ALBANY MED Health System

GLENS FALLS HOSPITAL

Implementation Strategy

2025 - 2027

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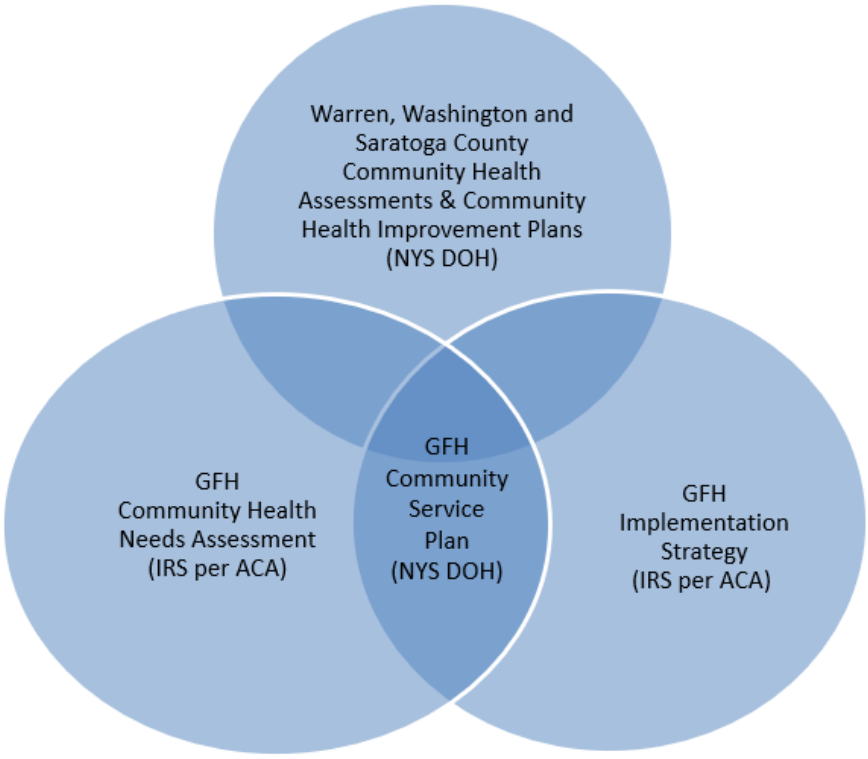
Introduction

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 2025-2030. 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 2,380 employees and a medical staff of over 563 providers.

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.

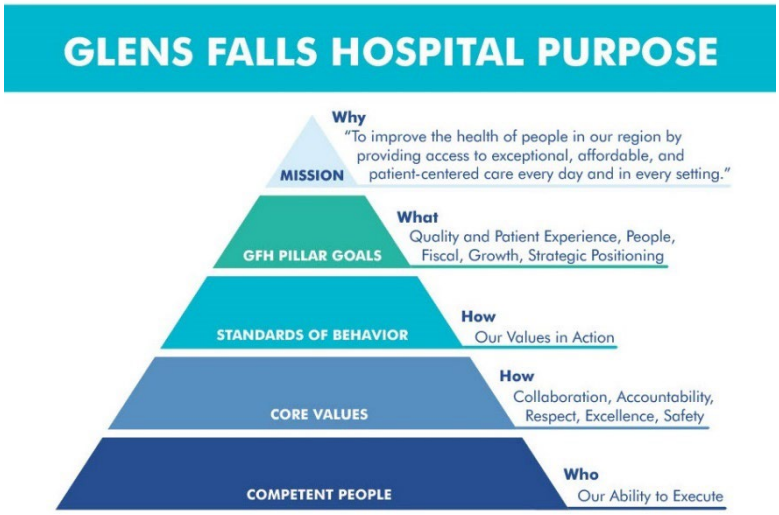
The primary and secondary service areas for GFH include Warren, Washington, and northern Saratoga counties, covering over 2,000 square miles. However, patients often travel from as far away as Essex and Hamilton counties to obtain services within the GFH system. With an extended service area that stretches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

Glens Falls Hospital Mission

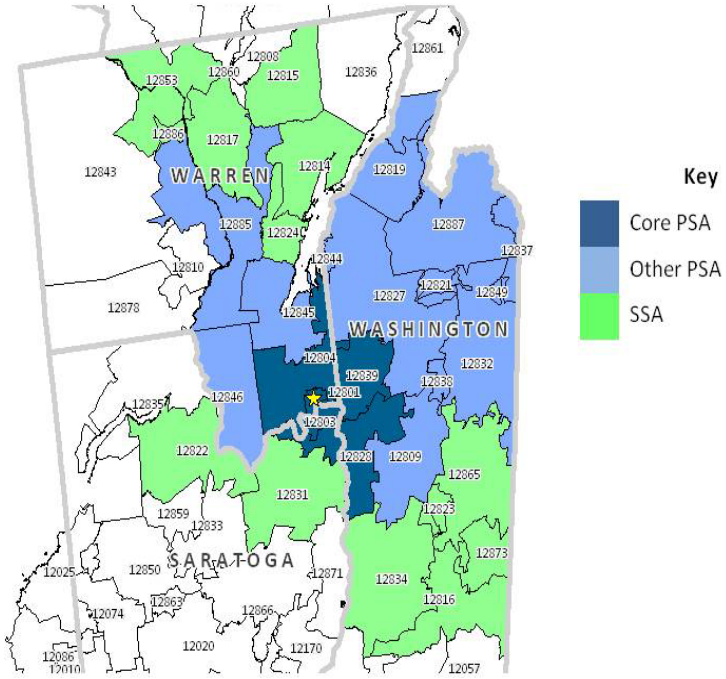
The mission of GFH is to improve the health of people in our region by providing access to exceptional, affordable and patient-centered care every day and in every setting. Our fundamental values are **C**ollaboration, **A**ccountability, **R**espect, **E**xcellence and **S**afety. The GFH Purpose combines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

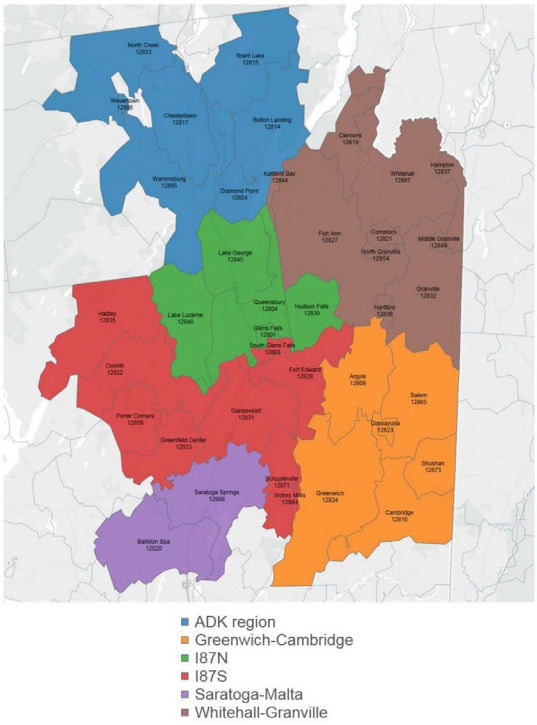
The GFH inpatient service area is defined by a Core Primary Service Area (PSA), Other Primary Service Area (Other PSA) and a Secondary Service Area (SSA). The Core PSA represents the ZIP codes immediately contiguous to the hospital. The SSA reflects more outlying areas where GFH has either a strong market 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 2025- 2030

The 2025–2030 Prevention Agenda takes a comprehensive approach to health, recognizing that well-being is shaped by more than just medical care, public health systems, and conventional prevention

[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).

strategies. It identifies 24 strategic priorities aimed at tackling a wide range of health conditions, behavioral factors, and systemic challenges—including poverty, education, housing, and equitable access to quality healthcare. Confronting these broader determinants is essential to narrowing health disparities and promoting healthier communities. Its vision is that every individual in New York State has the opportunity, regardless of background or circumstances, to attain their highest level of health across the lifespan. The overarching strategy of the Prevention Agenda is to implement public health approaches that improve the health and well-being of entire populations and achieve health equity. In addition, the Prevention Agenda serves as a guide for local health departments as they work with their community to develop CHIPs and CHAs and for hospitals as they develop mandated CSPs and CHNAs and an IS as required per the ACA requirements.

The Prevention Agenda 2025-2030 has five Domains with 24 priority-specific action plans developed collaboratively with input from community stakeholders. Each priority-specific action plan includes focus areas, goals, objectives, 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:

- Domain: Economic Stability
    - Priority Area: Economic Wellbeing
        - Poverty
        - Unemployment
        - Nutrition Security
        - Housing Stability and Affordability
- Domain: Social and Community Context
    - Priority Area: Mental Wellbeing and Substance Use
        - Anxiety and Stress
        - Suicide
        - Depression
        - Primary Prevention, Substance Misuse, and Overdose Prevention
        - Tobacco/E-Cigarette Use
        - Alcohol Use
        - Adverse Childhood Experiences
        - Healthy Eating
- Domain: Neighborhood and Built Environment
    - Priority Area: Safe and Healthy Communities
        - Opportunities for Active Transportation and Physical Activity
        - Access to Community Services and Support
        - Injuries and Violence
- Domain: Health Care Access and Quality
    - Priority Area: Health Insurance Coverage and Access to Care

        - Access to and Use of Prenatal Care
        - Prevention of Infant and Maternal Mortality
        - Preventive Services for Chronic Disease Prevention and Control
        - Oral Health Care
    - Priority Area: Healthy Children
        - Preventive Services
            - Immunization
            - Hearing Screening and Follow Up
            - Lead screening
        - Early Intervention
        - Childhood Behavioral Health
- Domain: Education Access and Quality
    - Priority Area: PreK-12 Student Success and Educational Attainment
        - Health and Wellness Promoting Schools
        - Opportunities for Continued Education

In addition, more information on the Prevention Agenda can be found at
Prevention Agenda 2025-2030: New York State's Health Improvement Plan

Glens Falls Hospital Prioritization of Significant Health Needs

Through the ARHN collaborative, GFH coordinated with Warren and Washington counties to conduct a CHA 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. While Saratoga County Public Health's CHA is not yet finalized, GFH remains in contact with county leadership 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 organization's CHA provides the rationale behind the prioritization of significant health needs. The following table outlines the most significant health needs identified in each county within the GFH service area.

	Warren County	Washington County	Saratoga County/Saratoga Hospital

Prevention Agenda 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. 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 2025-2027:

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 CSP 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 Development

GFH utilized the results of the corresponding CHNA to develop this 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 and community assets and identified new initiatives to complement and further enhance these existing programs. As a result, this Implementation Strategy 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 Glens Falls Hospital Affairs Committee for approval.

Priority Populations

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 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 2025-2027

The following three-year action plan includes initiatives led by GFH to address the prioritized community health needs. It includes initiatives to address 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.

The interventions were selected by GFH by aligning with the Prevention Agenda goals, building on existing initiatives and community assets, and identifying new initiatives to complement and further enhance these existing programs. Capacity, funding, and potential impact were also major considerations. The inventions with a checkmark are the selected strategies that are included in the formal DOH required Community Service Plan.

In the corresponding action plan, 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.

Social and Community Context

- **Mental Wellbeing and Substance Use**
  - Tobacco/E-Cigarettes Use
    - ✓Health Systems for Tobacco Free New York
    - ✓CR Wood Cancer Center – Smoking Cessation Programs

Healthcare Access and Quality

- **Health Insurance Coverage and Access to Care**
  - Preventive Services for Chronic Disease Prevention and Control
    - ✓Cancer Services Program
- **Healthy Children**
  - Preventative Services
    - Hearing Screening and Follow Up
      - ✓Audiology screenings

Education Access and Quality

- **PreK Student Success and Educational Attainment**
  - Health and Wellness Promoting Schools
    - ✓Creating Healthy Schools and Communities

Glens Falls Hospital Initiatives

GFH Initiative/Improvement Strategy: Creative Healthy Schools and Communities

Brief Description/background:

Creating Healthy Schools and Communities (CHSC) addresses obesity through the increase of physical activity and access to healthy foods. CHSC assists school districts, the community and early childcare centers in policy adoption and implementation efforts. 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. CHSC works utilizes the School Wellness Policy required by the USDA under the Federal School Meals program to wellness committees by incorporating a wide range of members, goals for wellness, and regulations related to creating a healthy school environment. CHSC uses both the Comprehensive School Physical Activity Program and the Whole School, Whole Community, Whole Child Model as tools for implementation. 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:

Chronic Illness, Access to healthy foods, Environmental Factors, Access to Physical Activity, Obesity

Goal:

School Wellness Policies, utilized by active School Wellness Committees, to address health disparities within the school environment to decrease the percentage of chronic absenteeism and implementation.

SMART(IE) Objective(s)	**Performance Measure(s)**
Decrease the percentage of chronic absenteeism (defined as missing more than 18 days (>10%) per academic year) among public school students in grades K-8 who are economically disadvantaged from 34.9% to 24.4%. **(SMARTIE)** Decrease the percentage of chronic absenteeism (defined as missing more than 18 days (>10%) per academic year) among public school students in grades K-8 from 26.4% to 18.5%.	• # of schools with update wellness policies • # of schools with wellness committees that meet four times a year • % of economically disadvantaged students with chronic absenteeism • % of students with chronic absenteeism • % of students obese or overweight • % of students who participate in school lunch, breakfast and other related food programs • % of schools participating in the New York State Farm to School Program • # of school meeting required New York State Physical Education Minutes • # of schools with update wellness policies

	• # of schools with wellness committees that meet four times a year • % of schools with Staff Wellness Programs • % of Schools with Family and Community Engagement Initiatives

Activities

Utilize resources to support updates of school wellness policies and implement wellness committee programs and goals, related to physical activity and nutrition.

Improve the nutrition environment throughout the school building as stated within wellness policies using available interventions such as universal meals school nutrition programs, healthy vending and ala carte, healthy marketing, and nutrition education in alignment with New York State Education Standards and Requirements.

Increase universal school meal participation by providing healthy options, fresh fruits and vegetables, grab and go breakfast options, taste testing, smarter lunchroom techniques, and Farm to School programming.

Utilize a Comprehensive School Physical Activity Program to increase physical activity for students throughout the day, incorporating movement into recess, classroom lessons, breaks, walking and biking to school, before and after school opportunities and physical education classes that focus on life-long physical activity.

Promote safe walking and biking to school to increase physical activity utilizing policy and Safe Routes to School programming and education.

Integrating the Whole School, Whole Community, Whole Child model (WSCC) into policy and practice to provide support and resources to implement the ten WSCC components.

Promote student wellness through the assessment, development, improvement, and implementation of local School Wellness Policies.

Partners/roles:

- Creating Healthy Schools and Communities technical assistance and implementation materials related to the School Wellness Policy, Farm to School Initiatives, physical activity, Safe Routes to School, and the Whole School, Whole Child, Whole Community Model, including Family and Community partnerships, events, and collaboration.
- School District Staff and Wellness Committees to adopt and implement policy related to health, nutrition environment, Farm to School programs, physical activity, and Whole School, Whole Community, While Child model, and Safe Routes to School.

- Community partners and organizations join school wellness committees to provide resources and technical assistance, if available.
- New York State Department of Education's capacity to perform audits of school food programs in districts reporting on compliance with wellness policy implementation.
- School Food Nutrition Staff utilizing campaigns such as Fruit and Vegetable of the Month, Farm to School, and School Lunch and Breakfast Week to increase participation.
- School and Community wide marketing of the Universal Free Meals Program.
- Comfort Food Community administration supports schools participating in Farm to School, providing local purchasing of fruit and vegetables.
- Cornell Cooperative Extensions with Farm to School initiatives and educational programs related to nutrition and growing.
- Local Towns and Village Boards, Department of Public Works, and decision makers adopting complete streets policies and implementing safe walking and biking infrastructure.
- School District Parent Teachers Organizations, School Led Parent Universities, and Community Partners, such as Cornell Cooperative Extension, providing family education programs.

GFH Initiative/Improvement Strategy: Preventative Services for Chronic Disease Prevention and Control – Cancer Services Program of Warren, Washington and Hamilton Counties

Brief Description/background: The Cancer Services Program (CSP) of Warren, Washington and Hamilton Counties will cover the cost of Colorectal Cancer Screenings for people aged 45+ who are uninsured or underinsured. The Cancer Services Program of Warren, Washington and Hamilton Counties is currently in a is a 5-year grant funded by the state of New York and held by Glens Falls Hospital.

Disparities Addressed: The CSP will cover the cost of those who are uninsured aged 45 and over or those that are younger but have been determined to be at a high or increased risk for colorectal cancer by a physician. In some instances, those that are insured but have a cost share that will deter them from being screened can also be enrolled in the CSP. The CSP targets those in rural populations that have barriers to care such as transportation, language barriers, familial obligations and limited resources and education. This population is prioritized because of the increased risk of cancer due to not being regularly screened.

Goal: Increase the percentage of adults aged 45 to 75 years who are up to date on their colorectal cancer screening.

SMART(IE) Objective(s)	**Performance Measure(s)**
Based on the most recent guidelines, the CSP wants to increase the percentage of adults aged 45 to 75 years who are up to date on their colorectal cancer screening.73.7% to 82.3%.	- Percent of clients who are male. - Percent of clients re-screened for fecal test within 10-14 months - Percent of female clients with comprehensive cancer screenings. - Percent of abnormal colorectal screenings with timely follow ups. - Monthly reports generated from Catalyst to evaluate progress.

Activities:

- The CSP will offer Fecal Immunochemical Test (FIT), Colonoscopy and/or Flexible Sigmoidoscopy to eligible clients.
- The CSP will hold education sessions in the community about the importance of colorectal cancer screenings and how to get screened.
- The CSP will offer patient navigation services to help with SDoH.
- Partner with community organizations to target population of focus.
- Partner with healthcare facilities to offer services and reach the population of focus.
- Meet with legislators to encourage support for the program.

Partners/roles:

- This initiative partners with Medical Health Systems, county health departments, community organizations, private businesses, schools, town and county chambers of commerce, to engage and refer eligible clients to the CSP and increase awareness by education.

GFH Initiative/Improvement Strategy: Health Systems for Tobacco Free NY	
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, all disparate populations age 18+ that are disproportionally targeted 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: Eliminate the harms caused by commercial tobacco product use and exposure.	
SMART(IE) Objective(s) Reduce the percentage of adults who use tobacco products from 19.7% to 17.0%. (ARHN Regional Stat)	**Performance Measure(s)** - Number of people served by intervention; number of successful referrals made - Participation among organizations of focus, number of people screened; number of successful referrals made - Number of health care providers trained, capacity of providers to treat tobacco use disorder, number of people treated by trained providers
Activities: • Connect patients with referral services • Implement screening for tobacco use and navigate to appropriate services (i.e., ask, advise, assist) in all health care practice settings • Promote evidence-based training programs such as Tobacco Treatment Specialist training for health care providers to treat tobacco use disorder.	
Partners/roles: • This initiative partners with Medical and Behavioral Health Systems and specifically looks to engage providers and administrators or other key decision makers of those systems. This could include hospital systems, Federally Qualified Health Centers and/or private practices.	

GFH Initiative/Improvement Strategy: Newborn Hearing Screenings
Brief Description/Background:. The New York State Early Hearing Detection and Intervention program supports the initiative to increase the proportion of newborns who are screened for hearing loss by no later than 1 month and have audiologic evaluations by 3 months. NYS Public Health Law requires all maternity hospitals and birthing centers to administer newborn hearing screening programs and track the outcomes in the New York Early Hearing Detection and Intervention System (NYSEHDI-IS) online via the Health Commerce System. The Glens Falls Hospital Snuggery and The Glens Falls Hospital Hearing Center collaborate to achieve this objective. • Newborns receive a hearing screening during their hospital stay at Glens Falls Hospital by the Snuggery Department and document results in the infant's chart and in the NYSEHDI-IS registry.

- Those newborns who do not pass the initial screening during their hospital stay are referred to the GFH Hearing Center for an outpatient newborn hearing screening to be performed within one month.
    - Referrals are sent over from the GFH Snuggery and documented by the Snuggery in the NYSEHDI-IS registry. Additional internal tracking is done for scheduling by the GFH Hearing Center.
- Newborns that fail their initial hearing screening will receive a second screening within one month by the GFH Hearing Center and document the results in the infant's outpatient chart and in the NYSEHDI-IS registry.
    - If the infant does not pass the second newborn screening, the GFH Hearing Center will:
        - Schedule the infant at AMC or Sunnyview for a full diagnostic audiological assessment as they have specific equipment for newborns to perform the testing.
        - Refer the infant for Early Intervention Services
        - Send the PCP also receives a report with recommendations.
- All information and return visits for screenings and diagnostic evaluation are entered into the NYS registry and in the infant's chart by the GFH Snuggery and/or the GFH Hearing Center.
    - Once a month, the NYSEHDI-IS registry is checked by the GFH Snuggery and GFH Audiology Department to be sure the newborn has returned for follow up.
        - If the infant does not return for the second screening, two attempts are made by the Snuggery to reschedule the screening. This is documented in the NYSEHDI-IS registry and in the infant's hospital chart.
        - If an infant who had failed the second screening, does not return for the full diagnostic assessment then two attempts are made by GFH Audiology Department to reach the parent. This is documented in the NYSEHDI-IS registry and in the infant's outpatient chart.

Goal: Increase the number of newborns born at Glens Falls Hospital who receive a hearing screening and follow up if warranted.

SMART(IE) Objective(s)	**Performance Measure(s)**
Increase the percentage of infants who receive a diagnostic hearing evaluation after not passing their newborn hearing screening 65% to 75%	Expressed as a percentage: Number of newborns delivered at Glens Falls Hospital who failed second screening compared to Number of newborns delivered at Glens Falls Hospital who failed second screening and had a full audiological evaluation
Increase the percentage of infants who receive a diagnostic hearing evaluation after not passing their newborn hearing screening by 3 months of age from 75% to 85% **(SMARTIE)**	Expressed as a percentage: Number of newborns delivered at Glens Falls Hospital who failed the second screening and received a full audiology assessment by 3 months compared to Total number of newborns who failed the second screening and received a full audiology assessment
Activities	

- Provide initial newborn hearing screening and second newborn screening if warranted
- Refer newborn for additional assessments and services if indicated by screening
- Collaborate with internal departments and external partners to schedule initial appointments and follow up and reschedule missed appointments
- Track and document newborn results, referrals and outcomes in NYSEHDI-IS and in newborn chart

Partners/roles:

- Glens Falls Hospital Snuggery-Initial screening, Facilitate and follow up on referrals to the Hearing Center, data entry and tracking in NY Health Commerce System
- Glens Falls Hospital Hearing Cetner-Outpatient screenings, Refer for Additional Audiology assessments and follow as warranted
- Albany Med Audiology Department-Full Newborn Audiology Assessments and follow up as warranted
- Sunnyview Audiology Department-Full Newborn Audiology Assessments and follow up as warranted
- Families-Utilizing the services

<table>
<tr><td colspan="2">GFH Initiative/Improvement Strategy: Cancer Services Program of Warren, Washington and Hamilton Counties</td></tr>
<tr><td colspan="2">Brief Description/background: The C.R. Wood Cancer Center offers a comprehensive program of cancer care services from advanced treatments and innovative education and support programs to early detection and cancer prevention. We offer smoking cessation programs for patients who are diagnosed and currently being treated for cancer or blood disorders.</td></tr>
<tr><td colspan="2">Disparities Addressed: Oncology patients who are current smokers will have a better health outcome and reduce their risk of getting a second smoking related cancer. Individuals at high-risk for poor health outcomes</td></tr>
<tr><td colspan="2">Goal: Promote tobacco cessation for oncology patients who smoke</td></tr>
<tr><td>SMART Objective(s) 14.0 Reduce the percentage of adults who use tobacco products from 9.3% to 7.9%.</td><td>Performance Measure(s)
-EMR will be used to monitor the number of newly diagnosed patients seen vs the number of patients screened for smoking status,
-Current smokers will be monitored for the number of patients who are referred to resources
-Total patients served per year
-Percent decrease of cigarettes smoked by oncology patients participating in program</td></tr>
<tr><td colspan="2">Activities:
Utilize 5 A’s and implement evidence-based tobacco treatment programming to patients identified as tobacco dependent
Identify a staff member as a Tobacco Treatment Lead (TTD) and complete virtual Rutgers Certified Tobacco Treatment Specialist Training
Establish a system to offer/provide NYS Quit line resources
Establish a referral system to onsite Certified Tobacco Treatment Specialist</td></tr>
<tr><td colspan="2">Partners/roles:
This initiative partners with Medical Health Systems, county health departments, community organizations, private businesses, schools, town and county chambers of commerce, to engage and refer eligible clients to the CSP and increase awareness by education. Partners will also include Health Promotion Center and North Country Nicotine Consultants, The Heart Network, NYS Quitline, Warren/Washington Country Tobacco Coalition</td></tr>
</table>

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 and in support of the interventions, initiatives, strategies and activities defined within this Community Service Plan. 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 support, 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, as well as Saratoga Hospital, 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 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 specialist 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/.

Dissemination

The GFH IS, along with the corresponding CHNA, is available at https://www.albanymed.org/glensfalls/glens-falls-hospital-health-promotion-center/.

The previous three most recent CSPs, CHNAs, and Implementation Strategies are also available on the site. GFH will use various mailings, newsletters and reports to ensure the availability of the CSP and the action plans are 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 CHNA Committee worked with Senior Leadership to develop the plans, which were presented to the Glens Falls Hospital Affairs Committee for approval. The Affairs Committee was provided with an overview summary of the CHNA and IS in advance and a brief presentation was conducted during a regular monthly meeting to communicate highlights and answer questions. The CHNA and IS were approved on November 20, 2025. A signed copy is available upon request.