Glens Falls Hospital
2023 Workplan

Planning Report Liaison Cathleen Traver
E-mail: ctraver@glensfallshosp.org

Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives through 2024	Disparities	Interventions	Family of Measures	By December 2023, we will have completed . . .	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	By December 2024, conduct cancer screenings in priority populations to ensure: •20% of clients screened are women who are rarely or never screened •20% of clients screened are male clients •20% of clients screened are those needing comprehensive screenings (breast, cervical and colorectal)	Low socio-economic status populations and uninsured individuals with limited access to screening services.	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,	% of clients screened (in each population identified in the objective)	By December 2023 we will have successfully implemented advertising campaigns through 3 key months each year. Our goal will be to have screened at least 22 women each year who are rarely or never screened, At least 10 men each year for colorectal cancer, and at least 20 women each year needing comprehensive screenings.	Providers	Strategic Partners are those who assist the program by referring patients / clients to the Cancer Services Program. Those include but are not limited to: Glens Falls Hospital Medical group, Hudson Headwaters Health Network, and Irongate Family Practice.
		Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	By December 2024, maintain above 75% completion of HCBS assessments By December 2024, increase enrollment of the HARP population by 5% annually	This patient population presents with multiple social determinants of health and compliance issues.	A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that a patient's needs are addressed in a complete and comprehensive manner. A HARP is a managed care product that manages physical health, mental health,	% completion of HCBS assessments % increase in enrollment of HARP patients	Increase in HCBS service availability, increase HCBS assessment completion and increase in HARP enrollment.	Other (please describe partner and role(s) in column D)	•AHI Lead health Home Training, Tracking and reporting back to the CMA •HCBS service Provider- Training and making sure the Lead HH & CMA's are aware of their services, staffing and availability •Patients- engaging in the programs
	Focus Area 1: Healthy eating and food security	Goal 1.1 Increase access to healthy and affordable foods and beverages	By December 2024, increase the number of worksites and community settings that implement food service guidelines by 15.	Disparities Addressed: Low socio-economic status populations as demonstrated by schools and communities with the 1) highest percent of district population living in poverty; 2) highest percent of the population with less than a high school education; 3) highest percent of students qualifying for free/reduced lunch; 4) highest percent of children living in poverty; and 5) highest percent of students who are obese.	The Creating Healthy Schools and Communities initiative works with communities and the school districts, Early Childcare Centers, worksites, and community organizations within those entities. 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. 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.	# of worksites and community settings recruited, assessed, and applying behavioral design strategies	By December 2023, increase the number of worksites and community settings that implement food service guidelines by 10.	Other (please describe partner and role(s) in column D)	•Worksites that have vending, cafeterias or similar food locations for their staff.
			By December 2024, increase the number of school districts that improve policies, practices, and environments for nutrition by 10.	Same as above	Same as above	# of school districts with established wellness committees and implemented Wellness Policies	By December 2023, increase the number of school districts that improve policies, practices, and environments for nutrition by 6.	Other (please describe partner and role(s) in column D)	•Within the districts we will work with Food service directors, teachers, administrators, school wellness committee to update and implement policies related to nutrition and physical activity. •County Public Health Departments- Provides sustainable programs to support school districts •County Cornell Cooperative Extensions Provides sustainable programs to support school district •Comfort Food Communities- Supporting Farm to School efforts and local food pantries •Food for Thought- Organization that supplies local schools with snacks for during the school day snack time
			By December 2024, increase the number of childcare providers that improve policies, practices, and environments for nutrition by 18.	Same as above	Same as above	# of childcare providers that improve policies, practices, and environments for nutrition	By December 2023, increase the number of childcare providers that improve policies, practices, and environments for nutrition by 10.	Other (please describe partner and role(s) in column D)	Early Childcare Centers, Home Daycares and Preschools •We will work the directors, owners, and employees to write policies and implement strategies in relation to nutrition and physical activity. Child Care Resource and Referral Network •Southern Adirondack Childcare Council will connect HPC to the Early Childcare Centers, Home Daycares and Preschools in the specifics townships and cities and provided resources for HPC to connect them back to in relations to nutrition and physical activity practices and trainings.
	Focus Area 2: Physical activity	Goal 2.2 Promote school, child care and worksite environments that increase physical activity	By December 2024, increase the number of childcare providers that improve policies, practices, and environments for physical activity by 18.	Same as above	Same as above	# of childcare providers that improve policies, practices, and environments for physical activity	By December 2023, increase the number of childcare providers that improve policies, practices, and environments for physical activity by 10.	Other (please describe partner and role(s) in column D)	Early Childcare Centers, Home Daycares and Preschools •We will work the directors, owners, and employees to write policies and implement strategies in relation to nutrition and physical activity. Child Care Resource and Referral Network •Southern Adirondack Childcare Council will connect HPC to the
			By December 2024, increase the number of school districts that improve policies, practices, and environments for physical activity by 10.	Same as above	Same as above	# of school districts with established wellness committees and implemented Wellness Policies and Comprehensive School Physical Activity Programs.	By December 2023, increase the number of school districts that improve policies, practices, and environments for physical activity by 6.	Other (please describe partner and role(s) in column D)	•Within the districts we will work with Food service directors, teachers, administrators, school wellness committee to update and implement policies related to nutrition and physical activity.

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Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1 Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	By December 2024, increase the number of municipalities that adopt and implement community planning and active transportation interventions to increase safe and accessible physical activity by 13.	Same as above	Same as above	# of municipalities identified, assessed, and receive training, technical assistance, and resources.	By December 2023, increase the number of municipalities that adopt and implement community planning and active transportation interventions to increase safe and accessible physical activity by 9.	Other (please describe partner and role(s) in column D)	Governmental Elected Officials of Municipalities •We will work the governing bodies of the municipalities to draft, approve and implement polices related to safe walking and biking and active-friendly routes to destinations. Community Organizations •Organizations in the community that work with active transportation such as but not limited to Promote Fort Edward, Feeder Canal Trail Alliance, Champlain Canal Trail Alliance, Bike Glens Falls, Adirondack Glens Falls Transportation Council, Washington and Warren County Planning Departments, Warren County Bikeway, Safe Routes to Schools, East End Action Committee, Adirondack Cycling Group, Food pantries, local farm to library programs,
	Focus Area 3: Tobacco prevention	Goal 3.2 Promote tobacco use cessation	By December 2024, 50% of target medical health care organizations will adopt PHS Guideline concordant comprehensive policies that improve tobacco dependence delivery.	Special consideration is given, 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.	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.	# of inventory and assessment of medical health systems serving disparate populations. # of medical system targets educated on the tobacco burden and importance of evidence-based treatment. # of active targets engaged in at least one performance improvement project # of adopted comprehensive policies that complete systems level change to address tobacco dependence as directed by the Public Health System's 2008 Clinical Guidelines for Treating Tobacco Use and Dependence.	By December 2023 25% of target medical health care organizations will adopt PHS Guideline concordant comprehensive policies that improve tobacco dependence delivery.	Providers	Hospital systems, Federally Qualified Health Centers, private practices and community based organizations
			By December 2024, individuals receiving smoking cessation supports will demonstrate a 20% decrease in the number of cigarettes smoked	Individuals at high-risk for poor health outcomes	The C.R. Wood Cancer Center offers smoking cessation programs for patients who are currently being treated for cancer or blood disorders. Each patient is assessed by the provider regarding motivation for smoking cessation and one on one counseling will be provided as needed.	# patients served per year % average decrease of cigarettes smoked by program participants	By the end of 2023, develop a more formalized referral and tracking process for patients who have been diagnosed with cancer or a blood disorder. Based on historical data, the goal is to work with at least 10 patients per year.	Other (please describe partner and role(s) in column D)	Health Promotion Center of Glens Falls Hospital provides printed workbooks and other printed handouts to the cancer center staff to work with each individual.

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Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.6 Reduce the mortality gap between those living with serious mental illnesses and the general population	By December 2024, 50% of target behavioral health care organizations will adopt PHS Guideline concordant comprehensive policies that improve tobacco dependence delivery.	Special consideration is given, but not limited to, those that serve disparate populations with behavioral health care needs. This specific population is prioritized because of their disproportionate use of tobacco products in comparison to the general population.	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.	# of inventory and assessment of behavioral health systems serving disparate populations. # of behavioral system targets educated on the tobacco burden and importance of evidence-based treatment. # of active targets engaged in at least one performance improvement project # of adopted comprehensive policies that complete systems level change to address tobacco dependence as directed by the Public Health System's 2008 Clinical Guidelines for Treating Tobacco Use and Dependence.	By December 2023 25% of target behavioral health care organizations will adopt PHS Guideline concordant comprehensive policies that improve tobacco dependence delivery.	Providers	Hospital systems, Federally Qualified Health Centers, private practices and community based organizations

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Prevent Communicable Diseases	Focus Area 1: Vaccine Preventable Diseases	Goal 1.1: Improve vaccination rates	By April 2024, increase by at least 25 the number of community education interventions for adolescents, health care providers and parents to support an increase in HPV vaccination	Children and families with limited access to health care and preventive services	The focus of the Cancer Prevention in Action (CPiA) initiative is to increase awareness about skin cancer as well as HPV related cancers while also assisting with policy change and providing community organizations the resources they need to help prevent and reduce cancer in our community. CPiA works to raise awareness of HPV vaccine among adolescents and educate their parents and guardians about the cancer prevention benefits of the HPV vaccine. This initiative looks to partner with healthcare providers such as pediatrician offices to promote the HPV vaccine as cancer prevention.	# of earned media attempts developed and submitted (press releases, letters to the editors, print and broadcast stories) # of target audiences engaged and educated such as dentists, parent teacher associations and pediatricians on the importance of HPV vaccines # of vaccination seminars developed and presented geared toward middle and high school students # of governmental decisionmakers met with and educated about the importance of the HPV vaccine as cancer prevention	1. CPiA will have had at least 6 earned media attempts placed 2. Engaged with at least 2 healthcare provider offices, 1 dental association, and 2 parent groups 3. Presented to at least 3 high school health classes within different districts 4. Engaged at least 2 governmental decisionmakers to educate regarding the HPV vaccine as cancer prevention, and other objectives	Local health department	NYS HPV Coalition •The NYS HPV coalition offers many resources and collaborative efforts with statewide agencies to increase vaccination rates statewide. This includes members of the American Cancer Society, SUNY Upstate medical professors, pediatricians and other healthcare workers. Hudson Headwaters Health Network • Hudson Headwaters will be utilizing our educational resources to hand out to patients to increase access to information among their population served. We will also be partnering to increase their providers current knowledge of the HPV vaccine and best practice for increasing vaccine uptake. Warren, Washington, and Saratoga County Public Health Departments • The County Public Health departments will assist with engaging and educating communities by mobilizing their health educators to increase awareness of our resources to their connections within the community.
	Focus Area 5: Antimicrobial Resistance and Healthcare-Associated Infections	Goal 5.2: Reduce infections caused by multidrug resistant organisms	By December 2024, facilitate antimicrobial resistance data evaluation using a standardized approach to provide local practitioners with an improved awareness of a variety of antimicrobial resistance problems to aid in clinical decision making and prioritize transmission prevention efforts.	The program faces challenges found consistently across healthcare including low health literacy, barriers to direct physical access to care in our rural service area, and comprehensive infection control practices while admitted in the hospital for care, attending an outpatient appointment or visiting a patient receiving care in the hospital. Cultural challenges faced by the Infection Prevention Control Program include preferences that relate to seeking, complying with and following up on medical care and advice.	Glens Falls Hospital Infection Prevention & Control uses a coordinated approach based on established epidemiological principles, statistical methodologies, surveillance and evidence-based information to minimize, reduce, or ultimately eliminate the risk of infection. The program is based on the underlying principle of continuous quality improvement. The National Health and Safety Network offers the Antimicrobial Use and Antimicrobial resistance modules as optional participation to provide a mechanism to report, analyze, benchmark and improve on both unnecessary usages, and to slow the potential resistance demonstrated on a facility, regional and national level. Glens Falls Hospital has purchased this module for testing in 2022 Q4 and implementation with validation in January 2023.	# of quarterly data sets provided to prescribers as compared to regional data	By December 2023, we will have completed no less than one PDSA cycle targeting the highest usage or microbial agent of concern for a targeted reduction of 20%.	Other (please describe partner and role(s) in column D)	•Antimicrobial Stewardship Pharmacist- Change Agent, validation studies •Infection Preventionist- NHSN administrator/submission data •Quality Management Director-implementation & change support •Medical Staff- Change actors •Committees; IP, ABX, P&T, Med Exec- rapid cycle change approval •Administration- support •IT- Electronic module integration
			By December 2024, facilitate antimicrobial resistance data evaluation using a standardized approach to provide facility-specific measures in context of a regional and national perspective (Specifically, benchmarking) that can inform decisions to accelerate transmission prevention efforts and reverse propagation of emerging or established resistant pathogens.			# of presentations to key stakeholders including Infection Prevention Committee, Antimicrobial Stewardship Committee, Pharmacy & Therapeutics, and Medical Staff Committees.	By December 2023, we will have completed no less than one PDSA cycle targeting the highest usage or microbial agent of concern for a targeted reduction of 20%.	Other (please describe partner and role(s) in column D)	•Antimicrobial Stewardship Pharmacist- Change Agent, validation studies •Infection Preventionist- NHSN administrator/submission data •Quality Management Director-implementation & change support •Medical Staff- Change actors •Committees; IP, ABX, P&T, Med Exec- rapid cycle change approval •Administration- support •IT- Electronic module integration
			By December 2024, allow regional and national assessment of antimicrobial resistant organisms of public health importance, including ecologic and infection burden assessment.			# of benchmarks compared based on validated data # of opportunities identified and change management model cycle (PDSA) conducted with a 30% reduction in usage	By December 2023, we will have completed no less than one PDSA cycle targeting the highest usage or microbial agent of concern for a targeted reduction of 20%.	Other (please describe partner and role(s) in column D)	•Antimicrobial Stewardship Pharmacist- Change Agent, validation studies •Infection Preventionist- NHSN administrator/submission data •Quality Management Director-implementation & change support •Medical Staff- Change actors •Committees; IP, ABX, P&T, Med Exec- rapid cycle change approval •Administration- support •IT- Electronic module integration