Community Health Needs Assessment (CHNA)

FY 2026-2028 Implementation Strategy

Corning Hospital

One Guthrie Drive, Corning, NY 14830

FY 2026

General Information

Contact Person: Paul VerValin, President

Date of Written Plan: June 6th, 2025

Date Written Plan was Adopted by Organization's Authorized Governing Body: June 18th, 2025

Date Written Plan was Required to be Adopted: June 30th , 2025

Authorizing Governing Body that Adopted Written Plan: Corning Hospital Board of Directors

Name and EIN of Hospital Organization Operating Hospital facility: Corning Hospital 16-0393490

Address of Hospital Organization: One Guthrie Drive, Corning, NY 14830

I. Purpose of Implementation Strategy

This Implementation Strategy has been prepared to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a community health needs assessment at least once every three years and adopt an implementation strategy annually to meet the community health needs identified through the community health needs assessment. This Implementation Strategy is intended to satisfy each of the applicable requirements set forth in proposed regulations released April 2013.

II. List of Community Health Needs Identified in Written Report

- Mental Health Problems: increasing services for mental & behavioral health
- Aging Problems: increasing preventive health / chronic disease management services
- Diabetes: increasing preventive health / chronic disease management services
- Cancers: increasing cancer prevention screenings
- Heart Disease and Stroke: increasing preventive health / chronic disease management services

III. Health needs planned to be addressed by facility

- Heart Disease & Stroke
- Diabetes

IV. Health needs facility does not plan to address

- Mental Health Problems
- Aging Problems
- Cancers

FY2026-2028 Corning Hospital Implementation Strategy

Priority: Chronic Disease Management
Focus Area: Heart Disease & Stroke
Goals: Reduce Readmission Rates
Objective: Reduce readmission rates for Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD) patients

	Intervention Description	Population Description	Effect Measure	Evaluation of Intervention	Program Frequency
Intervention #1	Discharge Interventions Ensure patients are discharged on the correct medications and determine any barriers to compliance (medication reconciliation).	Patients admitted to the hospital and treated for COPD or CHF exacerbations.	Increase in % of patients discharged with successful medication reconciliation.	Determine success in reducing COPD and CHF readmissions by comparing readmission rates from current fiscal year to previous fiscal year utilizing reports in the electronic medical record EPIC Report.	Quarterly

Commented [AK1]: are we putting copd with chf?

Intervention #2	Discharge Interventions Utilize Care Pathways.	Patients admitted to the hospital and treated for COPD or CHF exacerbations.	Increase in % of patients enrolled in a care pathway.	Determine success in reducing COPD and CHF readmissions by comparing readmission rates from current fiscal year to previous fiscal year utilizing reports in the electronic medical record EPIC Report.	Quarterly
Intervention #3	Patients contacted within 2 business days post discharge by office nurse or care coordinator.	Patients admitted to the hospital and treated for COPD or CHF exacerbations.	Increased % of patients contacted within 2 business days post discharge by office nurse or care coordinator.	Determine success in reducing COPD and CHF readmissions by comparing readmission rates from current fiscal year to previous fiscal year utilizing reports in the electronic medical record EPIC Report.	Quarterly

Intervention #4	Increased follow-up/transitional care management (TCM) appts. scheduled for COPD/CHF patients within 7 days of discharge from the hospital.	Patients admitted to the hospital and treated for COPD or CHF exacerbations.	Increased % of patients scheduled for follow-up/TCM appointments within 7 days of discharge from the hospital.	Determine success in reducing COPD and CHF readmissions by comparing readmission rates from current fiscal year to previous fiscal year utilizing reports in the electronic medical record EPIC Report.	Quarterly

FY2026-2028 Corning Hospital Implementation Strategy
Priority: Prevent Chronic Diseases
Focus Area: Diabetes
Goals: Increase Diabetic Bundle Compliance Among Diagnosed Diabetic Population
Objective: Improve Diabetes Bundle Program Compliance. To be eligible for the Diabetic Bundle Program, patients must be Diabetic Patients Seen in the Past 2 Years Who Have an Active Guthrie PCP, With an A1C <= 8 in the Past 6 Months, (or currently prescribed a moderate or high dose statin or a statin exemption code) in the Past Year and age 40-75, AND Negative Eye Exam In the Past Two Years Or Positive Exam In the Past Year.

	Intervention Description	Population Description	Effect Measure	Evaluation of Intervention	Program Frequency
Intervention #1	Ensure patients with diabetes achieve all their goals.	Patients with diabetes.	Increase in % of patients with diabetes achieving the bundle measure.	Increase in diabetic bundle compliance as noted in the EPIC Report.	Monthly
Intervention #2	Ensure patients with diabetes have their hemoglobin A1C tested every 6 months with goal of <8.	Patients with diabetes.	Increase in % of patients with diabetes having hemoglobin A1C tested every 6 months with goal of <8.	Achieve A1C goal as noted in the EPIC Report.	Monthly
Intervention #3	Ensure patients with diabetes	Patients with diabetes.	Increase in % of patients with	Increase in patients who	Monthly

Commented [AK2]: in collab w medical group

Commented [AK3]: Do we want to focus on medicaid-only patients?

Commented [AK4R3]: Combine hospital tactics with outpatient tactics?

Commented [AK5R3]: Do we want to keep it specific to diabetic bundle?if we expand, denom would be "Diabetic Patients Seen in the Past 2 Years With an Active Guthrie PCP"

	receive their eye exam.		diabetes who receive comprehensive eye exam or get retinal photo done in PCP office.	diabetes who have completed their eye exam as noted in the EPIC Report.	
Intervention #4	Increase patients with diabetes receiving statin therapy.	Patients with diabetes.	Increase in % of patients with diabetes who have been prescribed statin therapy.	Increase in patients with diabetes who have been prescribed for statin therapy as noted in the EPIC report.	Monthly