Glens Falls Hospital

Implementation Strategy

2013 - 2015

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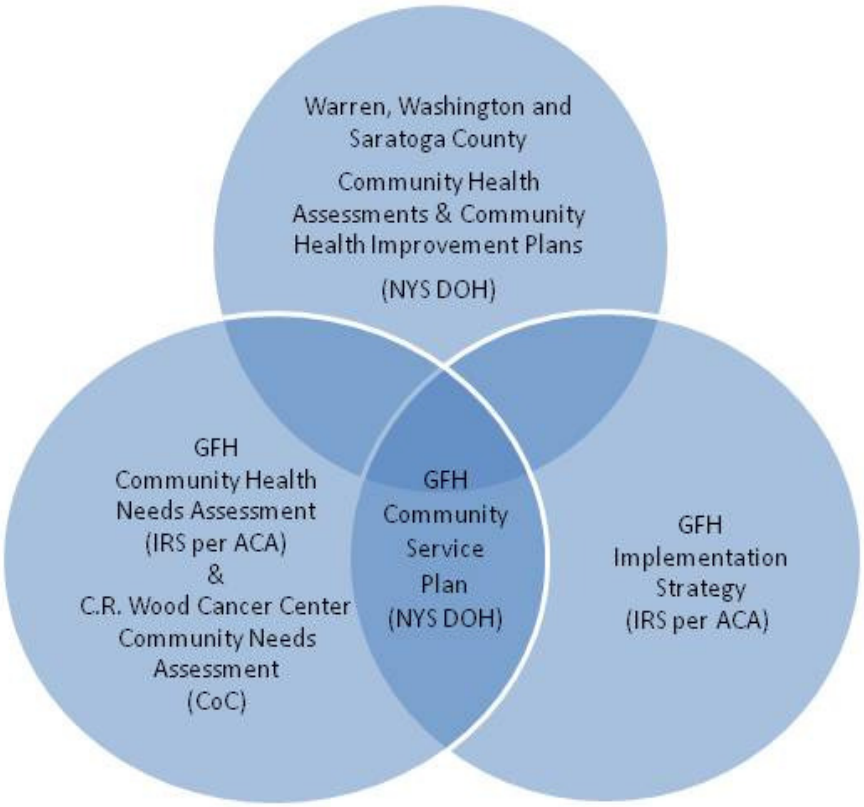
Introduction

Glens Falls Hospital (GFH) developed this Implementation Strategy (IS) to address the prioritized community health needs of the patients and communities within the GFH service area. It is a three-year plan of action including goals, objectives, improvement strategies and performance measures with measurable and time-framed targets. Strategies are evidence-based and align with the NYS Prevention Agenda 2013-2017. The prioritized community health needs were identified in the corresponding Community Health Needs Assessment (CHNA).

The CHNA and IS will address the requirements set forth by the Internal Revenue Service through the Affordable Care Act (ACA). The community health needs assessment provision of the ACA (Section 9007) links hospitals' tax exempt status to the development of a needs assessment and adoption of an implementation strategy to meet the significant health needs of the communities they serve, at least once every three years. The GFH CHNA also addressed the American College of Surgeons Commission on Cancer requirements to complete a community needs assessment. The NYS Department of Health requires hospitals to work with local health departments to complete a Community Service Plan (CSP) that mirrors the CHNA and IS per the ACA. Consequently, this IS will be combined with the CHNA to develop the CSP. County health departments in NYS have separate yet similar state requirements to conduct a Community Health Assessment (CHA) and a corresponding Community Health Improvement Plan (CHIP). Aligning and combining these requirements ensures the most efficient use of hospital resources and supports a comprehensive approach to community health and population health management in the region.



Glens Falls Hospital

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 two rural school-based health centers. 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. See Appendix A for a map of the GFH regional health care system.

GFH has worked to create healthier communities since its founding in 1897, and is actively implementing numerous care transformation initiatives to support the Institute for Healthcare Improvement's Triple Aim of better health, better care and lower costs:

- **Patient-Centered Medical Homes:** Within the 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 coordinated care and a long-term healing relationship between the patient and provider.

- **NYS Medicaid Health Home:** In addition, GFH is designated as a lead Medicaid Health Home 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.

- **Community-based Care Transitions Program:** Through the Community-based Care Transitions Program, GFH is working with a consortium consisting of six community-based organizations and ten hospitals serving ten counties to reduce the risk of readmission when a patient is transitioned from hospital to home.

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

- **Community Health and Wellness:** Additional community health initiatives include an extensive set of outreach programs and population-based initiatives to improve the health status of those living in the region. These include, but are not limited to, NYS DOH-funded initiatives such as Creating Healthy Places to Live Work and Play, the Tobacco Cessation Center, Healthy Schools New York, and the Cancer Services Program.

Enhancing the quality of life and access to health care services for the geographically scattered population of this region, many of whom struggle economically, is a priority for GFH.

Glens Falls Hospital Mission

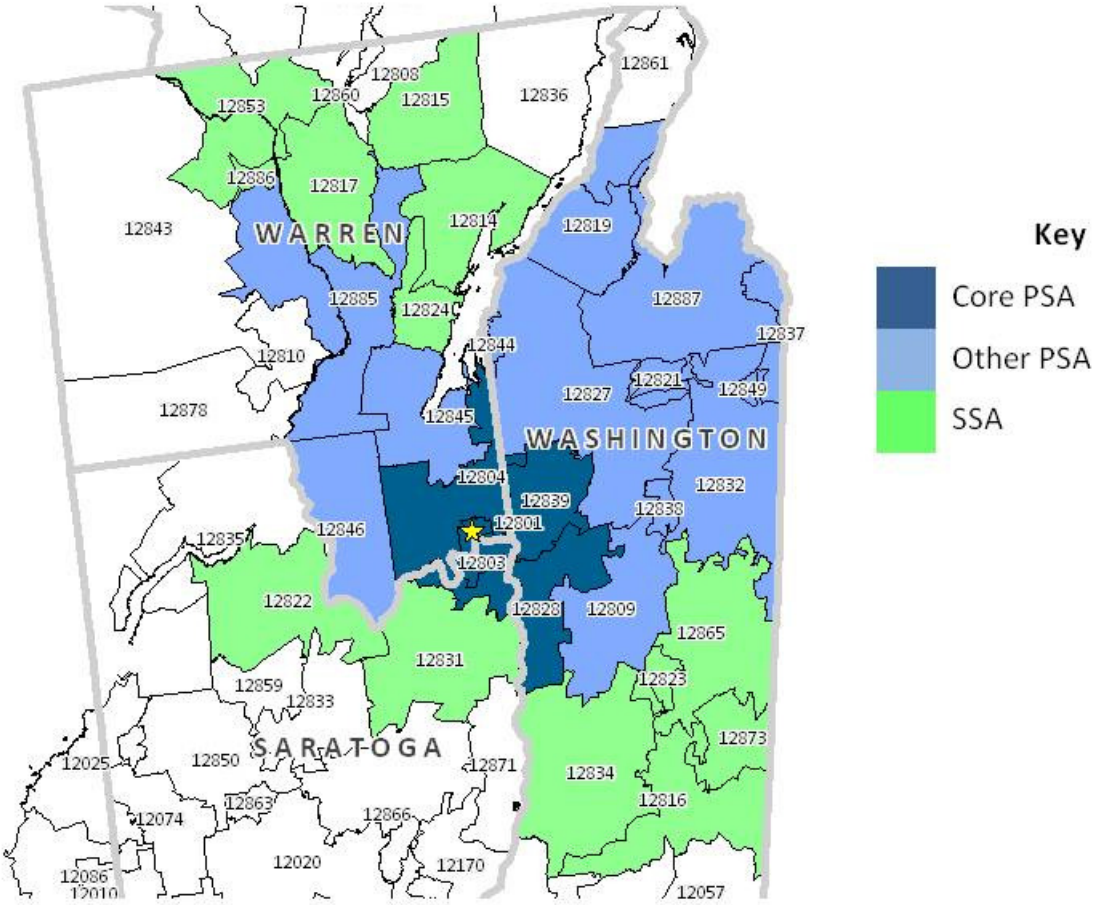
The GFH mission is to improve the health of people in our region by providing access to exceptional, affordable and patient-centered care every day and in every setting. Our fundamental values are (1) Respect, by treating each individual with courtesy and compassion, (2) Responsiveness, through innovation and continuous improvement, and (3) Responsibility, to assure a wide range of high quality healthcare services to all.

Glens Falls Hospital Service Area

The service area for GFH is composed of ZIP codes in Warren, Washington and northern Saratoga counties. This definition is the result of a recent analysis of patient origin, market share (which reflects how important GFH is to a particular community), and geographic considerations, including the need to ensure a contiguous service area.

The GFH service area is defined by a Core Primary Service Area (PSA), Other Primary Service Area and a Secondary Service Area (SSA). The Core PSA represents the ZIP codes immediately contiguous to the hospital. These five ZIP codes have a combined patient origin of 51% and a GF H market share of 85%. The Other Primary Service Area rings the Core PSA and includes 14 ZIP codes with a combined patient origin of 20% and GFH market share of 79%. Combined, the Core PSA and Other PSA have a patient origin of 71% and GFH market share of 83%. The Secondary Service Area (SSA) reflects more outlying areas where GFH has either a strong market share or a critical mass of patients that come to the hospital. These 13 ZIP codes have a combined patient origin of 13% and GFH market share of 49%. The Core PSA, Other PSA and SSA combined represent the residence of 84% of patients that are served by GFH. This service area definition also aligns with the counties included in the service area definition for the GFH Medical Staff Development Plan (MSDP).[2]

[2] The MSDP justifies financial support for physician recruitment into private practices, and is also a strategic tool to assess broader physician need including development of new programs and services. Consequently, there is significant overlap between both the content and purpose of the CHNA and MSDP (both federal requirements).



New York State's Prevention Agenda 2013 - 2017[3]

Glens Falls Hospital utilized the NYS Prevention Agenda framework to plan, inform and guide the development of a Community Health Needs Assessment and Implementation Strategy. *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, 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:

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

- 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 CHNA, 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.

GFH Prioritization of Significant Health Needs

Glens Falls Hospital and Warren, Washington and Saratoga County Public Health collaborated in the development of the hospital Community Health Needs Assessment and county Community Health Assessments. Additionally, GFH coordinated with Fulton, Montgomery, Essex, Hamilton, Franklin and Clinton County Public Health, in addition to seven other hospitals in the eight-county region, through the regional health assessment and planning efforts coordinated by the Adirondack Rural Health Network (ARHN). ARHN is a regional multi-stakeholder coalition that conducts community health assessment and planning activities. Collaboration is an essential element for improving population health, and working together reduced duplication and facilitated an effective and efficient approach.[4]

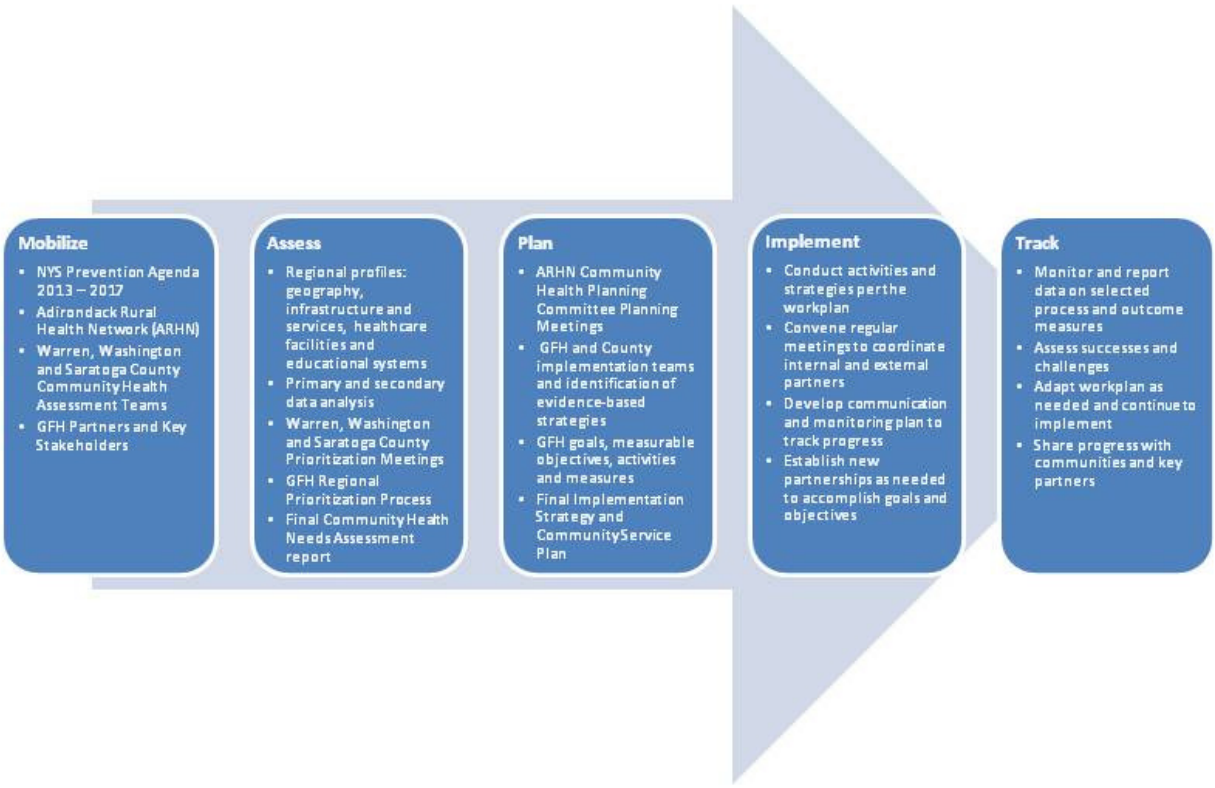
GFH serves a multi-county area, which encouraged a strategic approach to ensure alignment with each county assessment and planning process. After careful consideration and extensive internal and external discussions, GFH determined that the most effective strategy would be twofold: 1) ensure the hospital coordinated with and/or participated in each of the public health departments' CHA 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. A detailed description of each county CHA process is included in the corresponding GFH CHNA.

The CHNA report provides a regional profile (geography, infrastructure and services, healthcare facilities, educational system) for Warren, Washington and Saratoga counties in addition to a detailed analysis of population and demographic data. The NYS Prevention Agenda is used as a framework to present county-level data regarding the community health needs for the region. The CHNA also includes results from numerous surveys that collected input from residents and key stakeholders representing health care and other service providing agencies. Lastly, a specific section was devoted to health disparities and barriers to care for patients and communities, along with an overview of the County

[4] More information about the guidance provided to counties and hospitals can be found at NYS Department of Health, Prevention Agenda 2013-2017, Community Health Planning Guidance and Data website, http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/planning_guidance.pdf

Health Rankings for Warren, Washington and Saratoga counties. Extensive details and information is available in the GFH CHNA.

Glens Falls Hospital Community Health Assessment and Improvement Process



Adapted from the Healthy People 2020 Map-It Framework for Implementation, available at http://healthypeople.gov/2020/implement/MapIt.aspx

Warren, Washington and Saratoga county CHAs provide the rationale behind the prioritization of significant health needs for each county. The following table outlines the most significant health needs identified in each county. GFH compared the priorities identified by each county to determine similarities and differences. Warren, Washington and Saratoga counties all selected focus area within Chronic Disease and Mental Health/Substance Abuse. Saratoga County is also planning to address focus areas related to Healthy Women, Infants and Children and Vaccines/Healthcare-Associated Infections.

	Warren County	Washington County	Saratoga County/Saratoga Hospital
Prioritized Health Needs	Increase access to high quality chronic disease preventive care and management in both clinical and community settings Promote mental, emotional and behavioral health (MEB)	Reduce obesity in children and adults Reduce illness, disability and death related to tobacco use and secondhand smoke exposure Prevent substance abuse and other mental, emotional and behavioral health disorders	Increase access to high quality chronic disease preventive care and management in both clinical and community settings Improve child health Prevent substance abuse and other mental, emotional and behavioral disorders Prevent vaccine-preventable diseases Prevent healthcare associated infections STDs

GFH considered expertise, capacity, funding, and potential impact to determine which needs to address on a regional level. The following have been identified as the most significant health needs for the population served by Glens Falls Hospital. These needs will be the major focus of GFH's community health strategies for 2013 – 2015, and inform the development of this Implementation Strategy:

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

By selecting all the focus areas related to the Chronic Disease priority area, GFH will be able to ensure consistency and alignment across the counties, and ensure resources are used most effectively and efficiently. GFH determined it would be more effective to focus on the entirety of chronic disease as opposed to solely focusing on certain risk factors, or only addressing prevention or management; current staffing structure ensures expertise in this area, and sufficient resources exist to meaningfully invest in evidence-based strategies. GFH will work to implement strategies that address all three focus areas in all three counties and will ensure collaboration with each of the Public Health departments and their respective partners.

Community Health Needs not Addressed in the Action Plan

GFH will not be directly addressing the focus areas under Substance Abuse and Other Mental, Emotional and Behavioral Disorders in the IS due to a variety of factors. It would not be prudent to spread hospital and community resources across too many initiatives. While behavioral health is a significant need for individuals and communities in the GFH service area, GFH is currently working to reassess the behavioral health services line to ensure long-term sustainability and maximum capacity. GFH is exploring partnerships to meet these needs, and will need adequate time to develop a solid infrastructure. Nevertheless, GFH will be addressing the behavioral health needs of select priority populations through

the Medicaid Health Home initiative, and the Integrated Behavioral Health in Primary Care initiative. Through both of these initiatives, patients will have increased access to chronic disease prevention and management, including behavioral health services, through integrated primary care and care coordination approaches.

With respect to the other focus areas being addressed in Saratoga County, GFH will serve as a collaborative partner as the need arises but does not intend to implement specific regional strategies. In general, HIV, STDs and healthcare associated infections are not a significant need across all three counties. GFH is not explicitly addressing the priority area Promote Healthy Women, Infants and Children in this plan, but is continuously working to support the needs of these patients. Through the creation of the Medical Staff Development Plan, GFH will ensure adequate resources for obstetrics and pediatrics through an emphasis on the utilization of mid-level providers and advanced practice nurses. These providers will be critical resources in the development of educational strategies for women, teens, and children. In addition, GFH will support the counties as the Public Health departments continue to serve these populations. GFH also continues to identify ways to expand education through both GFH school-based health centers at Stuart M. Townsend Middle School and Whitehall Elementary School.

With respect to the priority area of Promote a Healthy and Safe Environment, the majority of these focus areas are beyond the capacity and scope of expertise of GFH and the healthcare sector. Efforts to address these focus areas are better lead by policy makers, elected officials and other community stakeholders through collaboration and support of the healthcare sector. The one area of particular relevance within this priority area is injuries, violence and occupational health. Falls and occupational injuries tend to be a significant challenge for residents in Warren and Washington counties. GFH will continue to support the counties as the Public Health departments develop and maintain relevant programs for these populations. GFH is currently recruiting a new leader for the Occupational Health department and is also working to identify appropriate staff to conduct a falls prevention program. Consequently, these two factors will require significant time to build capacity and therefore the initiatives that will be managed by these two positions have not been included in this plan.

Implementation Strategy Development

GFH utilized the results of the corresponding CHNA to develop this Implementation Strategy. The Director of Research and Planning worked with Senior Leadership to identify evidence-based initiatives to address the prioritized community health needs related to chronic disease. Throughout this process, GFH built on existing initiatives and community assets and also identified new initiatives to complement and further enhance these existing programs. As a result, the Implementation Strategy is a comprehensive, aligned plan with evidence-based strategies that will have significant impact on the health and well-being of the people and communities in the region.

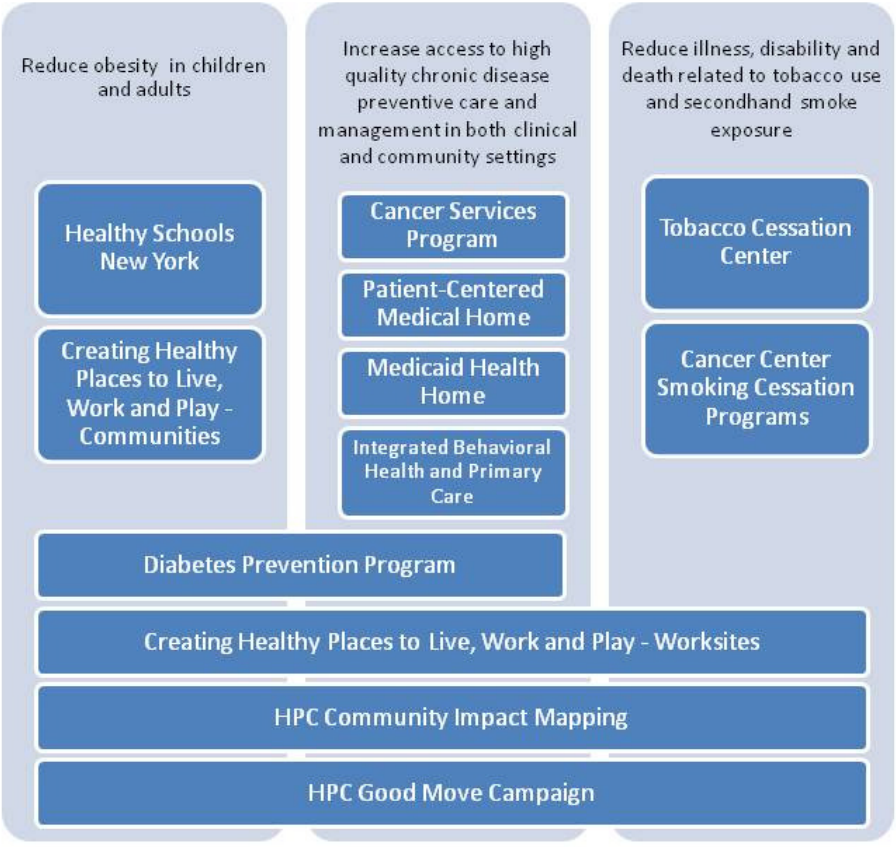
GFH developed common terminology throughout the various departments within the institution to ensure consistent communication about goals, objectives, performance measures and activities. For each initiative, a Manager or Director participated in the development of a three-year action plan. GFH coordinated with Warren, Washington and Saratoga County Public Health throughout the process, and included other existing and new partners to ensure a collaborative and coordinated approach. Where applicable, GFH provided input into each county plan to ensure coordination and alignment with the hospital plan. Once finalized, the Implementation Strategy was reviewed by Senior Leadership and presented to the Board of Governors for approval.

Priority Populations

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. As described in the CHNA, Warren, Washington and Saratoga counties do not face the traditional racial or ethnic disparities typically found in more urban or populated areas. Instead, populations in upstate New York face a unique combination of factors that create health disparities, which are often rooted in the social determinants of health. Economic factors, cultural and social differences, educational shortcomings, and the isolation of living in a rural area all conspire to repress this population in their struggle to lead a healthy life. Many sections of the region face significant distance and transportation barriers to accessing community resources, service opportunities, and health care. These communities are traditionally underserved by most assistance programs; thereby creating health disparities among the people living and working in this area. Throughout the action plan below, priority populations for each specific initiative are noted within the section highlighting the health disparities addressed.

Action Plan

The following 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. Many of the initiatives will impact 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. GFH continues to be actively involved in the counties' and other partner-led initiatives.



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.	

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.	

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.	

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.	

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.	

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.	

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.	

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.	

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.

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.	

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.	

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.	

Partner Engagement

GFH will continue to partner with Warren, Washington and Saratoga county Public Health departments to implement the strategies in this action plan. GFH has a long-standing history of partnerships with these and other community-based organizations and agencies to support implementation of community health initiatives. Many of these partners participated in the various county health assessments and planning processes through the Community Health Assessment Teams (CHATs)[5] . The partners included in each county's CHAT are listed in the hospital's corresponding CHNA report. As discussed in the CHNA, GFH serves a multi-county area, which encouraged a strategic approach to ensure alignment with each county. GFH did not convene an additional regional team of community partners as this would have duplicated efforts and created confusion among community leaders. GFH will continue to partner with each county to convene the CHATs and be actively involved in the implementation of each county's CHIP to ensure partner engagement on the county and regional level.

[5] Each county's group of partners was called something slightly different. However, for ease of reference the term CHAT is utilized in this report to describe the partners that collaborated to conduct the assessment and prioritize needs for each county.

Evaluation Plan

GFH will work with Warren, Washington and Saratoga Public Health Departments to develop a comprehensive evaluation plan that includes both process and outcome evaluation. GFH will ensure this plan aligns with and compliments the evaluation plans developed by each county. Process evaluation will demonstrate if the activities were implemented, if the appropriate populations were reached, and how external factors influenced the implementation. Progress will be tracked through discussion at quarterly meetings with internal and external partners responsible for each initiative. Through these discussions, mid-course corrections may be made to the plan to ensure goals and objectives are met. Outcome evaluation will demonstrate the impact of the activities and the ability to meet the objectives outlined in the action plan. This information will be used to provide regular updates to the NYS Department of Health and the Internal Revenue Service, as requested or required. In addition, this information will be used to share successes and challenges, and inform broader communications with the community and key partners.

Dissemination

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

Approval

The Director of Research and Planning worked with Senior Leadership to present the CHNA and IS to the Board of Governors. The Board was provided with an executive summary in advance of the meeting. A brief presentation was conducted at the meeting to communicate highlights and answer questions. This Implementation Strategy has been reviewed and approved by the Glens Falls Hospital Board of Governors. A signed copy is available upon request.