Community Health Needs Assessment (CHNA)

FY 2025-2028 Implementation Strategy

Guthrie Lourdes Hospital

169 Riverside Drive Binghamton, NY 13905

FY 2026

General Information

Contact Person: Kathryn Connerton

Date of Written Plan: June 6. 2025

Date Written Plan was Adopted by Organization's Authorized Governing Body: June 20, 2025

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

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

Name and EIN of Hospital Organization Operating Hospital facility: Our Lady of Lourdes Memorial Hospital, Inc. 15-0532221

Address of Hospital Organization: 169 Riverside Drive Binghamton, NY 13905

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

- Cancers
- Heart Disease and Stroke

IV. Health needs facility does not plan to address

- Mental health problems
- Aging problems
- Diabetes

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Priority: Cancers: increasing cancer prevention screenings
Focus Area: Cancer Screening
Goal: Increase rates of breast cancer screening for patients within the primary care network
Objective: Increase rates of breast cancer screenings

	Intervention Description	Population Description	Effect Measure	Evaluation of Intervention	Program Frequency
Intervention #1	Provider discussion with patients at Primary Care Physician (PCP) visit if identification of need for Breast Cancer (BC) screening.	Active Guthrie patients aged 45-75 seen in Primary Care Practices.	% of patients aged 45-75 with Breast Cancer screening completed.	Improve BC screening as noted in the electronic medical record EPIC Report.	Monthly
Intervention #2	Outreach by Population Health Coordinators to promote follow-up by patients with PCP or schedule patient for mammogram.	Active Guthrie patients identified by reporting from EPIC and payers needing BC screening.	% of patients aged 45-75 with Breast Cancer screening completed.	Improve BC screening as noted in the electronic medical record EPIC Report.	Monthly

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Priority: Cancers: increasing cancer prevention screenings
Focus Area: Cancer Screening
Goal: Increase rates of colorectal cancer (CRC) screening for patients within the primary care network
Objective: Increase rate of colorectal cancer screenings

	Intervention Description	Population Description	Effect Measure	Evaluation of Intervention	Program Frequency
Intervention #1	Provider discussion with patients at Primary Care Physician (PCP) visit if Identification of need for CRC screening.	Active Guthrie patients aged 45-75 seen in the Primary Care practices.	% of patients with CRC screening completed.	Improve CRC screening as noted in the electronic medical record EPIC Report.	Monthly
Intervention #2	Outreach by Population Health Coordinators to promote follow-up by patients with PCP on best screening options.	Patients identified by reporting from EPIC and payers needing CRC screening.	% of patients with CRC screening completed.	Improve CRC screening as noted in the electronic medical record EPIC Report.	Monthly

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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 the current fiscal year to the previous fiscal year utilizing reports in the electronic medical record EPIC Report.	Quarterly
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 the current fiscal year to the previous fiscal year utilizing reports in the	Quarterly

				electronic medical record EPIC Report.	
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 the current fiscal year to the previous fiscal year utilizing reports in the electronic medical record EPIC Report.	Quarterly
Intervention #4	Increased follow-up/transitional care management (TCM) appointments 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.	Determine success in reducing COPD and CHF readmissions by comparing readmission rates from the current fiscal year to the previous fiscal year utilizing reports in the electronic medical record EPIC Report.	Quarterly