Glens Falls Hospital

Community Service Plan

2013 – 2015: Update for 2015

Table of Contents

Introduction

The purpose of this document is to provide an update to the three-year Community Service Plan. Glens Falls Hospital (GFH) developed the Community Service Plan (CSP) for 2013-2015 to identify and prioritize the community health needs of the patients and communities within the GFH service area, and develop a three-year plan of action to address the prioritized needs. The plan was developed in collaboration with Warren, Washington and Saratoga County Public Health Departments, and includes strategies that are evidence-based and aligned with the NYS Prevention Agenda 2013 – 2017. The CSP addresses the requirements set forth by the NYS Department of Health, which asks hospitals to work with local health departments to complete a CSP that mirrors the Community Health Needs Assessment (CHNA) and Implementation Strategy (IS) required by the Affordable Care Act (ACA). GFH combined the CHNA and IS documents to create the CSP. The original CSP can be found on the Glens Falls Hospital website at http://www.glensfallshospital.org/services/health-promotion-center.cfm.

This update is provided as of December 2015 and represents the progress on the three-year Plan.

Glens Falls Hospital

GFH is the largest and most diverse healthcare 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, the largest employer in the region, and the tenth largest private sector employer in Northeastern New York. The Healthcare Association of New York State (HANYS) estimates GFH's total annual economic impact on the region to be more than $516 million.[1] More than 300 affiliated physicians and more than 100 physician extenders provide services that combine advanced medical technology with compassionate, patient-centered care.

GFH serves as the hub of a regional network of healthcare 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 hospital's main campus, these services are provided through 11 neighborhood primary care health centers and physician practices, several outpatient rehabilitation sites, seven specialty practices (including three staff endocrinologists), three occupational health clinics, and a rural school-based health center. These community-based care sites afford GFH unique opportunities to link hospital-based services to primary care and community health services in historically underserved rural communities.

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 core values, which support our ability to fulfill our mission in our community, are **C**ollaboration, **A**ccountability, **R**espect, **E**xcellence and **S**afety (CARES). GFH has worked to create healthier communities since its founding in 1897, and is actively implementing countless care transformation initiatives to support the Institute for Healthcare Improvement's Triple Aim of better health, better care and lower costs.

[1] Healthcare Association of New York State, *The Impact of Glens Falls Hospital on the Economy and the Community*, January 2013.

New York State's Prevention Agenda 2013 - 2017[2]

In collaboration with regional planning partners, Glens Falls Hospital utilized the NYS Prevention Agenda framework to plan, inform and guide the Community Service Plan. *The Prevention Agenda 2013-17* is New York State's Health Improvement Plan for 2013 through 2017, developed by the New York State Public Health and Health Planning Council (PHHPC) at the request of the Department of Health (DOH), in partnership with more than 140 organizations across the state. This plan involves a unique mix of organizations including local health departments, health care providers, health plans, community-based organizations, advocacy groups, academia, employers as well as state agencies, schools, and businesses whose activities can influence the health of individuals and communities and address health disparities.

The *Prevention Agenda* serves as a guide to local health departments and hospitals as they work with their community to assess community health needs and develop a plan for action. *The Prevention Agenda* vision is "New York as the Healthiest State in the Nation." The plan features five areas that highlight the priority health needs for New Yorkers:

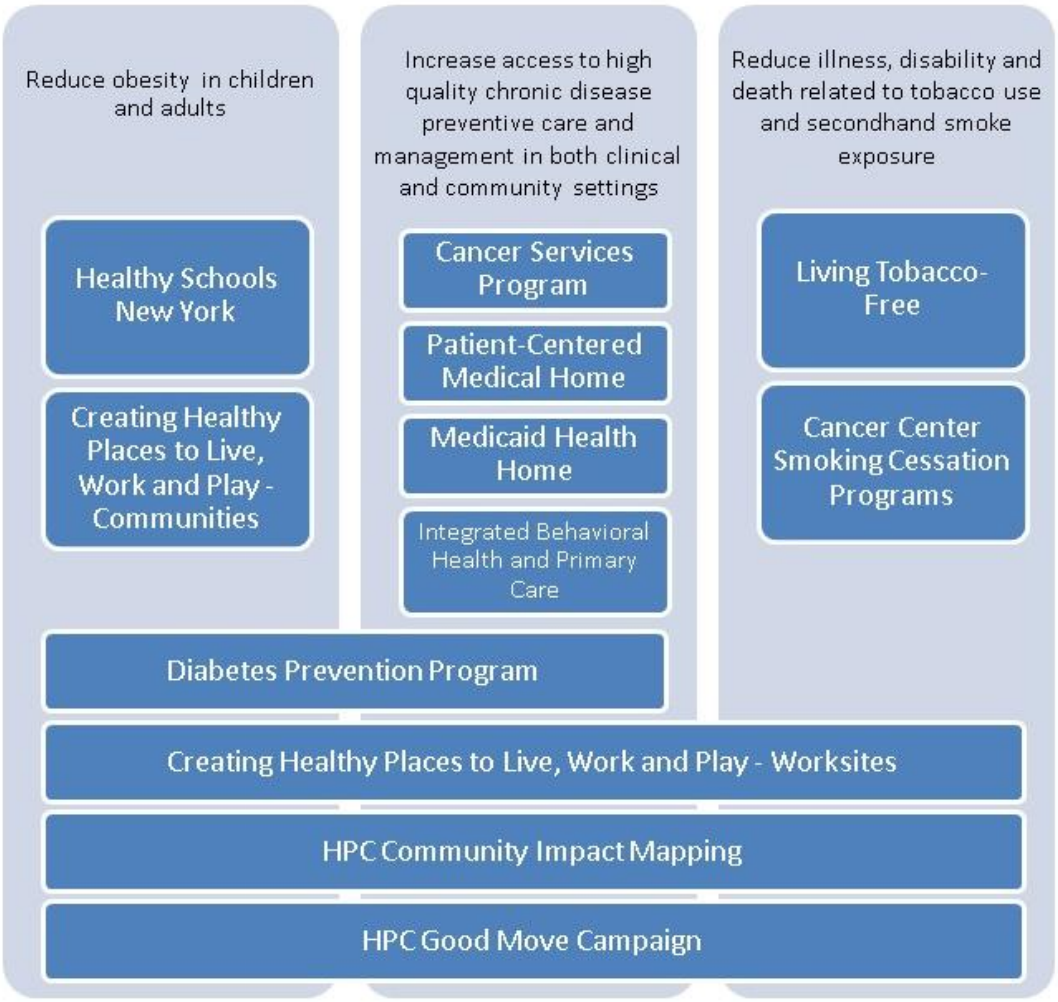
- Prevent chronic disease
- Promote healthy and safe environments
- Promote healthy women, infants and children
- Promote mental health and prevent substance abuse
- Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases and healthcare-associated Infections

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. Throughout the assessment, these priority areas were used as a foundation for determining the most significant health needs for the GFH service area. More information about the Prevention Agenda can be found at http://www.health.ny.gov/prevention/prevention_agenda/2013-2017.

Action Plan Update

The Community Service Plan update is structured using the original three-year Action Plan. The three-year Action Plan includes initiatives led by GFH to address the prioritized community health needs. It includes 12 initiatives to address the three focus areas under the Prevent Chronic Disease priority area of the NYS Prevention Agenda. These focus areas and initiatives were selected through a systematic, community-led process for prioritizing community health needs. This process is outlined in detail within the original Community Service Plan for 2013 – 2015. Many of the initiatives have impacted more than one focus area and three of the initiatives address all three focus areas. Each initiative is presented below and includes a brief description, health disparities addressed, goal, SMART objective(s) and corresponding performance measure(s), and key activities for the improvement strategy. At the bottom of each initiative, a narrative update is provided to highlight progress and accomplishments over the past three years, from 2013 - 2015. Within the narrative, the current status of each performance measure is also provided. GFH continues to be actively involved in the counties' and other partner-led initiatives.

[2] Adapted from the New York State Department of Health, Prevention Agenda website, http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/summary.htm



All of the originally identified initiatives have continued to be priorities for GFH. However, it is important to note changes in the scope of work for four of the originally identified initiatives. The Tobacco Cessation Center, which is included in the original Community Service Plan, ended in June 2014 due to the end of a five-year contract with NYS DOH. GFH successfully submitted two proposals for continued and expanded funding, which is now supporting a larger tobacco cessation initiative entitled Living Tobacco-Free. Living Tobacco-Free incorporates many of the same goals of the previous Tobacco Cessation Center, and also expanded GFH tobacco cessation strategies to communities and youth. Consequently, the visual above depicting the priority initiatives was updated at the end of 2014 to remove the Tobacco Cessation Center and replace it with Living Tobacco-Free. In addition, Healthy Schools New York, Creating Healthy Places to Live, Work and Play – Communities, and Creating Healthy Places to Live, Work and Play – Worksite ended in September 2015 due to the end of a five-year contract with NYS DOH. GFH also submitted a successful proposal for continued funding, which is now supporting a new, combined initiative, Creating Healthy Schools and Communities. The impact of the previous three initiatives is outlined within the following narrative and the progress relating to Creating Healthy Schools and Communities will be included in the GFH Community Service Plan for 2016 – 2018.

GFH Initiative/Improvement Strategy: Healthy Schools New York	
Initiative – Brief Description/Background: The Healthy Schools New York initiative works with school districts to implement policy, systems and environmental changes to promote consumption of healthy foods and beverages, and expanded opportunities to be physically active, including compliance with state physical education requirements. Healthy Schools NY is a program of the Health Promotion Center of Glens Falls Hospital and is partially funded by the New York State Department of Health. This initiative is implemented in Warren, Washington and Saratoga counties, in addition to Fulton and Montgomery counties.	
Health Disparities Addressed: Low socio-economic status populations as demonstrated by schools with the highest levels of students qualifying for free/reduced lunch	
GFH Goal: Improve the health of people in the GFH region through prevention of childhood obesity in early child care and schools**.**	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, increase opportunities for physical activity, before, during and after the school day for all students in grades K-12 by developing or revising the physical activity policy in 12 school districts.	# of school districts initiating the process of assessing and developing or revising the policy as either a separate school board approved policy or integrated into the school district's local school wellness policies
By December 2015, improve school environments to support and promote healthful eating for all students in grades K-12 by developing or revising the nutrition policy in 12 school districts.	# of school districts initiating the process of assessing and developing or revising the policy as either a separate school board approved policy or integrated into the school district's local school wellness policies
Activities	
Obtain administrative commitment from school, finalize MOU and identify a primary school liaison.	
Establish or enhance a wellness committee and assist the committee in establishing a physical activity/nutrition policy assessment, development, implementation and evaluation timeline.	
Review the current policies and/or develop new policies and identify strengths, weaknesses and opportunities for improvement.	
Engage key PA and nutrition staff to support implementation of the policies and provide support to ensure approval.	
Provide assistance and guidance to ensure effective implementation of policies and communication throughout the school community.	

2013-2014 Update:
Through the end of 2014, the Healthy Schools New York program has successfully engaged 15 school districts to begin initiating the process of assessing and developing or revising wellness policies as either a separate school board approved policy or integrated into the school district's local school wellness policies, specifically those policies that are reflective of increased physical activity and increased nutritional offerings. Of these districts, 11 initiated this process between 2013 and 2014, and four began prior to 2013.

To date, this work has resulted in the evaluation, revision, Board of Education adoption and implementation of six comprehensive wellness policies that increase opportunities for physical activity and nutrition. Seven additional policies have been drafted with anticipated completion, adoption and implementation dates in 2015.

This work has reached over 41,000 students and their families through the implementation of sustainable policies and interventions that increase student access to better nutritional choices and increased opportunities for physical activity during the school day.

2015 Update:
Over the course of the five-year funding cycle, Healthy Schools New York actively engaged 15 local school districts to work on the initiatives prescribed under this funding guidance, including wellness policy change related to physical activity and healthful eating. Of that, 13 districts progressed to the point of completing baseline WellSAT pre-assessments and 8 completed the entire process of policy assessment, revisions, administrative approval and implementation of comprehensive local wellness policies. Two additional districts completed revisions to their required Physical Education, which were submitted to the New York State Department of Education. The interventions from this program have changed both policy and practice when looking at how to best provide the school community with opportunities and access to quality nutrition and physical activity. The funding to deliver this program ended September 2015. Progress and strategies from this initiative will be continued through the Healthy Schools and Communities initiative, funded through the NYS Department of Health beginning October 2015.

GFH Initiative/Improvement Strategy Creating Healthy Places to Live, Work and Play - Communities	
Initiative – Brief Description/Background: The Creating Healthy Places to Live, Work and Play initiative works with community leaders and local governments to design and implement the types of policy, systems and environmental changes that create more opportunities for physical activity and healthful eating. Creating Healthy Places to Live, Work and Play is a program of the Health Promotion Center of Glens Falls Hospital and is partially funded by the New York State Department of Health. Due to funding restrictions, this initiative is only implemented in Warren and Washington counties.	
Health Disparities Addressed: Low socio-economic status populations with limited access to physical activity and healthful foods	
GFH Goal: Improve the health of people in the GFH region through the creation of community environments that promote and support healthy food and beverage choices and physical activity.	
GFH SMART Objective(s)	**Performance Measure(s)**

By December 2015, enhance opportunities for physical activity by implementing 12 policy or environmental changes such as park revitalizations, Complete Streets policies, and other community improvements.	# of joint use agreements, Complete Streets policies and other environmental changes established
Activities	
Engage communities in a GIS mapping exercise to identify community supports for recreation and physical activity. Systematically rate each asset using the Physical Activity Resource Assessment (PARA) tool and collect baseline data to evaluate current usage.	
Identify gaps or deficiencies in community environment and work with partners to create a revitalization plan.	
Conduct evaluation using PARA tool to rate assets after improvements have been made and gather follow-up usage data .	
Develop and implement strategies to increase awareness about the enhancements and promote the improvements and community support.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, improve the food retail environment by implementing 4 policy or environmental changes in the community to support increased availability and visibility of healthful foods.	# of policy/environmental changes that promote healthy foods and increase availability or visibility in grocery stores, convenience stores and other retail outlets
Activities	
Develop and conduct a community nutrition assessment to collect information regarding consumer's food-related behaviors and perceived community assets and barriers to accessing healthy foods.	
Analyze data and generate report of findings, including a plan for action to improve the food retail environment.	
Engage partners to support implementation of the plan of action.	
Assess successes and challenges and communicate regularly with the community on progress and lessons learned.	
2013-2014 Update: In 2013/2014, CHP2LWP engaged 4 communities in a "healthy community mapping" project. The goals of this project were: 1) identify where healthy community assets already exist; 2) create a plan to strategically expand this network of assets in order to build a community that supports healthy behaviors; and 3) utilize resources from CHP2LWP to begin to implement the plan to expand this network of assets. As a result of this project and other similar initiatives coordinated by CHP2LWP, the following environmental and policy changes have been achieved to enhance opportunities for physical activity : • 4 municipalities have adopted "complete streets" policies to enable safe travel for all users, particularly pedestrians and bicyclists • 13 underused parks have been revitalized • 2 schools have adopted or strengthened polices to allow public use of their grounds and facilities and made environmental changes to these facilities to foster active recreation In addition, a community nutrition assessment was conducted and results analyzed. Based on the results of this assessment, an action plan was developed. This action plan included initiatives to link small farms with community service agencies and to pilot a "healthy grab and go" program at small	

grocery stores. The following results have been achieved to support increased availability and visibility of healthful foods:

- 4 farms have been linked to service agencies where fresh produce has been distributed
- 2 " Healthy Grab and Go Produce" pilot programs have been initiated at 2 small, locally-owned grocery stores

2015 Update:
In 2015, CHP2LWP completed its "healthy community mapping" project in 4 communities by implementing plans to expand the network of healthy assets available. At its conclusion, this project achieved 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.

Additionally, in 2015, the "Healthy Grab and Go Produce" pilot program and small farm programs concluded. Due to its involvement with the CHP2LWP pilot program, one small, locally owned grocery store made permeant changes to the layout of the store in order to better promote healthy items. The small farm program resulted in a total of 6 farms distributing fresh produce to 9 service agencies.

GFH Initiative/Improvement Strategy Good Move Campaign	
Initiative – Brief Description/Background: *Good Move* 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, breastfeeding and making use of preventative care. Good Move is a program of the Health Promotion Center of Glens Falls Hospital and is partially funded by the New York State Department of Health through Healthy Schools NY and Creating Healthy Places to Live, Work and Play.	
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 2015, coordinate chronic disease messaging by establishing 60 distribution sites for a campaign to promote awareness of and demand for community, school, and worksite resources as well as preventive care services.	# of community organizations, partners and/or sites distributing and promoting the Good Move campaign
Activities	
Develop a campaign highlighting physical activity, nutrition, breastfeeding, smoking cessation and preventive care messages to encourage individuals and families to take steps toward good health in the community, in the workplace, and in the school.	
Develop a communications 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.	

Conduct an evaluation of the campaign to understand successes and challenges and inform future plans including development of materials and distribution strategies.

2013-2014 Update:
From 2013-2014, *Good Move* promotional materials were distributed to 82 unique entities that included community partners, schools and worksites.

In 2014, the *Good Move* campaign was updated to align with the newly implemented branding guidelines developed by Glens Falls Hospital. A plan was developed to re-launch the campaign and further increase the reach and recognition of the *Good Move* campaign. Strategies included tabling at community-based events, promotional material distribution to partner agencies, displaying banners and bus ads and developing radio ads in our catchment area. In Fall 2014, GFH developed and broadcasted radio ads resulting in 400 radio plays on five local stations.

GFH is also partnering with the Adirondack Flames hockey team for the 2014-15 season to help promote the *Good Move* campaign and its goals of healthful eating and the importance of physical activity. *Good Move* promotional materials and messages are distributed at all 38 Flame's home games.

2015 Update: The *Good Move* campaign continues to be used in the communities we serve to support and reinforce our policy and interventions around increasing physical activity, eating healthy foods, tobacco cessation, breastfeeding and making use of preventative care. Glens Falls Hospital continued to expand additional partnerships throughout the community, as well as maintaining the partnership with the local minor league hockey team, The Adirondack Thunder. Good Move materials and messaging will be distributed and integrated in to all 35 home games during the 2015-16 season. An additional 50+ community partners received the materials in 2015, totaling distribution to over 130 partners in New York State.

GFH Initiative/Improvement Strategy
Creating Healthy Places to Live Work and Play - Worksites

Initiative – Brief Description/Background: The Creating Healthy Places to Live, Work and Play initiative for Worksites supports businesses to design and implement the types of policy, systems and environmental changes that create more opportunities for physical activity, healthful eating, preventive screenings and tobacco cessation. Creating Healthy Places to Live, Work and Play is a program of the Health Promotion Center of Glens Falls Hospital and is partially funded by the New York State Department of Health. Due to funding restrictions, this initiative is only implemented in Warren County.

Health Disparities Addressed: Low socio-economic status populations at high risk for developing chronic disease with limited access to community resources

GFH Goal: Improve the health of people in the GFH region by expanding the role of public and private employers in obesity prevention, tobacco use cessation, and the use of evidence-based care to manage chronic disease.

GFH SMART Objective(s)	Performance Measure(s)
By December 2015, 10 worksites will improve comprehensive worksite wellness programs as measured by an increase in their wellness score by a minimum of 15%.	# of worksites completing a pre and post assessment whose score increases by at least 15%

Activities
Recruit small- to medium-sized businesses to commit to working on evidence-based wellness strategies.
Work with each business to conduct a baseline assessment of worksite wellness.
Provide training and technical assistance to worksites to support implementation of strategies and comprehensive worksite wellness plans.
Work with each business to conduct a post assessment of worksite wellness.
Provide general information on worksite wellness to partners and key stakeholders and develop a promotional campaign to increase awareness of wellness goals and strategies for the business community.
Engage worksites in transition planning to enhance sustainability.
2013-2014 Update: Thirteen small- to medium-sized businesses of varied industries are participating in the Creating Healthy Places Worksite Wellness initiative. Baseline assessments were completed with all worksites; post-assessments have been conducted with six businesses. Four of those six businesses achieved a 15% or greater change in their score across the pre- and post-assessments. Worksites implemented 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. The *Good Move* campaign resources were shared with the business community through meetings, informational events, and placement in local organizations. In addition, information regarding employee health promotion goals, strategies, and processes has been offered to partnering worksites and the larger business community through a variety of newsletters articles and events. **2015 Update:** Over the course of the five-year intervention, all thirteen engaged businesses completed pre- and post-assessments. Seven of the thirteen businesses that completed baseline and post assessments achieved a 15% or greater change in their score across assessments. Worksites implemented 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. The funding to deliver this initiative ended September 2015.

GFH Initiative/Improvement Strategy	Diabetes Prevention Program
Initiative – Brief Description/Background: The Diabetes Prevention Program (DPP) is an evidence-based 16-week lifestyle modification program for people at high-risk for diabetes, or with pre-diabetes. GFH is working to build capacity to deliver the intervention for patients and community members.	
Health Disparities Addressed: Low socio-economic status populations at high risk for developing diabetes with limited access to community resources	

GFH Goal: Improve the health of people in the GFH region by linking health care-based efforts with community prevention activities.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, average weight loss achieved by participants attending at least four core sessions of the DPP is a minimum of 5% of body weight.	% average weight loss for participants attending at least 4 core sessions
Activities	
Establish capacity to deliver the program by training staff to become Lifestyle Coaches	
Determine target population and develop materials, information and a communication plan to promote the DPP and recruit eligible participants.	
Identify a system to manage participant inquiries and interest.	
Establish a schedule for the programs and identify appropriate locations and times for each program.	
Recruit and enroll participants in the program(s) and implement at least 2 16-week lifestyle intervention programs.	
Collect all necessary data and submit to the CDC for recognition.	
Work with internal and external stakeholders to identify sustainability plan including additional funding streams and/or third party reimbursement.	
2013-2014 Update: Between 2013 and 2014, GFH established the necessary capacity to deliver the National Diabetes Prevention Program locally in two GFH health centers. An internal referral system was developed to connect high-risk patients with pre-diabetes to the community-based lifestyle modification program. To date, GFH has held 2 16-week programs and recruited 19 participants. The average weight loss achieved by these participants who attended at least four core sessions of the DPP was 4.7% of body weight. In 2015, GFH plans to offer the program four additional times at four primary care health centers throughout the region. **2015 Update:** Glens Falls Hospital used lessons learned in 2013 and 2014 to define a model for piloting in 2015. This model included the use of an RN from each health center, to provide better linkages to the primary care practice, ensure coverage in case of illness, vacation or staff turnover, and provide a more dynamic coaching experience. Glens Falls Hospital planned to train two RN Care Coordinators to become Lifestyle Coaches. These individuals would then co-lead the sessions with the existing Lifestyle Coaches. Unfortunately, due to the staff turnover, competing priorities and the timing of available trainings, this particular activity has not occurred. Glens Falls Hospital secured funding to continue this program and hopes to reprioritize the plans once staffing is stable, trainings are available and the practices are able to revisit program implementation and participant recruitment plans.	

GFH Initiative/Improvement Strategy	Tobacco Cessation Center
Initiative – Brief Description/Background: The Tobacco Cessation Center works with healthcare provider organizations to implement policies and practices for screening & treating tobacco dependence in accordance with the Clinical Practice Guidelines for Tobacco Use Dependence. The TCC is a program of the Health Promotion Center of Glens Falls Hospital and is partially funded by the New York State Department of Health. This initiative is implemented in Warren, Washington and Saratoga counties, in addition to Fulton and Montgomery counties.	

GFH Goal: Improve the health of people in the GFH region through the promotion of tobacco use cessation.	
Health Disparities Addressed: Low socio-economic status populations at high-risk for chronic disease	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, work with 1 FQHC and 50 other healthcare provider organizations (HCPOs) to adopt systems-level change to screen all patients for tobacco use, provide brief advice to quit at every patient visit and provide assistance to quit successfully.	# of providers signing MOU that complete systems level change
Activities	
Conduct outreach and obtain administrative commitment from new HCPOs.	
Conduct staff training needs assessments with targeted HCPOs.	
Identify site champion and provide on-site training and technical assistance to clinicians and staff.	
2013-2014 Update: The Tobacco Cessation Center (TCC) met its goal of working with 1 FQHC and 50 health system providers to successfully work toward systems change for treating and screening for tobacco dependent patients. All organizations have systems to address tobacco dependence and are working to incorporate it into their EMR systems. Six organizations have adopted Opt-to-Quit and have found it to be an effective addition to their patient education strategies. Over the last five years, the TCC has provided training and consultation to over 175 provider organizations. These organizations developed and adopted health systems change to ensure all patients are screened and treated for tobacco dependence. By solidify these policies, consistent and effective treatment successfully reached the most vulnerable populations. The Tobacco Cessation Center completed its five year grant contract with NYS DOH on June 30, 2014. **2015 Update:** N/A - See Living Tobacco-Free on Page 21	

GFH Initiative/Improvement Strategy	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 twice a year, lead by a health psychologist and held at the Cancer Center. The Cancer Center is currently working to build capacity to offer two additional programs per year, for a total of four programs annually.	
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 2015, 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	
Partner with the Tobacco Cessation Center to certify two additional staff members to provide smoking cessation counseling.	
Provide semi-annual (2013) and quarterly (2014 and 2015) 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.
2013-2014 Update: In early 2014, two resource nurses within the Cancer Center were certified as smoking cessation counselors. There were 4 free 4-week smoking cessation programs held in 2014 with a total of 32 participants for the year. Approximately, 5% of the participants quit smoking entirely and continue to be non-smokers. Another 5% quit for a short time and are working to reduce their current amount smoked. An estimated 15% demonstrated a decrease in the amount smoked and the rest felt they were not ready to commit to quitting at this time. Post evaluation of each session demonstrated that the program was helpful in the amount of knowledge and support offered. We will continue to provide quarterly smoking cessation group classes and individual smoking cessation sessions as needed in 2015. **2015 Update:** The cancer center held four, free 5-week smoking cessation programs in 2015. Previous evaluation results revealed the need for extending the program, as a result, an additional week of support was added to each program. In total, 20 people participated in the smoking cessation programs. Approximately 5% of individuals successful quit smoking and continue to be non-smokers. Approximately 10% quit for a short time and are working on reducing their consumption. An estimated 20% stated a reduction in the amount of cigarettes consumed per day. The rest of the participants were not ready to quit smoking and ongoing support and encouragement was offered as needed. Post evaluations of each session stated the information was helpful for education and support. GFH plans to continue to provide quarterly smoking cessation programs free to the community.

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 Glens Falls Hospital and is partially funded by the New York State Department of Health.		
Health Disparities Addressed: Low socio-economic status populations and uninsured individuals with limited access to screening services		
GFH Goal: Improve the health of the people in the GFH region by increasing screening rates for breast/cervical/colorectal cancer.		
GFH SMART Objective(s)		**Performance Measure(s)**
By December 2015, 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, and • 20% of clients screened are those needing comprehensive screenings (breast, cervical and colorectal)		NYSDOH Cancer Services Program Monthly Performance Measures; PM#2 PM#4 PM#7
Activities		
Develop and implement advertising campaigns during breast, cervical and colorectal cancer awareness months. (October, January & March)		

Broaden inreach efforts within GFH to include ER and Behavioral Health 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.

2013-2014 Update:

The CSP works closely with many community-based organizations, businesses and 'community ambassadors' on campaigns to increase screening rates, which includes a formal committee for planning and implementing cancer awareness campaigns. In 2013-2014, breast cancer awareness radio ads featured local medical providers who participate with the Cancer Services Program. Additionally, newspaper ads featuring the *Greenwich Goes Pink* event were placed throughout the month of October.

A poster was developed to address PM# 2: *rarely to never screened for cervical cancer,* and was distributed to all participating Providers for display in their exam rooms, waiting rooms, and bathrooms. The poster image was also used as a newspaper ad during the month of January. This performance measure is at 45.9%, well above the statewide benchmark of 20%. Colorectal Cancer awareness month in March featured the *Main Streets Go Blue* public event, with campaign posters and blue ribbons placed throughout our catchment area, along with newspaper and radio ads. All three major campaigns successfully increased awareness of the CSP and specifically the colorectal screening rates continue to increase incrementally each month.

Performance measure #4: *percent of clients who are male* remains at the 7.7% mark. Colorectal cancer awareness campaigns will continue as an effort to increase the number of males screened.
In reach efforts are conducted within the GFH Community Health Centers, and the Glens Falls Hospital Breast Center. Referrals are made to the CSP from all departments within GFH when an uninsured individual is identified. Formal inreach practices have not yet been initiated in the ER and Behavioral Health.

With respect to Performance measure # 7, comprehensive screening rates for CSP clients has increased by 13%, based on performance measure data released by DOH for time period 1/13 through 12/14. Referrals, screening and diagnostic services are provided by over 50 participating medical providers in the three-county region (Warren, Washington & Hamilton Counties). In addition, a strong referral based system with approximately 10 area human service agencies and county social service departments is in place.

2015 Update:

Collaborative efforts with community-based organizations and the CSP continue with a more formalized approach in place. Five strategic partnerships were formed during 2015 with local human service agencies. Each agency signed a Memorandum of Understanding (MOU) with the CSP with the intent to refer eligible people for free cancer screenings. Additionally, the CSP increased the amount of radio advertising as a result of proven success with this outreach activity.

Efforts to increase PM#2: rarely or never screened for cervical cancer continued with the poster campaign, in-reach within GFH health centers, GFH Breast Center, the provision of cervical screening education and guidelines to Providers, PSA's and paid radio commercials. This performance measure has increased from 45.9% to 61%. The Statewide average for this PM is 42%.

PM # 4: (percent of clients who are male) has increased from 7.7% to 14.6%. We attribute the success of doubling our screening rates for males to consistent radio advertising with commercials airing throughout the year. The commercials are geared toward the male population, and additionally the ease of enrollment is promoted. The messaging emphasizes that all it takes is a phone call and a take-home fecal screening test will be mailed to those who meet eligibility requirements. Feedback has shown that this is instrumental to reach the male population.
Our work on PM#7 to increase the rates of comprehensive screenings (breast, cervical, colorectal) are showing improvement at 51.2%, however we still remain below the statewide average at 63.2%. We have initiated measures to address this; both at the intake process and again after screenings are completed when data collection begins, to ensure that all eligible screenings are completed.

GFH Initiative/Improvement Strategy	GFH Patient-Centered Medical Home Initiative
Initiative – Brief Description/Background: Within the 11 health centers, GFH is working to transform the model of primary care delivery through implementation of patient-centered medical homes. This transformation will strengthen the physician-patient relationship by replacing episodic care with comprehensive primary care focused on providing high quality, evidence based care and coordinating care across all settings. Whole-person and patient-centered care is facilitated by a team based approach to self-care support, care management/ coordination, and enhanced access.	
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 2015, expand the use of the patient-centered medical home model in 11 GFH health centers.	# of health centers receiving level 3 PCMH recognition from NCQA
Activities	
Adapt and use certified electronic health records to support clinical decision making, population management, improvement in clinical quality measures, and coordination of care.	
Upgrade to the 2012 functionality of Epic, the electronic medical record system for GFH.	
Attest to Meaningful Use	
Engage GFH health centers in the completion of the Enhanced Primary Care training program through CDPHP.	
Create linkages with and connect patients to community resources for physical activity, nutrition and social support.	
Develop a referral tracking process that ensures follow up and coordination of care.	
Support and inform care delivery, coordination, and patient engagement through the utilization of a longitudinal plan of care.	
Develop and implement patient advisory councils for all primary care health centers to involve patients in quality improvement process.	

2013-2014 Update:
All 11 Primary Care Physician Practices have attained Level Three Patient-Centered Medical Home Recognition through NCQA and completed the Enhanced Primary Care Training Program through CDPHP. The formation of Patient Advisory Councils in each practice has led to valuable feedback regarding the patient experience and opportunities for performance and quality improvement. All Eligible Professionals within the Physician Practices successfully met and attested to Stage 1 of Meaningful Use in February 2014 for the 2013 reporting year. The Epic Electronic Medical Record has been successfully upgraded to support Stage 2 of Meaningful Use as well as additional population and care management workflows. The referral process has been enhanced to include a tracking process for all ordered referrals as well as a streamlined process for providing outside care providers with a summary of care document to enhance communication during transitions.
Care Coordinators have been embedded in several health centers to support care delivery, initiate a longitudinal plan of care, support self-care activities and enhance coordination and evaluation of needed services.

2015 Update: -
Glens Falls Hospital continued to expand the patient-centered medical home model in 2015. Currently, all 11 health centers maintain NCQA recognition through the 2011 standards. A gap analysis was conducted to determine areas for improvement to satisfy the application requirements for the 2014 standards. A focus for 2015 was care management strategies, including revised criteria for how patients would be selected for care management support. Care management includes systematically identifying individual patients to plan, manage and coordinate care, based on need. This includes treatment, lifestyle and self-management goals, as well as comprehensive medication management. Glens Falls Hospital selected the following priority populations for care management: individuals with uncontrolled diabetes (HbA1c >9), individuals with depression (PHQ9 score >9), individuals referred through Medicaid Health Home, individuals with 20 or more medications, and unemployed individuals. The workflow in the EMR was modified to eliminate additional navigation through the chart and allow for medication management and barriers to be documented within the care plan. The goal is to streamline where care management documentation and planning is throughout the chart.

An additional focus for 2015 was formally defining the primary care team roles and responsibilities in order to ensure provision of patient-centered and population-focused care. Further clarification and roles were outlined for the Office Manager, Lead Physician and Nurse Ambassador, as well as the embedded Care Coordinator as it relates to patient-centered care. Glens Falls Hospital continues to strategically identify health centers for embedded care coordinators, with a goal to ensure care coordination is available to all high-risk, high utilizing patients, or those in need of the support. Patient Advisory Councils also continue to meet twice a year.

Glens Falls Hospital completed the corporate application in December 2015 for recognition under the NCQA 2014 standards. Next steps include the submission of site specific applications in 2016, along with continued enhancements to the practices to support the model and future plans for advanced primary care.

GFH Initiative/Improvement Strategy: Integrate Behavioral Health and Primary Care	
Initiative – Brief Description/Background: GFH is working to advance health care for older adults 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 by promoting the use of evidence-based, integrated care to prevent and manage chronic disease.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, 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.	
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.	
Finalize and implement communications plan, including the development of relevant educational materials.	
Ensure appropriate orientation and training for newly hired NPPs and LCSWs.	

2013-2014 Update:
Integration is a strategic priority for Glens Falls Hospital and continues to be a major focus for our primary care practices. In 2014, GFH successfully launched our primary care and behavioral health integration effort at the Greenwich Family Health Center. Nearly 300 patients took advantage of the integrated service offered by the psychiatric nurse practitioner providing psychiatric assessment and diagnosis, integrated care planning, referrals, ongoing treatment and medication management. Additionally, in late 2014 an LCSW was successfully added to the care team introducing the capacity for verbal therapy, health education and the facilitation of psycho-social interventions. Next steps include expansion of the care team model to the second practice (Granville Family Health Center), workflow redesign supporting a fully integrated electronic health record and population-based screening and assessment specific to behavioral health needs (i.e., depression, anxiety and substance abuse).

2015 Update:
In 2015, Glens Falls Hospital launched the integrated social work model in the Greenwich Family Health Center. The purpose of this role was to enhance the existing services provided by the psychiatric nurse practitioner through education and verbal therapy based on primary care provider consultation and referral. Early in 2015, the psychiatric nurse practitioner (NPP) role was vacated. Glens Falls Hospital continues to recruit to this position for Greenwich and other practices, however, the severe national shortage of behavioral health practitioners, including NPPs, is extremely evident in Upstate NY. This shortage has created many challenges in trying to expand the model within Greenwich or to other practices. However, Glens Falls Hospital has continued to explore alternative models for integrated care and has reached 615 distinct patients through December 2015. Greenwich continues to be the sole health center with a psychiatric provider or social worker. Glens Falls Hospital continues to plan for expansion to other regional locations, pending successful recruitment.

GFH Initiative/Improvement Strategy	Medicaid Health Home Program
Initiative – Brief Description/Background: GFH is designated as a health home provider under the New York State Medicaid Health Home Program. A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. The target population is individuals with complex chronic conditions including medical and behavioral care needs that drive a high volume of high cost services such as inpatient and long term institutional care.	
Health Disparities Addressed: Low socio-economic status populations on Medicaid disproportionately affected by complex chronic conditions	
GFH Goal: 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 2015, 50% of enrolled members will be affiliated with a GFH primary care practice.	% of enrolled members that have a GFH provider listed as their PCP
Activities	
Convene an internal care coordination workgroup to begin to identify current capacity, gaps and needs.	
Utilize Epic 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, 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.	

2013-2014 Update:

In March 2014, Glens Falls Hospital (GFH) joined Adirondack Health Institute (AHI) as a member organization. As a result of this collaboration, the two Health Homes merged. As a member of AHI, GFH no longer needed to maintain 'lead Health Home' designation. GFH continued to provide Health Home care management services, as a subcontractor of the AHI lead Health Home, effective on or around July 1, 2014. This collaboration served to further enhance the effectiveness of this initiative, while consolidating the administrative functions for both Health Homes. Consequently, GFH will no longer focus on identifying new downstream providers.

In the Fall 2014, the existing GFH Intensive Case Management and Health Home services transitioned into the Community Care Coordination (CCC) department of Glens Falls Hospital. Currently, CCC includes the services provided to individuals and families in this region through the Health Home program, Intensive Case Management for youth, and the Coordinated Children's Services Initiative. The CCC department will continue to evolve overtime to include additional population health management functions relevant to PCMH, DSRIP, the Adirondacks ACO and other quality improvement initiatives.

As of December 2014, GFH was providing Health Home services to nearly 240 eligible Medicaid members, 46% of which have a GFH clinician listed as their primary care provider. An internal care coordination workgroup continues to meet as needed to address capacity, gaps and needs. This workgroup, in addition to other key stakeholders, helped to inform a care coordination assessment conducted in the Fall of 2014. The results of this assessment serve as a roadmap to guide the development of cohesive, integrated and system-wide care management. GFH continues to expand partnerships with community-based agencies, including behavioral health organizations and other major primary care providers, to respond to regional needs and align Health Home with other Medicaid and system transformation priorities. Outreach to existing PCPs continues to be a priority, in addition to

coordination with other internal departments, such as the Emergency Care Center, Inpatient Case Management and Behavioral Health Services.

2015 Update:
Community Care Coordination of Glens Falls Hospital continues to operate as a downstream care management agency for the Adirondack Health Institute Health Home. Outreach and enrollment in Health Home has grown from 240 members in 2014 to nearly 540 individuals as of December 2015. Current reporting challenges with the web-based care management platform do not allow for an accurate assessment for PCP affiliation. However, it is anticipated that it has increased from 46% in 2014. Glens Falls Hospital added a part time Outreach Coordinator/hospital Liaison to engage the individuals in care management support through linkages with the Emergency Department and inpatient Case Management. Glens Falls Hospital continues to plan for numerous administrative changes in 2016 regarding Health Home standards & requirements, as well as the conversion of the Children's Intensive Case Management (ICM) model to Health Home. Community Care Coordination continues to expand partnerships with community-based services, other care management agencies within our region and other internal departments within Glens Falls Hospital.

GFH Initiative/Improvement Strategy	Community Impact Mapping
Initiative – Brief Description/Background: The Health Promotion Center is planning to develop a series of maps to serve as a communication tool with current and future partners, as well as key stakeholders and decision makers. These maps will demonstrate collective impact of DOH funding/initiatives for this area, encourage additional partnerships and engagement in areas that show gaps, and develop a cohesive and integrated strategy to evaluate progress over time.	
Health Disparities Addressed: Low socio-economic status populations with limited access to health care and community resources	
GFH Goal: Improve the health of people in the GFH service area by increasing support for local community initiatives that increase access to high-quality chronic disease preventive care and management services.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, increase awareness of local chronic disease initiatives by sharing the maps with 10 key partners, stakeholders and decision makers.	# of partners, stakeholder and decision makers receiving the maps through formal discussion with HPC staff
Activities	
Select a consultant with expertise and capacity to develop the appropriate maps.	
Develop 5-7 maps to show the entirety of the GFH and grant-specific service areas, disparate populations, initiative-specific engagement, and overall impact of collective DOH-funding/HPC efforts.	
Identify most effective methods to share maps including websites, meetings, mailings, presentations and other formal and informal interactions.	
Present information to key partners, stakeholders and decision makers and offer information on appropriate next steps.	

2013-2014 Update:
In 2013, Glens Falls Hospital worked with a local agency to conceptualize and develop a series of maps to demonstrate the impact of DOH funding and initiatives in this region. In total, five maps were created. One map demonstrated the presence of all the Health Promotion Center's initiative, which was further supported through four initiative-specific maps that outlined the partnerships and impact of each program.

The maps were posted on the Glens Falls Hospital website (http://www.glensfallshospital.org/services/health-promotion-center.cfm) and also used on an Annual Report that was mailed in February 2014 to over 200 organizations, agencies and providers, including all elected officials and key partners. Poster size versions of the maps have also been shared at numerous community events and health care seminars to raise awareness about the presence and impact of DOH-funded initiatives. Currently, the Health Promotion Center has not been able to utilize the maps to engage key partners as they became outdated quickly due to changing regions, priorities and funding. The Health Promotion Center plans to update the maps within the next year once priorities and regional coverage are stabilized for a consistent period of time.

2015 Update: As of 2015, the Health Promotion Center exceed the goal of sharing the maps with new partners. The programs utilize the relevant maps with key partners, stakeholders and decision makers to help educate and raise awareness around the chronic disease prevention initiatives. To date, the maps have not been updated as many of the initiatives ended due to funding. However, these maps continue to be used to illustrate the possibility of impact with new initiatives having similar goals and comparable geographic targets.

In 2015, the Living Tobacco-Free Communities Initiative developed a new map to depict the number of tobacco retailers in close proximity to schools and other vulnerable populations. These maps illustrate the importance of raising awareness of tobacco marketing to youth and populations at highest risk for tobacco initiation and use. The Health Promotion Center of Glens Falls Hospital will continue to explore how best to utilize maps into the future as they were proven to be an effective communication tool.

GFH Initiative/Improvement Strategy	Living Tobacco-Free
Initiative – Brief Description/Background: The Living Tobacco-Free initiative encourages community members to work together to fix the major health and economic implications caused by tobacco-use through education, mobilization and policy change. Living Tobacco-Free is a program of the Health Promotion Center of Glens Falls Hospital and is funded by the New York State Department of Health. The Community and Reality Check components are implemented in Saratoga, Warren and Washington Counties and the Health Systems component is implemented in Clinton, Essex, Fulton, Franklin, Hamilton, Montgomery, Saratoga, Warren and Washington counties.	
Health Disparities Addressed: Low socio-economic status populations at high risk for smoking and/or negatively affected by tobacco dependency.	
GFH Goal: Improve the health of people in the GFH region through education, mobilization and the execution of policies that reduce tobacco dependency.	
GFH SMART Objective(s)	**Performance Measure(s)**
By June 2015, create a local environment that successfully demands passage of:	# tobacco-related policies (total) in development for

• At least 12 tobacco-related policies across four different initiatives: point of sale, tobacco-free outdoors, smoke-free housing, and smoke-free media.	point of sale, tobacco-free outdoors, smoke-free housing, and smoke-free media.
By June 2015, create partnerships and working groups with area physical and behavioral health systems to implement policy change to treat and screen for tobacco dependent patients: • At least 12 physical and behavioral health systems will commit to working on implementation of policy to have sustaining tobacco dependency treatment and screen for all patients.	# MOU's adopted by physical and behavioral health administrators to implement systems change for tobacco dependent patients.
Activities	
Establish and maintain relationships with local community-organizations, health systems and key stakeholders.	
Garner earned media for initiatives and tobacco-related holidays.	
Support community partners in adopting tobacco-related policies.	
Conduct regional training with accredited tobacco expert to enhance understanding of best practices with treating tobacco dependency with patients.	

2013-2014 Update:
Since the inception of Living-Tobacco Free in July 2014, five staff have been hired to help coordinate initiatives and assist in executing goals and objectives. The brand 'Fix It' was developed for Living-Tobacco Free as a call to action, and to help unite the Health Systems component with the Reality Check and Community Partnerships components. Staff have been working to coordinate the design and production of marketing materials, build relationships in the community, and meet program goals.

2015 Update:
Living Tobacco-Free staff have completed the coordination of the design and production of marketing materials for the 'Fix It' campaign. Staff developed palm cards, website content, newsletters, info sheets, flyers, folders, posters and toolkits that have assisted in building and maintaining relationships in the community and completing program goals. The community has responded positively to the 'Fix It' brand and related materials distributed by Living Tobacco-Free staff.

By June 2015, the community engagement and Reality Check components of the Living Tobacco-Free initiative created local environments that successfully supported passage of 7 of the 12 tobacco-related policies that were targeted. The 7 policies include: 1 multi-unit housing policy (Midtown Apartments, South Glens Falls - 100 units) and 6 tobacco-free outdoor policies (Saratoga Balloon and Craft Festival, Schuylerville Public Library, Town of Ballston, Town of Fort Ann, Town of Warrensburg, Washington County Fair). From June 2015 – December 2015 a smoke-free media policy (Adirondack Broadcasting/Pamal Broadcasting, Queensbury) was achieved, for a total of 8 policies. As of December 2015, there were multiple policies in progress, some of which were projected to be finalized in the next year, including a potential point of sale policy. As tobacco policies often take years to develop and execute, Glens Falls Hospital has focused on building relationships and partner engagement, which has positioned this region as a leader for policy change.

By June 2015, the Health Systems component of the Living Tobacco-Free Initiative obtained 12 MOUs from physical and behavioral health administrators to implement systems change for tobacco dependent patients. This number has increased to 14 MOUs by December 2015. Living Tobacco-Free

staff will continue to advance efforts with health systems, focusing on leveraging existing relationships and momentum through regional transformation efforts.

Dissemination

The Glens Falls Hospital Community Service Plan Update for 2015, along with the original Community Service Plan, Community Health Needs Assessment and Implementation Strategy, is available at http://www.glensfallshospital.org/services/health-promotion-center.cfm. GFH will also use various mailings, newsletters and reports to ensure the CSP, CHNA and IS are widely publicized. Hard copies will be made available at no-cost to anyone who requests one.