Little Falls Hospital 2015 Prevention Agenda CSP Summary Table Update

County	Hospital	Priorities	Focus Area	Goals	Interventions
Herkimer	Bassett Healthcare Network: Little Falls Hospital	Access to Quality Health care	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings	Increase number of adults with access to primary care providers	Recruit and hire primary care providers Create linkages with local health care systems to connect patients to community preventative resources
				Promote evidence based care	Participating in DSRIP for NCQA patient centered medical home. Actively working toward achieving PCMH utilizing NCQA standards Number of individuals navigated to and/or through cancer screening NYS Insurance Navigation for Uninsured patients LFH community service plan for uninsured patients
		Preventing Chronic Disease	Increase screening rates for diabetes; and breast, cervical and colorectal cancers, especially among populations experiencing health disparities.	Reduce disparities in the following types: Income/SES, Gender, Disability, Geography, Age	Defining target population – establishing clear goals Identifying process and outcome measures to monitor progress toward reaching goals Reviewing and monitoring progress with partners Maintaining involvement of the majority of stakeholders at all stages throughout intervention implementation

					DSRIP initiatives related to chronic disease management and patient centered medical home requirements NYS insurance plan navigation for uninsured Community service plan for uninsured NYSDPP, AHA Hands Only CPR, Lunch & Learn educational series
				Promote evidence-based care Promote culturally relevant chronic disease self-management education	Number of municipalities that adopted and implemented policies, plans, and practices that promoted Complete Streets Number and type of evidence-based initiatives offered by partners Number of cancer screening events held in partnership with community providers Number of individuals navigated to and / or through cancer screening Collaborate with the New York State Diabetes Prevention Program – To increase the percentage of adults whose hemoglobin a1c levels are in good control [less than 8%]. Provide support and guidance to participants enrolled in 16-week program, followed by 6-8 months of monthly post-core sessions.