Community Health Needs Assessment and Implementation Strategy
2019 - 2021
Executive Summary

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

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

Working within the framework provided by New York State's (NYS) Prevention Agenda, GFH and Warren, Washington and Saratoga County Public Health Departments collaborated in the development of the CHNA. Additionally, GFH coordinated with Fulton, Essex, Hamilton, Franklin and Clinton County Public Health, as well as with several other hospitals in the region, through the regional health assessment and planning efforts coordinated by the Adirondack Rural Health Network (ARHN). Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning in the region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of hospitals and county health departments working together to utilize a systematic approach to community health planning and assessment. Saratoga County worked with a different regional planning group to determine the needs of their residents. Representatives from GFH were members of the community-based groups that were assembled to review and assess the available health data and determine priority areas for each county. Each county's needs assessment process was similar and involved both data analysis and consultation with key members of the community.

A variety of data sources were used to inform the county and hospital assessments. The two most significant resources used were developed and provided by the ARHN collaboration: 1) publicly available county health indicator data and 2) data collected from a regional community stakeholder survey. Each county public health department, as well as GFH, used additional data sources to supplement this information and inform the process based on their needs. Additional data sources used by GFH include the NYS Prevention Agenda Dashboard, County Health Rankings, the NYS Cancer Registry, the Governor's Cancer Research Initiative – Warren County Cancer Incidence Report, and an attitudinal tobacco assessment conducted in Warren, Washington and Saratoga counties.

While the information collected through the community health assessment process was extremely comprehensive, there are a variety of gaps in information. First, there is limited data available by zip code, and much of the data is often at least two to three years old. Second, data sources are extremely limited to quantify the challenges and needs associated with the social determinates of health. Metrics are not available to wholly

understand issues such as child care, housing, transportation, food insecurity, and other social barriers facing our populations. Similarly, while racial and ethnic disparities are often easily identified in other parts of New York State, disparities in this region are difficult to measure or quantify.

After careful consideration and extensive internal and external discussions, GFH determined that the most effective strategy would be twofold: 1) ensure the hospital coordinated with and/or participated in each of the public health departments' assessment processes and 2) utilize the results of each of the county assessments to inform a coordinated and complementary regional CHNA for the GFH service area. The following table outlines the priorities selected by each county:

	Warren County	**Washington County**	**Saratoga County / Saratoga Hospital**
Prevention Agenda Priority and/or Focus Area	Prevent Chronic Diseases • Tobacco Prevention • Chronic Disease Preventive Care and Management Promote Well-Being and Prevent Mental and Substance Use Disorders • Promote Well-Being • Mental and Substance Use Disorders Prevention	Prevent Chronic Diseases • Tobacco Prevention Promote Well-Being and Prevent Mental and Substance Use Disorders • Mental and Substance Use Disorders Prevention	Prevent Chronic Diseases • Obesity Prevention (Healthy Eating and Food Security & Physical Activity) Promote Well-Being and Prevent Mental and Substance Use Disorders • Substance Use Disorder Prevention

In addition to evaluating the priorities and county level data indicators for our local county health departments, GFH considered our expertise, capacity, funding, and potential impact. The following have been identified as the most significant health needs for the population served by GFH. These needs will be the major focus of GFH's community health strategies for 2019 – 2021, and informed the development of a corresponding IS:

Priority Area: Prevent Chronic Disease

- **Focus Area 1 - Healthy Eating and Food Security**
- **Focus Area 2 - Physical Activity**
- **Focus Area 3 - Tobacco Prevention**
- **Focus Area 4 - Chronic Disease Preventive Care and Management**

Priority Area: Prevent Communicable Diseases

- **Focus Area 5 - Antibiotic Resistance and Healthcare-Associated Infections**

It is important to note that GFH chose similar chronic disease related priorities during both our 2013-15 and our 2016-18 CHNA process. Continuing to focus on these areas will improve, strengthen and sustain the impact of our interventions. Emphasis will be placed on interventions that impact disparate and underserved populations in the service area, especially low-income populations and those with limited access to healthcare and other

community resources. Additionally, in this CHNA process, GFH is expanding the scope of work to include the priority area of Prevent Communicable Diseases, with a specific focus on antibiotic resistance and healthcare-associated infections.

Regional Priority

In addition to GFH choosing the four focus areas under the Prevent Chronic Diseases priority area, as part of the community health planning and assessment process, the CHA Committee identified and selected Prevent Chronic Diseases as one of the regional priorities in support of the NYS Prevention Agenda 2019-2024. The CHA Committee also selected a second priority, Promote Well-Being and Prevent Mental and Substance Use Disorders. CHA partners will work in tandem with the ARHN in a variety of ways to both support strategies to address and raise awareness about chronic disease prevention and mental and substance use disorder prevention.

Community Health Needs Not Addressed in the Action Plan

Additional analysis revealed an increasing demand and need for mental health and substance abuse services throughout the three-county region. GFH recognizes this trend and the need for quality services and program, however, has not historically formalized strategies into the plan due to lack of resources and capacity. Currently, Glens Falls Hospital is the contracted behavioral health provider for Warren and Washington counties. The need will only increase, and we are working to proactively ensure patients have access to the care they need. Most recently, Glens Falls Hospital is working with Warren and Washington Counties to conduct a thoughtful and deliberate partnership exploration process for outpatient behavioral health and substance use services. We are working with the Counties to identify potential partners who can help us better serve patients, with a goal to expand access to much needed specialized behavioral health services in our community. Simultaneously, GFH will continue to work through initiatives such as Health Home and DSRIP to work with all providers on integrated care models and population health strategies.

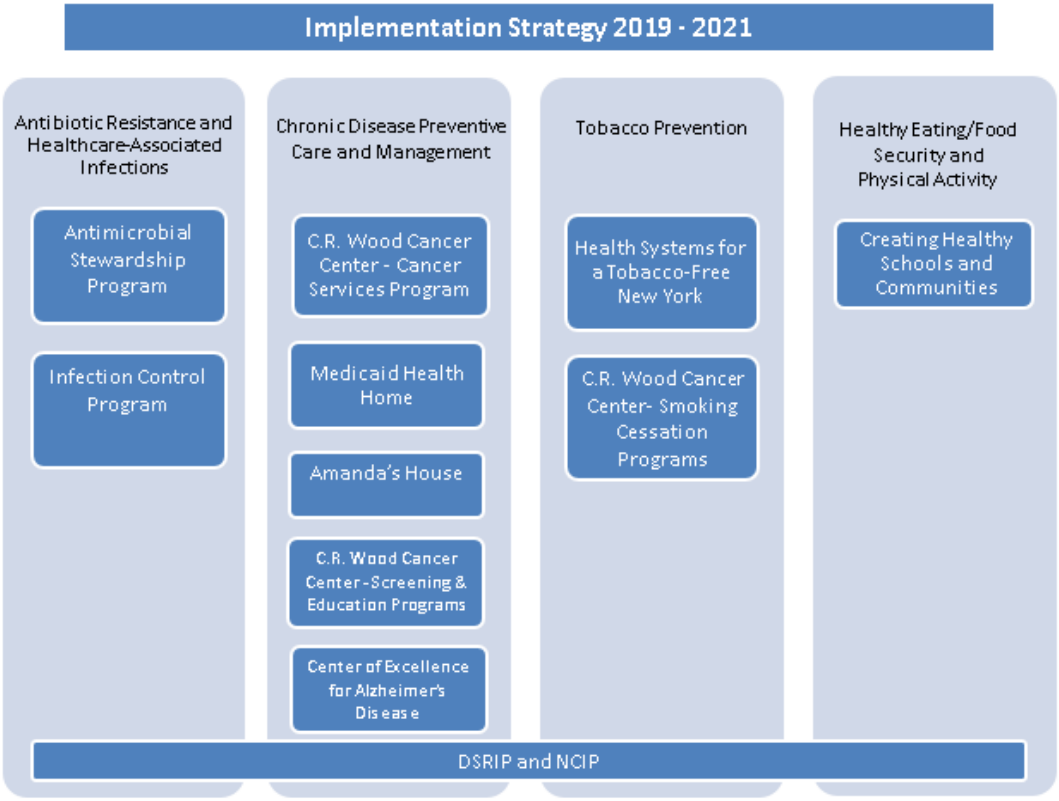
Additional community health needs, such as housing, transportation, and other social determinants of health, are not addressed in the action plan due to lack of resources, expertise and/or quantitative data to support a proper assessment and plan.

Implementation Strategy

GFH developed the 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 for initiatives led by GFH, that includes goals, objectives, activities, partners and performance measures. Strategies are evidence-based and align with the NYS Prevention Agenda 2019-2024, addressing the four focus areas under the Prevent Chronic Disease priority area and the one focus area under the Prevent Communicable Diseases priority area. Certain initiatives, including the Medicaid Health Home, Amanda's House, Cancer Center education programs, the Center of Excellence for Alzheimer's Disease, Delivery System Reform Incentive Payment (DSRIP) program, and the North Country Innovation Pilot (NCIP), do not directly align with the Prevention Agenda strategies, but are included as additional community benefit.

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

populations in the service area, especially low-income populations and those with limited access to healthcare and other community resources.



GFH will use various mailings and other methods to ensure the availability of the CHNA and IS is widely publicized. Once approved by the GFH Board of Directors, both documents will be posted to the GFH website, along with the NYS DOH-required CSP.

Impact of Previous Community Health Needs Assessment:
As a result of 2016-2018 CHNA process, GFH chose the following health needs as priorities.

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

The complete 2016-2018 IS and corresponding CSP can be found on the GFH website at http://www.glensfallshospital.org/services/community-service/health-promotion-center.

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 2016 - 2018.

- Provided **Health Home care coordination** services to adults and children enrolled in Medicaid, for a total of 3551 encounters in 2016, 4108 encounters in 2017 and 3455 encounters in 2018. 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 improved to 61%.
- Continued to conduct **smoking cessation programs** for community members that resulted in approximately 20% of individuals successfully reducing consumption of nicotine products. Approximately 5% quit for a short time and are working on reducing their consumption.
- 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. The retreats were held twice a year between 2016 and 2018, for a total of six women's retreats with a total of 56 attendees. A men's retreat was also piloted reaching 10 attendees. All participants evaluated stated that the program helped them with tools for coping after their diagnosis and 100% stated that they felt better connected to services and others with similar diagnosis.
- 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 900 patients used the salon between 2016 and 2018, and over 375 wigs were provided free of charge.
- Conducted 5 **Comfort Camps** between 2016 and 2018, 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. Over 100 individuals participated and evaluation of the program showed that 100% of the families found the education and support helpful in reconnecting their families during the stressful treatment timeframe.
- Conducted **free skin cancer screening** once per year, for a total of three screenings between 2016 and 2018, which are free and open to the community. Nearly 430 individuals participated and each year, 75% of participants stated they had spots that needed to be checked and would not have otherwise seen a provider.
- Provided free accommodations through 1,300 room nights and over 2,000 guest nights, between 2016 and 2018, 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. The house accommodates guests from as close as an hour away to states as far as Florida and California and countries and territories as far as Canada, Venezuela, Puerto Rico, and Columbia. 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.
- Conducted 12 **support groups** and 6 **diabetes education classes** between 2016 and 2018.
- Achieved NCQA recognition for all 8 primary care practices operated by Glens Falls Hospital under the **2017 Patient-Centered Medical Home (PCMH)** standards. These practices are now enrolled in the annual sustainability model. 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.
- Established all GFH primary care medical centers as **Comprehensive Primary Care Plus** (CPC+) sites.
- Piloted **primary care and behavioral health integration**, developed a solid step up and step-down algorithm whereas patients received a warm hand off within the office and then triaged to the appropriate setting and clinician. Due to recruitment and retention challenges, the model is evolving, and we are working to explore the use of telehealth.
- Established new services, including a NYS designated **Stroke Center** and a **Center of Excellence for Alzheimer's Disease**.
- Participated in regional **care delivery transformation through the DSRIP program**:

- Renovated 4 medical centers to create a physical space conducive to integrating behavioral health services into primary care. Through these projects, two of the medical centers also increased their footprint to expand primary care capacity.
- Established a new Crisis Care Center to expand services of the Emergency Department.
- Accessed DSRIP workforce and training support to send staff to 30 trainings/conferences for professional development that would not have otherwise been possible. This includes a hospital-wide initiative to address crisis prevention and behavioral safety.
- Established the Glens Falls Medical Group, a provider engagement and alignment initiative which established a physician-driven governance structure; created a data driven strategic plan that outlined goals around quality improvement, financial stability and patient satisfaction; and improved communication and referrals amongst providers through a newly established meeting framework, newsletters, education and training, data dashboards and a provider directory.
- Formed new or enhanced existing collaborations with community partners to reach and serve our most vulnerable patients.

- Continued to **advance tobacco prevention and control efforts** across the region:
  - Provided training to over 30 agencies to increase **implementation of evidence-based intervention and care** for tobacco dependence.
  - Established 15 new **tobacco or smoke-free policies** throughout Warren, Washington, and Saratoga Counties by community partners in areas such as parks, worksites, and multi-unit housing complexes. Partners included the Double H Ranch, Skidmore College, and the Saratoga Springs Housing Authority, which resulted in 330 smoke-free homes. Another housing policy resulted in the creation of over 200 new smoke-free homes.
  - Supported 10 **public housing authorities to provide tobacco cessation** opportunities for residents as they develop tobacco free living spaces as per new federal housing law.
  - Sponsored a **Certified Tobacco Treatment Specialist training** resulting in 40 new tobacco treatment professionals throughout the region.
  - Collaborated with the **Medical Society of the State of New York** to train 50 clinicians from Glens Falls Hospital, Hudson Headwaters Health Network, Irongate, Adirondack Health, CVPH, Alice Hyde and others, in contemporary and evidenced-based protocols for Tobacco Dependence Treatment.
  - Partnered with 13 medical and 17 behavioral health system partners to **enhance interventions, policies and workflow protocols** to address tobacco dependence with patients.
- Continued to advance policy and environmental changes to **promote physical activity and nutrition:**
  - Partnered with local agencies to deliver a **Mobile Fresh Produce Pantry** that has provided 2,429 households with 17,557 pounds of fresh produce over two years.
  - Assisted 4 local school districts in improving their **Local Wellness Policies** to provide students with increased opportunities for physical activity and nutrition.
  - Provided local school districts with **hydration stations, healthy food items** for taste testing events, **cafeteria equipment** and equipment to support a **hydroponic vegetable garden** for use in school foods, in addition to **equipment for increased physical activity** during recess, breaks and PE class and after school programs.
  - Hosted **Math and Movement Family Nights** in the Granville Central School District and the Hadley-Luzerne Central School District to bring families together to improve students' math skills while being physically active. The events hosted approximately 120 students and their families.
  - Provided 8 schools in Hudson Falls, Fort Ann, Whitehall, Granville and Lake Luzerne with nearly $15,0000 of **equipment and supplies to increase physical activity** during the school day and recess.
  - Created **safer streets for pedestrians and bicyclists** by providing over $35,000 in Complete Streets support (such as speedbumps, signage, and speed feedback detectors) to Hadley, Kingsbury, Hudson Falls and Whitehall.