agenda 2025-2030, addressing one priority area under the Social and Community Context domain, one priority area under Education Access and Quality domain, and two priority areas under the Health Care Access and Quality domain of the NYS Prevention Agenda. Many of the initiatives impact more than one focus area and some influence all focus areas.

GFH utilized the results of the corresponding CHNA to develop the Implementation Strategy. After thorough data review and discussions with Senior Leadership, GFH identified evidence-based initiatives to address the prioritized community health needs related to our chosen priority areas. Throughout this process, GFH built on existing initiatives, resources, capacity and community assets. As a result, the Implementation Strategy is a comprehensive, aligned plan with strategies that will have significant impact on the health and well-being of the people and communities in the region. Emphasis throughout the Implementation Strategy is placed on interventions that impact disparate and underserved populations in the service area, especially low-income populations and those with limited access to healthcare and other community resources.

Implementation Strategy 2025-2027

Once approved by the Glens Falls Hospital Affairs Committee, both documents will be posted to the GFH website, along with the NYS DOH-required CSP.

Impact of Previous Community Health Needs Assessment

As a result of 2022-2024 Community Service Plan 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: 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

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 2022 - 2024.

Communicable Disease Prevention:
Clostridioides difficile (CDI) Performance Update

- Standardized Infection Ratio (SIR) Performance
  - 2022 SIR: 0.435
  - 2023 SIR: 0.142
  - 2024 SIR: 0.537

Summary of Performance (2018–2024)

Glens Falls Hospital has demonstrated sustained progress in reducing hospital-onset Clostridioides difficile infections (CDI) over the past several years. From the baseline period (2018–2019), the organization achieved a 50 percent reduction, decreasing the SIR from 0.88 to 0.44 in 2022.

The onset of the COVID-19 pandemic temporarily shifted organizational priorities, contributing to a slight increase in the SIR from 0.44 in 2019 to 0.53 in 2020. However, improvement efforts resumed with notable success, resulting in a 31 percent decline from 0.53 to 0.36 in 2021. Overall, despite pandemic-related operational challenges and ongoing staffing pressures, Glens Falls Hospital achieved a 59 percent reduction in CDI between 2018 and 2021.

Post-pandemic recovery trends are reflected in subsequent years, with SIR results of 0.435 (2022), 0.142 (2023), and 0.537 (2024). These data continue to inform targeted quality-improvement strategies, including antimicrobial stewardship, environmental hygiene optimization, diagnostic stewardship, and adherence to evidence-based infection-prevention practices.

Healthcare-Associated Infections:

Surgical Site Infection (SSI) Performance Update

- Standardized Infection Ratio (SIR) Performance
  - 2022 SIR: 1.162
  - 2023 SIR: 1.134
  - 2024 SIR: 0.488

Summary of Performance (2018-2024)

Glens Falls Hospital has continued to implement and sustain evidence-based strategies to reduce surgical site infections (SSIs) across surgical service lines. These initiatives—including preoperative optimization, standardized skin antisepsis, enhanced intraoperative sterile technique, and postoperative wound surveillance—enabled the organization to achieve and maintain a 57 percent reduction in all SSIs in 2019, significantly outperforming the original 30 percent reduction target.

Performance over the 2022–2024 period reflects ongoing recovery and stabilization following the operational disruptions of the COVID-19 pandemic. SIRs of 1.162 (2022) and 1.134 (2023) improved markedly to 0.488 in 2024, demonstrating renewed progress in aligning surgical infection outcomes with state and national benchmarks.

These results continue to guide focused QI efforts, including perioperative workflow standardization, antimicrobial stewardship, surgical safety bundle reinforcement, and cross-disciplinary performance monitoring to sustain long-term reductions in SSIs.

Chronic Disease Prevention:

- Provided **Health Home care coordination** services to adults and children enrolled in Medicaid. A ´Health Home´ is a group of health care and service providers working together to make sure Medicaid members get the care and services they need to stay healthy.
- Partnered with 5 strategic local human service agencies to refer eligible individuals for **free cancer screenings.** The rates of comprehensive screenings for breast, cervical, colorectal cancer stayed steady compared to prior years at 60%.
- 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 2022 - 2024 there were 6 retreats held with 10 participants at each retreat. Each spring the retreat is held for women who have metastatic or stage 4 cancer and every fall are for women whose cancer are treated for cure. All participants evaluated stated that the program helped them with tools for coping after their diagnosis and 100% stated that they felt better.
- 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 850 patients used the salon between 2022 and 2024, and over 350 wigs were provided free of charge.
- Conducted 1 Comfort Camp each year in 2022-2024, 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. Each camp had 35 children and evaluation of the program showed that 100% of the campers found the education and support helpful in reconnecting with their families during the stressful treatment timeframe.
- Conducted **free skin cancer screening** once per year, for a total of three screenings between 2022 and 2024, which are free and open to the community. Total number of individuals screened over the three years was 368. There were 5 early-stage melanomas found during this time frame. 80% of the attendees did not do annual screening and do not have a dermatologist and were thankful for this free event.
- Provided free accommodation through 755 room nights between 2022 and 2024, 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. 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
- Continue to build dementia capacity across the 17-county region that is served by the two AMHS "CEADs" **(Centers of Excellence for Alzheimer's Disease and Related Dementias)** and fulfill the objectives of the NYS Department of Health (NYS DoH) grant (June 1, 2022-May 31, 2027).

- Facilitate continuing education for Health Professionals to enhance the quality of care rendered to constituents, with an emphasis on diagnostic/management skills and research opportunities.
- Maintain the MOU with the region's Federally Qualified Health Center (FQHC) to collaborate on initiatives that help identify neurocognitive diseases earlier in their progression. Continue to provide case review education sessions to the providers of Hudson Headwaters Health Network.
- Execute on the work that is outlined in the BOLD grant which was awarded to the Glens Falls Hospital's CEAD by NYS DoH and The Centers for Disease Control to support public health initiatives for earlier diagnoses.
- Leverage the CEAD program to obtain additional funding and research opportunities in the Aging and Alzheimer's/Other Dementia space.
- Embed health professional education into the local nursing education programs to elevate nursing students' knowledge of dementia.
- Extend the impact of the GFH's original designation as an Age-Friendly Health System which was achieved in 2022 with the CEAD and an interdisciplinary group of professionals. Contribute to continuous improvement priorities, as established by the institution that help with aging and brain health; build on the foundation by serving Quality workgroups such as *Age-Friendly Health* and *Geriatric Emergency Care*.
- Continue to administer the grant that helps to underwrite, in-part, the salaries of the Neurologists, Advanced Practice Providers, and Social Worker who comprise the Neurology team. Fulfill the organization's grant obligation of operationalizing a successful interdisciplinary medical-social model.

- Implemented and sustained telehealth services post Covid era through 2022-2024. GFH leadership received the Telehealth Innovator of the Year for the entire north country.

Completed efforts to advance tobacco within the GFH Region:

- Outreached, engaged and/or re-engaged 15 medical and behavioral health systems and their key administrators to ascertain the current state of each systems tobacco use and dependence interventions and to assist and support the integration of evidence-based, tobacco-dependence treatment services and policies across the healthcare system
- Educated 5 health systems on the benefits of integrating evidence-based, tobacco dependence treatment services and policies across the healthcare system
- Met with and enlisted influential local and regional organizations and members in activities to support and advance advocacy with decision makers of the targeted medical health systems.
- Obtained 1 system wide policy to the integration of evidence-based, tobacco dependence treatment services and policies across the healthcare system
- Obtained 5 MOU agreements to increase the delivery of comprehensive, evidence-based treatment for nicotine addiction and tobacco-use prevention.
- Collaborated on 2 HHHN Pilot Projects to identify gaps to increase the integrated of evidenced based tobacco treatment services via the Community Needs Assessment and the CD

Glens Falls Hospital: CR Wood Cancer Center

- Obtained MOU to utilize 5 A's and implement evidence-based tobacco treatment programming to newly diagnosed patients identified as tobacco dependent
- Identified gaps, successes within current tobacco screening practices

- Established a system to offer/provide NYS Quit line resources
- Identified a RN Onc Navigator as a Tobacco Treatment Lead (TTD) and completed Certified Tobacco Treatment Specialist Training with Rutgers University
- Established a referral system to new onsite Certified Tobacco Treatment Specialist

HHHN:

- ***Community Needs Assessment Pilot Project:*** Obtained an MOU with HHHN to address tobacco use and health disparities within communities, and for HHHN to become the first Federally Qualified Health Center (FQHC) to complete a The Tobacco Use Treatment Capacity Needs Assessment Tool. This tool is designed to be utilized by HSTFNY grantees to engage healthcare organizations and their staff in reviewing their current clinical practices related to the delivery of tobacco use treatment services to the patients they serve. The HHHN CNA team identified three of nineteen focus areas available to improve clinical practices related to the delivery of tobacco use treatment services to the patients they serve. The three focus areas were:
    - Focus Area 10: Prescribing and Providing NRT
    - Focus Area 12: Maximize Billing and Reimbursement
    - Focus Area 13: Competent and Trained Staff
- ***Heart Network CDCCN Pilot Project:*** collaborated to do an internal Train the Trainer training of 5 A's and the process of referral for Nurse Leaders, Care Coord and others to improve implementation of comprehensive tobacco treatment

ASCEND:

- Improved implementation of a comprehensive tobacco dependence treatment with the adoption of a standard of care with North Country Nicotine Consultants and the Health Systems for a Tobacco Free NY grant at GFH.
- Re-ignited this partnership, obtained an MOU and facilitated partnership and collaboration with Washington County Public Health TTS via the Commit to Quit Program to support the integration of comprehensive, evidence-based tobacco treatment program for nicotine within 2 locations
- Formed and maintained a committee meet to work toward the goals of increasing the delivery of comprehensive, evidence-based treatment for nicotine addiction and tobacco-use prevention.
- Offered/provided NYS Quitline resources within Quit Kits

SUNY ADK:

- Signed an MOU to increase the delivery of comprehensive, evidence-based treatment for nicotine addiction and tobacco-use prevention.
- Identified tobacco champion lead for CTTS training
- Coordinated with Washington County Public Health TTS to support the integration of comprehensive, evidence-based programs for nicotine addiction on campus
- Conducted E-Check Up to Go Assessment
- Establishing a referral system to tobacco treatment specialists and the NYS Quitline

Washington County Public Health and Disparity Project:

- Obtained an MOU to increase the delivery of comprehensive, evidence-based treatment for nicotine addiction and tobacco-use prevention via Washington County Public Health's Commit to Quit Program at ASCEND Mental Wellness, Washington County Jail, and at SUNY Adirondack.

- Supported the development and implementation of a system to document referrals and services to assist and support the integration of evidence-based, tobacco dependence treatment services and policies across the healthcare system
- Formed and maintained a committee to increase the delivery of comprehensive, evidence-based treatment for nicotine addiction and tobacco-use prevention.
- Facilitated partnership with the NYS Quitline to promote, refer and offer NYS Quitline resources
- Supported the development of the Tobacco Treatment Tablet Project with public libraries located within Washington County to implement and sustain online cessation. 2 tablets were provided and are maintained by Glens Falls Hospital. 3 individuals were supported virtually.
- Coordinated with community-based organizations within Washington County to promote the Washington County Commit to Quit Program and expand outreach.
- Funded the designing and creation of the Commit to Quit, Quit Kits
- Continued to advance policy and environmental changes to **promote physical activity and nutrition:**
    - Number of 3 worksites and 7 community settings recruited, assessed, and applying behavioral design strategies
    - 14 childcare providers that improve policies, practices, and environments for physical activity and nutrition
    - 9 of municipalities identified, assessed, and received training, technical assistance, and resources
    - 8 school districts with established wellness committees and implemented Wellness Policies and Comprehensive School Physical Activity Programs

The complete 2022-2024 Community Service Plan can be found on the GFH website at https://www.albanymed.org/glensfalls/glens-falls-hospital-health-promotion-center/.