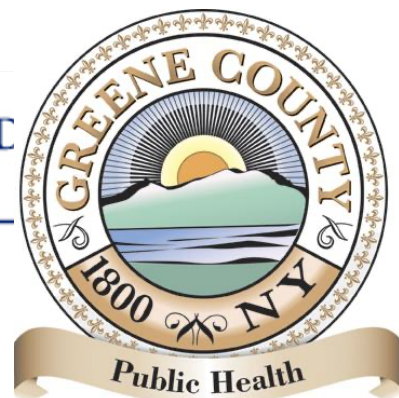


2022-2024

**Community Health Needs Assessment
Implementation Strategy
Community Health Improvement Plan
and Community Service Plan for
Columbia and Greene Counties, NY
and their Hospital**

**Jointly prepared and submitted by
the Columbia-Greene Planning Partners:
Columbia County Department of Health
Greene County Public Health Department
Columbia Memorial Hospital**



In fulfillment of the requirements of the New York State Department of Health's Prevention Agenda and the Internal Revenue Service. The Community Health Needs Assessment, the Community Service Plan, and Implementation Strategy were adopted by vote of the Columbia Memorial Hospital Board of Trustees on November 29, 2022.

To comment on this document pursuant to the Patient Protection and Affordable Care Act of 2010, please contact Columbia Memorial Hospital:

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Hudson, NY 12534
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2022-2024 Collaborative Community Health Needs Assessment, Implementation Strategy, Community Health Improvement Plan, and Community Services Plan for

Columbia and Greene Counties and their Hospital

**Jointly prepared by the Columbia-Greene Planning Partners:
Columbia County Department of Health, Greene County Public Health Department, and
Columbia Memorial Hospital**

A. New York State Required Cover Page

1. Counties Covered:

Columbia and Greene

2. Participating Local Health Departments:

Columbia County Department of Health
325 Columbia Street, Suite 100
Hudson, NY 12534
(518) 828-3358

Greene County Public Health Department
411 Main Street
Catskill, NY
(518) 719-3600

3. Participating Hospital:

Columbia Memorial Hospital
71 Prospect Avenue
Hudson, NY 12534
(518) 828-1400

4. Coalition/entity completing Community Health Needs Assessment and Plans:

Community Health Needs Assessment:
Healthy Capital District (HCD)
175 Central Avenue, Albany, New York 12206
518-486-8400

Prioritization and Plan:
Columbia-Greene Planning Partners and the Columbia-Greene Healthy People Partnership

Executive Summary

1. Prevention Agenda Priorities and Disparity

This document serves as the Community Health Needs Assessment, Implementation Strategy, Community Health Improvement Plan, and Community Service Plan (hereinafter, collectively known as “the Plan”) for Columbia and Greene Counties for the three-year period beginning 2022 and ending in 2024. As such, it identifies the Priorities from the 2019-2024 Prevention Agenda that will be the focus of collaborative community health improvement activities in these counties during this period. These are as follows:

- **Priority Area #1: Prevent Chronic Disease (Obesity-related illnesses)**
Focus areas: Healthy Eating and Food Security
Physical Activity
Chronic Disease Preventive Care and Management
- **Priority Area #2: Promote Well-being and Prevent Mental/Substance Use Disorders**
Focus area: Mental and Substance Use Disorders Prevention
- **Priority Area #3: Prevent Communicable Diseases (COVID-19)**
Focus areas: Vaccine Preventable Diseases (COVID-19)
Healthcare-Associated Transmissions

With regard to addressing disparities, this Plan will focus on ensuring that the rurality of our service area and population do not lead to meaningfully lower rates of COVID-19 vaccination.

2. Data Reviewed to Identify Priorities

The selection of priorities was informed by a review of data extracted from the Community Health Needs Assessment for the Capital Region (see Volume Two) that had been prepared by the public health organization, Healthy Capital District (HCD). HCD staff shared data on a total of 25 health issues that had been derived from a variety of public use data sets. This data included information on the number of people impacted (count), the proportion of people impacted in comparison to other geographies (rate), any trends that could be detected in prevalence, any difference among sub-populations that may exist (disparity), and the relative seriousness of the issue.

3. Partners and Roles; Engagement of Broad Community

The Columbia County Department of Health, the Greene County Public Health Department, and Columbia Memorial Hospital, collectively known as the **Columbia-Greene Planning Partners**, worked collaboratively throughout the assessment and planning process and are committed to working jointly, both across agencies and county lines, throughout the implementation phase as well.

The Columbia-Greene Planning Partners were assisted in the assessment and planning phase by a diverse stakeholder group (see a list of members in Section D, Part 1, page 35) that was convened in March 2022 to review data from the Community Health Needs Assessment and inform the selection of community health priorities (see the PowerPoint presentation used at this meeting as Appendix A). This broad stakeholder group, referred to as the **Columbia-Greene Healthy People Partnership**, will continue to have a role throughout the implementation process. The Partnership will be charged with reviewing reports, monitoring progress, and providing feedback.

4. Evidence-Based Interventions – Identification and Selection

The selection of interventions/strategies/activities fell largely to the Planning Partners, who frequently referenced and were strongly influenced by the discussions that occurred in the Columbia-Greene Healthy People Partnership meeting. Additional consideration was given to the community's existing assets and resources, including programs and services that may already be delivered, gaps in the availability of or access to programs and services, and whether health disparities or inequities exist. Whenever possible, evidence-based interventions were selected directly from those offered in the Prevention Agenda.

With regard to **Priority Area #1: Prevent Chronic Disease**, the Planning Partners selected the following interventions:

- Providing nutritional education in one-on-one and group settings to patients in the inpatient psychiatric unit at Columbia Memorial Hospital
- Expanding access to the Biggest Loser Contest, a 16-week, independent weight loss program
- Providing an exercise program to patients in the inpatient psychiatric unit at Columbia Memorial Hospital
- Promoting evidence-based medical management in accordance with national guidelines
- Utilizing a diabetes educator, provide nutrition education and dietary consults to patients of the family care centers (i.e. outpatient) with a diabetes diagnosis
- Expanding access to the National Diabetes Prevention Program, a lifestyle change program for preventing type 2 diabetes
- Increasing knowledge and awareness of Type 2 Diabetes through a media campaign

With regard to **Priority Area #2: Promote Well-being and Prevent Mental/Substance Use Disorders**, the Planning Partners selected the following interventions:

- Increasing the availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers
- Building support systems to care for opioid users or others at risk of an overdose by partnering with Greener Pathways, a program of Twin County Recovery Services, to embed a Certified Peer Recovery Advocate (CRPA) into the Emergency Department and Inpatient setting
- Establishing additional permanent safe disposal sites for prescription drugs and organizing take-back days
- Embedding behaviorists in CMH's outpatient setting to assist patients with goal-setting, MH/SUD screening and referrals, as well as coordinate consultation between Primary Care prescribers and psychiatry
- Expanding mental health service capacity in CMH's outpatient psychiatric center by contracting with a third-party virtual provider
- Increasing the availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine

With regard to **Priority Area #3: Prevent Communicable Disease** (namely, COVID-19), the Planning Partners selected the following interventions:

- Implementing and promoting the use of standing orders for vaccine administration
- Promoting vaccination, and improving vaccine rates, at CMH's clinical service sites

- Offering vaccines in locations and hours that are convenient to the public including pharmacies, vaccine only clinics, and other sites that are accessible to people of all ages
- Preventing and mitigating COVID-19 transmission among the CMH workforce and patients by providing COVID testing and the use of PPE / masking in public and clinical areas

Greater detail about these intervention strategies, including related objectives and process measures, are provided below in the Work Plan Template, found as Appendix B.

5. Progress and Improvement Tracking, with Process Measures

Throughout the implementation period, it will be essential for the Columbia-Greene Planning Partners to monitor progress, to identify improvements made as a result of the interventions or a *lack* of improvements, which might suggest the need to adjust the approach and/or activities.

With regard to **Priority Area #1: Prevent Chronic Disease**, the Planning Partners selected the following measures:

- RE: the nutritional education program for patients in the inpatient psychiatric unit at CMH: # of patients receiving nutrition education one-on-one; # of patients receiving nutrition education in groups
- RE: the weight loss program: # of registrants, # of participants initiating the program; # of participants completing the program; % of participants completing the program; # of participants who have lost at least 5% of their beginning weight
- RE: the exercise program for patients in the inpatient psychiatric unit at CMH: # of patients who participate in the program when offered; % of patients who participate in the program when offered
- RE: the measures related to diabetes control in the outpatient setting: # of additional diabetic eye exams performed using retinavue technology; HgbA1C, with the aim to reduce the number of people with a HgbA1C of greater than 9; # of diabetics screened for nephropathy, with the aim to improve the number of diabetics who have nephropathy screening with a microalbumen to creatinine test annually; blood pressure control; and, Statin use in patients with diabetes, with the aim of increasing its use
- RE: the nutrition education and dietary consults performed by the diabetes educator at CMH's family care centers: # of patients with a diabetes diagnosis who meet with a diabetes educator; % of patients with a diabetes diagnosis who meet with a diabetes educator
- RE: the Diabetes Prevention Program: # of health systems that have policies/practices for identifying and referring patients to the National DPP programs; # of National DPP programs in the community setting; # of patients referred to the National DPP; # of patients who participate in the National DPP; % of patients who complete the National DPP
- RE: the diabetes awareness media campaign: # of awareness campaigns; # of mediums used to reach the public; # of impressions; # of clicks to webpage; # of ads run; # of post-engagements

With regard to **Priority Area #2: Promote Well-being and Prevent Mental/Substance Use Disorders**, the Planning Partners selected the following interventions:

- RE: efforts to increase the availability of/access to overdose reversal (Naloxone) trainings: # of trainings; # of kits provided; # of agencies able to provide overdose reversal trainings to their staff and community; # of staff who complete naloxone administration training

- RE: the CRPA embedded into CMH's ED and hospital: # of individuals educated about the availability of peer support; # of individuals referred to peer support; # of individuals who meet with a peer; # of individuals who engage with peers, harm reduction strategies, and/or traditional treatment with 90 days
- RE: the efforts to establish safe disposal sites and organize take-back days: # of new medication disposal sites; # of take-back days
- RE: the embedded behaviorists in CMH's outpatient setting: # of behaviorists working in the outpatient setting; # patients referred to behaviorists; # of patient contacts with behaviorists
- RE: the expanded mental health service capacity in CMH's outpatient psychiatric center: # additional patient visits delivered via telehealth
- RE: the efforts to increase the availability of/access and linkages to MAT: # of patients prescribed MAT; # of patients inducted on MAT; # of patients maintained on MAT; # of patients titrated off MAT)

With regard to **Priority Area #3: Prevent Communicable Disease** (namely, COVID-19), the Planning Partners selected the following interventions:

- RE: implementing and promoting the use of standing orders for vaccine administration: # vaccination clinics provided; # vaccinations provided; COVID-19 vaccination rates; rate of fully immunized (eligible ages) residents
- RE: promoting vaccination at CMH's clinical service sites: # of posters and flyers created for primary care and rapid care settings; # visits to www.capitalregionvax.org, the website created by the Albany Med Health System, and established for Capital Region residents, which provides information about vaccine, locations and related health information
- RE: offering vaccines at convenient locations/times: # of vaccine clinics in rural areas
- RE: preventing and mitigating COVID-19 transmission among the CMH workforce and patients: # of staff who are educated on infection prevention and control measures; COVID-19 infection rates among CMH staff

Greater detail about these intervention strategies, including related objectives and process measures, are provided below in the Work Plan Template, found as Appendix B.