**Community Health Needs Assessment (CHNA)**

**FY 2026-2028 Implementation Strategy**

**Guthrie Cortland Hospital**

**134 Homer Avenue, Cortland, NY 13045**

**FY 2026**

**General Information**

**Contact Person:** Jennifer Yartym, President

**Date of Written Plan:** June 6th, 2025

**Date Written Plan was Adopted by Organization's Authorized Governing Body:** June 24th, 2025

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

**Authorizing Governing Body that Adopted Written Plan:** Guthrie Cortland Hospital Board of Directors

**Name and EIN of Hospital Organization Operating Hospital facility:** Guthrie Cortland Medical Center 15-0532079

**Address of Hospital Organization:** 134 Homer Avenue, Cortland, NY 13045

## 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
- Mental Health Problems

**IV. Health needs facility does not plan to address**

- Aging Problems
- Diabetes
- Cancers

**FY2026-2028 Cortland Hospital Implementation Strategy -**

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

| | Intervention Description | Population Description | Effect Measure | Evaluation of Intervention | Program Frequency |
|---|---|---|---|---|---|
| Intervention #1 | Discharge Interventions<br><br>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?

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| Intervention #2 | Discharge Interventions<br><br>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 |

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| 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 |

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| 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 Cortland Hospital Implementation Strategy**

**Priority:** Increasing Services for Mental/Behavioral Health
**Focus Area:** Mental Health Problems
**Goals:** Increase Support for Patients with Mental Health Needs
**Objective:** Increase Access to Guthrie Mental Health Resources

| | Intervention Description | Population Description | Effect Measure | Evaluation of Intervention | Program Frequency |
|---|---|---|---|---|---|
| Intervention #1 | Increase the number of mental health medical providers (including telepsychiatry). | Inpatient: Providers in inpatient setting<br><br>Outpatient: Providers in ambulatory setting | Increase in total number of mental health medical providers. | Determine success with an increased number of mental health medical providers by comparing the total number to the previous fiscal year. | Quarterly |
| Intervention #2 | Partner with local and regional mental health resources. | Cortland County | Number of partnerships. | Relationships with local and regional mental health resources. | Quarterly |

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|---|---|---|---|---|---|
| Intervention #3 | Increase number of therapy providers, Master of Social Work (MSWs), and Licensed Clinical Social Worker (LCSWs). | Inpatient: Providers in inpatient setting<br><br>Outpatient: Providers in ambulatory setting | Increase in total number of therapy providers, MSWs, & LCSWs | Determine success with an increased number of mental health medical providers by comparing the total number to the previous fiscal year. | Quarterly |
| Intervention #4 | Increase number of inpatients served who require mental health services. | Inpatients requiring mental health services. | Increase in inpatients receiving mental health care. | Determine success with an increased number of inpatients requiring mental health services cared for. | Quarterly |