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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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

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   <u>Prioritization and Plan:</u>
   Columbia-Greene Planning Partners and the Columbia-Greene Healthy People Partnership

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Volume Two

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https://www.healthycapitaldistrict.org/CHNA2022

B. 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.

C. Community Health Needs Assessment for Columbia and Greene Counties

1. Definition and Description of Communities Assessed

The Columbia County Department of Health, the Greene County Public Health Department, and Columbia Memorial Hospital--collectively known as the **Columbia-Greene Planning Partners**—have defined the communities to be served by this Plan as Columbia and Greene Counties, sometimes jointly referred to as the "Twin Counties." These two counties were selected as the service area for the purposes of this Plan because one or more counties are aligned with the service area of each Planning Partner. The Columbia County Department of Health is a unit of the Columbia County Government and is responsible for all public health and environmental health activities and enforcement throughout Columbia County. Similarly, the Greene County Public Health Department is a unit of Greene County Government, and is responsible for all public health activities in Greene County. Lastly, Columbia Memorial Hospital is the only hospital situated in Columbia and Greene Counties, and serves a large number of its residents. There is little evidence at this time that residents from other counties are seeking their care at Columbia Memorial Hospital, although the Hospital's affiliation with the Albany Medical Center Health System may change this in the future. Consequently, the Hospital views Columbia and Greene Counties as its service area.

The Columbia-Greene Planning Partners committed to develop a single, unified plan for the Twin Counties for a variety of reasons. Although Columbia and Greene Counties are not identical, they are similar in many respects, as will be illustrated by the descriptions that follow. They also share multiple institutions, including the Hospital and a community college, and numerous private, not-for-profit organizations that serve both Counties. Finally, they are both currently in receipt of external funding from both state and federal sources that require a similar set of activities in the next few years. The Planning Partners also chose this approach in order to reflect the history of collaboration between the Counties and their ongoing commitment to continue working closely together, both across agencies and county lines.

a. Demographics of Populations Served

Columbia County

Columbia County (population 60,371) is located in the southeast central part of New York State, nestled between the Berkshires and the Catskills, with the Hudson River as the western border. A total area of approximately 635 square miles, Columbia County includes the City of Hudson, 18 towns (Ancram, Austerlitz, Canaan, Chatham, Claverack, Clermont, Copake, Gallatin, Germantown, Ghent, Greenport, Hillsdale, Kinderhook, Livingston, New Lebanon, Stockport, Stuyvesant, and Taghkanic), and four villages: Chatham, Valatie, Kinderhook, and Philmont. Columbia County is governed by the Board of Supervisors, which is led by the Chairman of the Board of Supervisors.

Columbia County has the highest median age in the Capital Region (48.2 years). About 13.9% of Columbia County's population is 14 years of age or younger, while 23.1% are over 65 years old.

Just under half of Columbia County residents are male (48.5%), and 6.6% of the population report being born outside the United States.

Columbia County's poverty rate (11.6%) is higher than the poverty rate of New York State (11.1%), excluding New York City. Approximately 11.0% of Columbia County's population is non-White, and 4.8% of the County's population is Hispanic. The Hudson neighborhood has the largest non-White population (21.2%) and also the highest neighborhood poverty rate (17.4%) in the county.

Of those in Columbia County over the age of 25, 91.0% hold a high school degree or higher; 33.7% hold a Bachelor's Degree. Employment rate of change for 2020 was a 1.3% increase. 95.4% of Columbia County residents have health insurance.

Columbia County residents living with a disability (14.8%) exceeds the the state average of 12.0%. Many of those who are disabled in Columbia County are older people over the age of 75. Sourced from the American Community Survey 2015-2019, the types of disabilities the residents of Columbia County live with are hearing difficulties (5.0%), vision difficulties (1.8%), cognitive difficulties (6.2%), ambulatory difficulties (7.3%), self-care difficulties (2.6%) and independent living difficulties (6.4%).

Greene County

Known as the Land of Rip Van Winkle, Greene County is the most rural county in the Capital Region, with a population of 47,424. Greene County residents have the opportunity to admire river, valley, and mountain all within 658 sq. miles. There are 5 villages within Greene County (Athens, Catskill, Coxsackie, Hunter, and Tannersville) and 14 towns (Ashland, Athens, Cairo, Catskill, Coxsackie, Durham, Greenville, Halcott, Hunter, Jewett, Lexington, New Baltimore, Prattsville, and Windham). Greene County is governed by the Greene County Legislature, and overseen by the County Administrator.

Greene County has the second highest median age (45.9 years) in the Capital Region. Approximately 13.5% of the population is 14 years of age or younger, while about 21.6% of the population is 65 years of age or older. Greene County's population is 10.4% non-white and 5.9% is Hispanic. The non-white/Hispanic population in Greene County has increased since 2010. The Coxsackie/Athens neighborhood has the largest non-white population (14.1%), as well as the largest Hispanic population (10.1%).

Greene County's poverty rate was the highest in the Capital Region (14%), and higher than the rest of New York State, excluding New York City (11.1%). The neighborhood of Catskill had the highest poverty rate (19.4%) in the County. Of those above the age of 25, 87.2% hold a High School Diploma or higher, while 12.4% hold a Bachelor's Degree. Approximately 96.3% of Greene County residents have health insurance.

Greene County residents living with a disability (13.9%) exceeds the state average of 12.0%. Many of those in Greene County who are disabled are over the age of 75 years old. Sourced

from the American Community Survey 2015-2019, the types of disabilities the residents of Greene County live with are hearing difficulties (2.8%), vision difficulties (1.9%), cognitive difficulties (4.6%), ambulatory difficulties (6.9%), self-care difficulties (2.7%) and independent living difficulties (7.6%).

b. Health Status of the Populations and Distribution of Health Issues

According to the 2021 Roberts Woods Johnson County Health Rankings, Columbia County ranked 21st in New York State for Overall Health Outcomes (length of life, quality of life) and 14th for Overall Health Factors (health behaviors, clinical care, social & economic factors, physical environment). Greene County was ranked 57th in New York State for Overall Health Outcomes and 52nd for Overall Health Factors. Columbia and Greene Counties share the same five leading causes of death. Columbia and Greene Counties' five leading causes of death in 2018 were as follows:

Cause of Death	Deaths per 100,000 Columbia	Deaths per 100,000 Greene
Heart Disease	175.1	202.9
Cancer	142.1	163.3
Chronic Lower Respiratory Disease	32.0	46.9
Unintentional Injury	36.6	68.0
Stroke	24.1	16.3

Information from the 2021 Regional CHNA comparing Columbia and Greene Counties to New York State (outside of New York City) provides a number of county-specific characteristics that helped the Columbia and Greene County Health Departments, our partner, Columbia Memorial Hospital, and our other community partners in determining the focus of the Plan. These include:

- Adult obesity rates in Columbia and Greene Counties of 24.3% and 34.5%, compared to the NYS rate of 29.1%
- Childhood obesity rates in Columbia and Greene Counties of 17.3% and 23.0%, compared to the NYS rate of 17.3%
- The obesity rate for WIC children in Columbia and Greene Counties of 19.5% and 19.6%, respectively, are higher than NYS rate of 15.1%;
- The percent of the Columbia County's and Greene County's population that do not have access to a reliable food source in 2018 is 10.2% and 10.9%, lower than the percent of the entire state; NYS excluding NYC (11.1%);
- Columbia County's and Greene County's opioid overdose mortality rates of 21.4/100,000 and 29.9/100,000, respectively, are considerably higher than NYS outside of NYC at 19.7/100,000, opioid overdose mortality rates were highest in Columbia and Greene county from 2016 to 2018 and,
- Columbia County's and Greene County's suicide mortality rates of 15.9/100,000 and 15.7/100,000, respectively, are higher than NYS excluding NYC (9.9%).

A unique characteristic common to both counties is the high rate of Lyme Disease. Greene County's rate of 550.9/100,000 and Columbia County's rate of 593.8/100,000 are considerably higher than the rest of the state, averaging around 65.4/100,000. Our community partners did see Lyme Disease as a serious issue for both Columbia and Greene Counties, however the consensus of the group was that significant resources, both financial and staff time, were already being expended and that additional time might not result in any significant drop in the disease rate.

As noted above, heart disease, stroke, and cancer are the leading causes of death among Columbia and Greene County residents. Columbia and Greene County heart disease mortality rates from coronary heart disease of 175.1/100,000 and 202.9/100,000 were higher than the statewide rate of 166.7/100,000. The stroke mortality rates for Columbia and Greene County were 24.1/100,000 and 16.3/100,000 compared to 27.3/ 100,000 for the rest of the state.

Lung cancer rates in Columbia and Greene Counties are 82.5/100,000 and 84.8/100,000, respectively, both higher than the NYS rate (excluding NYC) of 66.6/100,000. The Chronic Lower Respiratory Disease (CLRD) hospitalization rates are 26.3/10,000 in Columbia and 27.5/10,000 in Greene, both higher than the NYS (excluding NYC) rate of 20.3/10,000, and the CLRD mortality rates are 42.6/100,000 (Columbia) and 40.5/100,000 (Greene), both higher than the NYS (excluding NYC) rate of 35.0/100,000. Not surprisingly, in the 2022 CHNA, Columbia County's adult smoking rate of 16.2% is higher than the NYS (excluding NYC) rate and Columbia's incidence of asthma, 10.3%, was lower than NYS (excluding NYC) rate of 10.8%. Of particular concern is the asthma rate for the city of Hudson. Visits to the hospital emergency departments and hospital admissions for Hudson residents ran twice as high as the state rate. It is also noteworthy that the Columbia County Health Department's Healthy Neighborhood Program focuses on asthma in the homes. This program is not available in Greene County. However, Greene County Family Planning (a program of the Greene County Public Health Department) addresses smoking cessation with all new and current clients. Greene County rates of smoking increased from 14.9% in 2016 to 18.5% in 2018. The rates of smoking remain high among low income adults and those with poor mental health.

c. Current Data, and Changes over Time

The Community Health Needs Assessment examined a wide variety of health data. The following are summaries of the data, categorized into five key areas which the reader will immediately recognize as related to the State's Prevention Agenda: Chronic Disease; Healthy and Safe Environment; Healthy Women, Infants and Children; Infectious Disease; and, Mental Health and Substance Abuse. Additional detail can be found in the complete Community Health Needs Assessment (Volume Six).

COLUMBIA COUNTY

Chronic Disease

- Hudson neighborhood had a 1.9 times higher 2014-18 age-adjusted asthma ED visit rate (79.4/10,000) than NYS excl. NYC (42.9)
- The 2016-18 age-adjusted asthma hospitalization rates were 6.3 times higher among Black non-Hispanic residents (24.7/10,000), and 3.6 times higher among Hispanic residents (13.9), than White non-Hispanic residents (3.9); higher ratios than in NYS, excl. NYC
- Columbia County's 2018 adult smoking rate (16.2%) was higher than that of NYS, excl. NYC (13.9%), did not meet the PA objective (11.0%), but fell from 18.9% in 2016
- Columbia County had the Region's highest 2016-18 age-adjusted COPD/CLRD hospitalization rate (30.0 per 10,000), higher than NYS, excl. NYC (22.2)
- Hudson had a 2.2 times higher the 2014-18 age-adjusted COPD/CLRD hospitalization rate (51.6/10,000), and a 1.6 times higher ED visit rate (109.8), than NYS excl. NYC (23.6, 68.5)
- Columbia County's 2016-18 age-adjusted COPD/CLRD mortality rate of 41.9 per 100,000 was higher than NYS, excl. NYC (35.0) but fell from 42.6, from 2013-15 to 2016-18
- About 12,000 Columbia County adults were considered obese; the prevalence rate of 24.2% was lower than NYS, excl. NYC (29.1) but did not meet the PA objective (24.2%)
- For 2017-19, approximately 1,400 school-aged children and adolescents (17.3%) were obese, a prevalence similar to NYS, excl. NYC (17.3%), but did not meet the PA objective (16.4%)
- The 2018 age-adjusted adult diabetes prevalence (7.6%) was lower than NYS, excl. NYC (9.2%) but up from 4.4% in 2016
- The 2016-18 diabetes short-term complication hospitalization rate was 4 times higher among Black (13.5/10,000) than White (3.3), non-Hispanic residents
- Columbia County's 2016-18 age-adjusted coronary heart disease mortality rate 118.7 per 100,000, was higher than NYS, excl. NYC, (115.6) but down from 130.1 in 2014-16
- Columbia County's 2016-18 age-adjusted congestive heart failure mortality rate of 19.0 per 100,000, was higher than NYS, excl. NYC, (16.7), and was up from 13.7 in 2013-15
- Columbia County's 2015-17 age-adjusted colorectal cancer incidence rate (39.1/100,000) and mortality rate (16.9/100,000) were higher than NYS, excl. NYC (38.6 and 11.9)
- Columbia County's 2018 colorectal cancer screening rate (68.6%) was higher than NYS, excl. NYC (66.5%) and met the PA objective of 66.3%
- Columbia County's 2015-17 age-adjusted female breast cancer incidence (143/100,000) and late stage incidence (51.4) rates, per 100,000, were higher than NYS, excl. NYC (140 and 42.1), while mortality was lower (13.6 vs. 18.3)
- Columbia County's 2018 female breast cancer screening rate (88.0%) was higher than NYS, excl. NYC,(80.9%) among women 50 to 74 years of age

Healthy and Safe Environment

- Columbia County's 2016-18 incidence rate of elevated blood lead levels (≥10 µg/dl) of 8.8 per 1,000 tested children under 6 years of age was 1.35 times higher than NYS, excl. NYC (6.5)
- The County's lead screening rates in children aged 9-17 months-one screen (58.5%) and two screens by 36 months (44.4%) were: the Capital Region's lowest, lower than NYS, excl. NYC, (71.8% and 56.7%), and higher than 2 years prior
- Columbia County had the Capital Region's lowest rate of 2019 cooling tower regulatory compliance, at 38.3%, lower than NYS, excl. NYC (62.4%) and did not meet the PA objective (93.0%)
- Columbia County had the Capital Region's 2nd highest 2016-18 age-adjusted Motor Vehicle mortality rate of 11.6/100,000, higher than NYS, excl. NYC (6.8)
- Columbia County's 2017 falls to the elderly (65 years and over) hospitalization rate of 199.0/10,000 was higher than NYS, excl. NYC (193.5) and did not meet the PA objective (173.7)
- Columbia County had the Capital Region's 2015-19 substandard housing rate of 25.4% of housing units, similar to NYS, excl. NYC (25.6%)

Healthy Women, Infants, and Children

- Columbia County's 2016-18 rate of births with adequate prenatal care (76.6%) was the Region's highest, and similar to NYS, excl. NYC (76.4)
- Columbia County's 2016-18 birth/pregnancy indicator rates (infant mortality, prematurity and low birthweight, teen pregnancy)were all lower than NYS, excl. NYC
- Hudson neighborhood had the county's highest rates of 2016-18 infant mortality (5.7 per 1,000 births), teen pregnancy (20.4 per 1,000 females aged 15-19 years), and premature birth (10.2%)
- Canaan neighborhood had the county's highest 2016-18 rate of low birth weight births (9.3%)
- Chatham neighborhood had the county's highest 2016-18 rate of births with late or no prenatal care (7.7%)

Infectious Disease

- Columbia County had the Region's 3rd lowest rates of COVID-19 vaccination (70.1% with at least 1 dose and 63.8% with complete series), as of 11/14/21, which were lower than NYS, excl. NYC (72.6% & 65.7%)
- Columbia County's 2018-19 HPV vaccination rate of 29.9% was slightly higher than NYS, excl. NYC (29.4%), but did not meet the PA objective (37.4%)
- Columbia County's 2016-18 HIV case rate of 6.1 per 100,000 was higher than NYS, excl. NYC (6.1) and did not meet the PA objective (5.2)
- Columbia County's 2016-18 Lyme disease incidence rate of 593.8/100,000 was significantly higher than NYS, excl. NYC (65.4), and the highest rate of all NYS counties

Mental Health and Substance Abuse

- Columbia County had the Region's 2nd highest 2014-18 age-adjusted rates of ED visits (178.9/10,000) and hospitalizations (95.0/10,000) due to mental diseases and disorders (primary diagnosis), both higher than NYS, excl. NYC (156.7, 72.3)
- Columbia County had the Capital Region's highest 2016-18 age-adjusted rate of suicide mortality (15.9/100,000), 61% higher than NYS, excl. NYC (9.9/100,000), and did not meet the PA objective of (7.0)
- Columbia County had the Region's highest 2018 age-adjusted rate of adult binge drinking (23.8%); higher than NYS, excl. NYC (18.4%), and did not meet the PA objective (16.4)
- Columbia County had the Capital Region's highest 2016-18 age-adjusted rate of cirrhosis mortality (8.9/10,000); higher than NYS, excl. NYC (7.9/10,000)
- Columbia County had the Capital Region's 2nd highest 2016-18 age-adjusted opioid overdose mortality rate (21.4/100,000), higher than NYS, excl. NYC, (19.7), 1.8 times higher than in 2013-15 (11.6), and did not meet the PA objective (14.3)
- Columbia's 2018 age-adjusted opioid overdose ED visit rate of 66.8 per 100,000, while lower than NYS, excl. NYC (71.9), did not meet the PA objective ((5.3.)
- Columbia County's 2017-19 opioid analgesic prescriptions for pain rate of 473/1,000 was the Region's 2nd highest, higher than NYS, excl. NYC (413), did not meet the PA objective (350)
- Columbia County had the Capital Region's highest 2018 rate of newborns with neonatal withdrawal symptoms and/or affected by maternal use of drugs of addiction (27.8/1,000 newborn discharges), which was 2.0 times higher than NYS, excl. NYC (14.0)

GREENE COUNTY

Chronic Disease

- Greene County's 2018 age-adjusted prevalence of adults with current asthma (13.9%): was the Capital Region's 2nd highest, was up from 12.0% in 2016, and was higher than the NYS, excl. NYC 2018 prevalence of 10.8%
- Greene County's 2018 age-adjusted asthma emergency department (ED) visit rate (57.6 per 10,000) was lower than NYS, excl. NYC (64.3) and below the Prevention Agenda 2024 objective of 131.1 per 10,000
- Catskill neighborhood (26.6/10,000) had a 1.6 times higher 2014-18 age-adjusted asthma hospitalization rate than NYS excl. NYC (17.0)
- Greene's 2016-18 age-adjusted Asthma hospitalization rates were 3.5 times higher among Hispanic residents (17.3/10,000), than White non-Hispanic residents; a higher ratio than in NYS, excl. NYC (4.9)
- Greene County's 2018 age-adjusted adult smoking rate (18.5%): was the Capital Region's highest, was higher than that of NYS, excl. NYC (13.9%), was above the Prevention Agenda 2024 objective of 11.0%, and rose from 14.9% in 2016
- Greene County's 2015-17 age-adjusted lung cancer incidence (80.5/100,000) and mortality (50.8) rates, per 100,000, were the highest in the Region
- Greene County, alone in the Capital Region, saw age-adjusted lung cancer mortality increase from 2012-14 to 2015-17
- Greene County had the Capital Region's 2nd highest 2016-18 age-adjusted COPD/CLRD hospitalization rate (28.1 per 10,000)

- Catskill neighborhood (38.2/10,000) had a 1.6 times higher 2014-18 age-adjusted COPD/CLRD hospitalization rate than NYS excl. NYC (23.6)
- Greene County's 2016-18 age-adjusted COPD/CLRD mortality rate (34.2/10,000) was lower than that of NYS, excl. NYC, (35.0) and fell by 16% (from 40.5), from 2013-15 to 2016-18
- Approximately 11,860 Greene County adults were obese, for a 2018 age-adjusted prevalence rate of 34.5%. This was the highest in the Capital Region, higher than NYS, excl. NYC (29.1%), an increase from 27.2% in 2016, and did not meet the PA objective (24.4%)
- Approximately 1,355 of Greene County's school-aged children and adolescents were obese for a 2017-19 prevalence rate of 23.0%. This was the highest in the Region, higher than NYS, excl. NYC (17.3%), an increase from 19.6% in 2016, and did not meet the PA objective (16.4%)
- Greene County's 2018 age-adjusted adult diabetes prevalence (13.2%) was higher than NYS, excl. NYC (9.2%) and up from 5.5% in 2016
- Greene County's 2016-18 age-adjusted diabetes short-term complication hospitalization rate of 6.4 per 10,000 aged 18+ years, was higher than NYS, excl. NYC, (5.1)
- Greene County's 2016-18 age-adjusted coronary heart disease mortality rate (125.9/100,000 was higher than NYS, excl. NYC, (115.6) and up from 121.4 in 2014-16
- Greene County's 2016-18 age-adjusted congestive heart failure mortality rate (22.2/100,000) was the Region's highest, higher than NYS, excl. NYC (16.7), and was up from 17.5 in 2013-15
- Greene County's 2016-18 age-adjusted stroke mortality rate (24.9/100,000) was lower than NYS, excl. NYC, (27.6), but was up from 21.8 in 2013-15
- Greene County's 2015-17 age-adjusted colorectal cancer incidence rate (47.2/100,000) and mortality rate (14.4/100,000) were higher than NYS, excl. NYC (38.6 and 11.9)
- Greene County's colorectal cancer screening rate (72.9%) was higher than NYS, excl. NYC (66.5%) and met the PA objective (66.3%)
- Greene County's 2015-17 female breast cancer late stage incidence rate (46.0/100,000) was higher than NYS, excl. NYC, (42.1), while total incidence and mortality rates were lower (131 vs. 140 and 14.3 vs. 18.3)
- Greene County's 2018 female breast cancer screening rate (75.6%) was lower than NYS, excl. NYC, (80.9%)

Healthy and Safe Environment

- Greene County's 2016-18 incidence rate of elevated blood lead levels (≥10 µg/dl), 9.2 per 1,000 tested children under 6 years of age, was 1.4 times higher than NYS, excl. NYC (6.5), but down from 2013-15 (11.0)
- Greene County's lead screening rates, one screen in children aged by 9-17 months (66.9%) and two screens by 36 months (49.5%) were the Capital Region's 2nd lowest, lower than NYS, excl. NYC, (71.8% and 56.7%), and lower than 2 years prior (70.3% and 54.5%)
- Greene County had the Region's highest 2014-18 age-adjusted motor vehicle accidents hospitalization rate (10.6/10,000), and 2016-18 age-adjusted mortality rate (14.3/100,000), both markedly higher than NYS, excl. NYC (5.9/10,000 and 6.8/100,000)
- Greene County's 2016-18 hospitalization rate for falls among children aged under 10 years (14.5/10,000) was the Capital Region's highest, and 2.4 times higher than NYS, excl. NYC (6.1)
- Greene County had the Capital Region's 2nd highest 2015-19 substandard housing rate (25.1%), but lower than NYS, excl. NYC (25.6%)

- Greene County had the highest 2018 percentage of population with food insecurity in the Capital Region (10.9%), but lower than NYS (11.1%)

Healthy Women, Infants, and Children

- Greene County's 2016-18 premature birth rate (9.5%) was higher than NYS, excl. NYC (9.0%) and did not meet the PA objective (8.3%)
- Greene County's 2016-18 births with late or no prenatal care (5.5%) were higher than NYS, excl. NYC (4.3%) and higher than in 2013-15 (5.0%)

Infectious Disease

- Greene County had the Region's lowest 2018-19 percentage of children aged 24-35 months with a completed 4:3:1:3:3:1:4 immunization series (61.9%), lower than NYS, excl. NYC (65.3%) and did not meet the PA objective (70.5%)
- Greene County's 2018-19 HPV vaccination rate 36.2%, while higher than NYS, excl. NYC (29.4%, did not meet the PA objective (37.4%)
- The county had the Region's highest COVID-19 mortality rate (124.2/100,000), for the period 1/12/21 to 1/11/22 , higher than NYS, excl. NYC (94.4)
- Greene County had the Region's lowest rates of COVID-19 vaccination (61.5% with at least 1 dose and 55.6% with completed series), as of 11/14/21, which were lower than NYS, excl. NYC (72.6% and 65.7%)
- Greene County's 2016-18 Lyme disease incidence rate of 550.9/100,000 was significantly higher than NYS, excl. NYC (65.4), and the 2nd highest rate of all NYS counties

Mental Health and Substance Abuse

- Greene County had the Region's highest 2018 age-adjusted rate of frequent mental distress (16.4%), higher than NYS, excl. NYC (11.8%), and did not meet the PA objective (10.7%)
- Greene County's 2014-18 rate of hospitalizations (87.6/10,000) due to mental diseases and disorders (primary diagnosis), which was higher than NYS, excl. NYC (72.3)
- Greene County had the Region's 2nd highest 2016-18 age-adjusted rate of suicide mortality (15.7/100,000), higher than NYS, excl. NYC (9.9/100,000), and did not meet the PA objective (7.0)
- Greene County had higher 2014-18 self-inflicted injury ED visit (7.7/10.000) and hospitalization (4.2) rates than NYS, excl. NYC (5.6, 3.3)
- Greene County had the Region's highest 2016-18 age-adjusted opioid overdose mortality rate (29.9/100,000), which was 1.5 times higher than NYS, excl. NYC, (19.7), 1.8 times higher than in 2013-15 (16.8), and did not meet the PA objective (14.3)
- Greene County had the Region's highest 2018 age-adjusted opioid overdose ED visit rate (84.6/100,000), which was 1.18 times higher than NYS, excl. NYC, (71.9), and did not meet thee PA objective (53.3)
- Greene County had the Region's highest 2017-19 age-adjusted opioid analgesic prescribing rate (559/1,000), which was 1.35 times higher than NYS, excl. NYC, (413) but was 27% lower than in 2014-16 (766); it did not meet the PA objective (350)

d. How the Data Were Obtained

The health indicators selected for this report were based on a review of available public health data and New York State priorities promulgated through the Prevention Agenda for a Healthier New York. The collection and management of these data has been supported by the state for an extended period and are very likely to continue to be supported. This provides reliable and comparable data over time and across the state. These measures, when complemented by the Expanded Behavioral Risk Factor Surveillance System and Prevention Quality Indicators, provide health indicators that can be potentially impacted in the short-term. The Common Ground Health provided SPARCS (hospitalizations and ED visits) data that were utilized to generate county and ZIP code level analyses of mortality, hospitalizations, and emergency room utilization, for all residents, by gender, race and ethnicity. The time frames used for the ZIP code analyses were 2012-2016 Vital Statistics and 2014-2018 Statewide Planning and Research Cooperative System (SPARCS) data. The 5-year period establishes more reliable rates when looking at small geographic areas or minority populations.

Additional data were examined from a wide variety of sources:
• Prevention Agenda 2019-2024 Dashboard of Tracking Indicators (2016-2018)
• Community Health Indicator Reports Dashboard (2016-2018)
• County Health Indicators by Race/Ethnicity (2016-2018)
• County Perinatal Profiles (2016-2018)
• Vital Statistics Annual Reports (2018)
• Behavioral Risk Factor Surveillance System (BRFSS) and Expanded BRFSS (2016, 2018)
• Cancer Registry, New York State (2014-2018)
• Prevention Quality Indicators (2016-2018)
• Communicable Disease Annual Reports (2013-2018)
• The Pediatric Nutrition Surveillance System (PedNSS) (2015-2017)
• Student Weight Status Category Reporting System (2017-2019)
• County Opioid Quarterly Reports (January 2020-October 2021)
• New York State Opioid Data Dashboard (2017-2019)
• New York State Child Health Lead Poisoning Prevention Program (2015 birth cohort; 2016-2018)
• New York State Kids' Well-being Indicator Clearinghouse (KWIC) (2016-2018)
• County Health Rankings (2021)
• NYS Division of Criminal Justice County Crime Rates (2019-2020)
• Bureau of Census, Tables and Maps (https://www.census.gov/data.html) (2019)
• Bureau of Census, American Community Survey (2015-2019)

These data sources were supplemented by a Capital Region Community Health Survey. The 2021 Community Health Survey was conducted in September-October 2021 by HCD with the assistance of the Albany, Columbia, Greene, Rensselaer and Schenectady health departments, and Albany Medical Center, Columbia Memorial, Ellis, and St. Peter's Health Partners hospitals. The survey was a convenience sample of adult (18+ years) residents of the Capital Region. The survey included 2,104 total responses. This consumer survey was conducted to learn about the health needs, barriers and concerns of residents in the Capital Region. The Appendix (2021 Capital Region Community Health Survey) contains a detailed summary of the findings, as well as the questionnaire used. Local data were compiled from these data sources and draft sections were prepared by health condition for inclusion in this community health needs assessment. Drafts were

reviewed for accuracy and thoroughness by two staff with specialized health data knowledge: Michael Medvesky, M.P.H. Director, Health Analytics, Healthy Capital District (HCD), and Spencer Keable, M.P.H., Public Health Data Analyst, HCD. The 2022 Capital Region Community Health Needs Assessment Draft was sent to local subject matter experts for review in the health departments of Albany, Rensselaer, Schenectady, Columbia and Greene Counties and in St. Peter's Health Partners, Albany Medical Center, Ellis Hospital, and Columbia Memorial, as well as being placed on the HCD website for public review and comment. Comments were addressed and changes were incorporated into the final document.

2. Identification of Significant Health Needs and Main Health Challenges

a. Behavioral Risk Factors

Behavioral risk factors identified by the Columbia-Greene Healthy People Partnership include sedentary lifestyle, unhealthy diet, tobacco use, and misuse and abuse of substances. Additionally, unsafe sex, poor disease management practices, and poor mental health days are behavioral risk factors believed to influence some of the negative health outcomes observed in the data for Columbia and Greene County residents.

b. Environmental Risk Factors

In addition to behavioral risk factors, the environment in which community members live, work, and play influences health outcomes and programming. Availability to safe and accessible places to spend time is a strong indicator in the likelihood that the population spends their time being physically active. In Columbia and Greene Counties there are plenty of outdoor opportunities in our beautiful state and local parks, but a very real challenge for many is the need for transportation to access these local recreation spaces. There are few indoor gyms in the Twin Counties that require membership fees. Additionally, those in the population with disabilities have access to many state parks that are accessible but require transportation to get there.

c. Socioeconomic risk factors

Socioeconomically, Columbia and Greene Counties suffer from many of the challenging issues that also face other rural communities. These include lack of affordable housing, children living in poverty, educational attainment, and food insecurity. These factors undermine the health and well-being of our community and are apparent influencers of the data reviewed by the Healthy People Partnership.

d. Policy Environment

There is only a modest amount of work in the Twin Counties that is explicitly focused on policy. One example is the Tobacco-Free Action Program of Columbia and Greene Counties, a program of the Healthcare Consortium, a rural health network located in Hudson, NY that serves both Columbia and Greene Counties. Tobacco-Free Action advocates for policy change that reduces

exposure to secondhand smoke, makes tobacco products less visible and accessible, and makes tobacco use more expensive, less convenient, and less socially acceptable. In Greene County, all tobacco use, including e-cigarettes, is prohibited on County-owned property. In Columbia County, all tobacco use is prohibited on County-owned property except in designated areas. This includes the main county buildings and all satellite locations. Columbia Greene Community College, the local community college serving both Columbia and Greene Counties, is also a tobacco-free and e-cigarette free campus.

The majority of municipal parks in both counties are tobacco-free. This includes town and village parks. In Columbia County, 38 parks, constituting 95%, are covered by a tobacco-free policy; in Greene County there are 22, which is 80% of the total number of municipal parks.

Among providers of subsidized multi-unit housing, the majority in each county has adopted a smoke-free policy. This includes all 19 senior affordable housing properties and three that provide housing for low-income individuals and families in Columbia County. Together, they provide over 1,100 units of smoke-free affordable housing. The Public Housing Authority in Hudson (134 units) and Catskill (85 units) are also smoke-free by HUD-directive.

Another example of work that has occurred at the policy level is the Columbia County Addiction Epidemic Response Plan, which was adopted by the Columbia County Board of Supervisors, the governing body, composed of elected officials, for Columbia County. This plan may be found on the County's website at www.columbiacountyny.com.

e. Other Unique Community Characteristics

One of the most unique health-related characteristics of Columbia and Greene Counties is a shared hospital. Columbia Memorial Hospital, located in Hudson (Columbia County), serves both Greene and Columbia County residents. The Hospital is part of a clinically integrated health system that includes acute care, primary and specialty care, lab and imaging services; it is also an affiliate of Albany Medical Center.

Columbia and Greene Counties have reportedly higher rates of provider shortage than the rest of NYS. In NYS, the number of residents per healthcare provider is 1,194:1. Columbia County has 2,497 residents per provider, and Greene County has 2,638 residents per provider. This is approximately twice the number of residents per provider, leaving Columbia and Greene residents chronically underserved.

Another unique characteristic of Greene and Columbia Counties, albeit an unfavorable one, is the staggering rate of opioid overdoses. While being two small, rural counties in New York, Greene and Columbia Counties have some of the highest rates of opioid overdose deaths and emergency department visits due to opioid use.

In 2016-2018, overdose death rates occurred at 14.3/100,000 individuals in the Capital Region. In 2016-2018, the Greene County overdose death rate was 29.9/100,000, the Columbia County rate was 21.9/100,000. Each county reported approximately twice the overdose death rate of the Capital Region. Opioid-related Emergency Department visits occurred at a rate of 56.9/100,000 in the Capital Region in 2018. Greene County had 84.6/100,000 visits, nearly

twice the Capital Region rate. Columbia County had 66.8/100,000, respectively higher than the Capital Region rate. As a result, both Columbia and Greene Counties were recipients of State Targeted Response (STR) monies from the Office of Alcohol and Substance Abuse Services (OASAS). Both counties have and will continue to receive Overdose Data 2 Action (OD2A) funding from the New York State Department of Health (NYSDOH). Columbia and Greene were included in a multistate study, funded by the National Institute of Drug Abuse (NIDA) and led by Columbia University that began in the fall of 2019 and will conclude in the spring of 2023.

3. Summary of Existing Health Care Assets, Facilities, and Resources

The following charts summarize the numerous health care assets, facilities and resources available to the Columbia-Greene Healthy People Partnership. They are organized by Prevention Agenda Priority.

Assets related to Priority Area # 1: Prevent Chronic Diseases (Obesity-Related Illness)

Ancramdale Neighbors Helping Neighbors Association Food Pantry	
Columbia	Mondays 5-6pm
Athens Community Food	
Greene	Emergency 3 Day Food Pantry; Open Tuesdays 2-3pm; Thursdays 4:30-5:30pm
Bryant Nutrition	
Columbia & Greene	Certified Diabetes Lifestyles Coaches, Nutritionist and Personal Trainers
	Offers Diabetes Prevention Program
	Specializes in diabetes education, chronic kidney disease and cardiac health
	Offers strength training, weight loss programs and group trainings
Cairo Food Pantry	
Greene	Provides assistance to residents of Cairo-Durham school district once a month
Catskill Food Pantry	
Greene	Open Fridays 1-4pm
Chatham Area Silent Pantry	
Columbia	Monday 10-12pm, Thursday 4-6 & Friday 10am-12pm
Coxsackie Community Food Pantry	
Greene	Open Saturdays 10-11am; Tuesdays 1-2pm; Thursdays 7-8pm
Columbia & Greene County Participating Health Plans	
Columbia & Greene	On-site workshops and wellness challenges
	Health fairs
	On-site health coaching and education
	On-site biometric screenings (Know your Numbers)
	Discounts for Jenny Craig and Fitness Centers
Catholic Charities of Columbia and Greene Counties	
Columbia & Greene	Providers of WIC (Women, Infant, and Children) Supplemental Nutrition Education Program
	Assistance with enrolling or recertifying for Supplemental Nutrition Assistance Program (SNAP), also known as food stamps
	Care management services through Adult Health Homes
Catholic Charities Food Pantry	
Columbia	Open Mondays 9am-12pm; Wednesdays 12-5pm

Charlie's Pantry-Immaculate Conception Church	
Columbia	Tuesday 10:30am-1pm
Christ Episcopal Church Food Pantry	
Columbia	Emergency Food Pantry Monday-Friday 9am-12pm
Church of St. Joseph Food Pantry	
Columbia	Friday (1/month)3-5 on Delivery Days
Columbia County Department of Health	
Columbia	Provides Healthy Monday Newsletters which focus on nutrition and health living
	Provides health educators who present at community events on sugar content, healthy eating behaviors, chronic disease prevention
	Provides health education programming at children's camps and after school programs
	Assists with planning and coordination of school and community wellness initiatives
	Collaborates on prevention activities of Columbia County obesity efforts
	Participates in the breastfeeding in workplace program
	Facilitates action-oriented planning meetings with community partners
	Delivers instruction on Tai Chi
Columbia County Recovery Kitchen	
Columbia	Prepares and delivers nutrient-rich, balanced meals to vulnerable adults and children who have been referred to us by county social service organizations, public school social workers and the Columbia County Sanctuary Movement.
Columbia Opportunity	
Columbia	Emergency Food Pantry Monday-Friday 10am- 3pm
Columbia Memorial Hospital	
Columbia & Greene	Columbia Memorial Hospital (CMH) operates an extensive primary care network engaged in medical management of obesity-related illnesses
Cornell Cooperative Extension of Columbia and Greene Counties	
Columbia & Greene	Nutrition Education, Food Safety, Sugar Sweetened Beverage and Healthy Recipe programs available for community groups

Community Action of Greene County	
Greene	Emergency food pantries
Elizaville Food Pantry	
Columbia	Serving residents of Clermont, Germantown School District and Tivoli
Germantown Community Cupboard	
Columbia	Serving residents of Germantown School District and Tivoli
Ghent Food Pantry	
Columbia	Monday & Thursday 9am-12pm
Greene County Department of Human Services	
Greene	Provides nutritious meals for seniors 60 years of age and older.
	Provides funding to community organizations to implement evidence based health initiatives.
Greene County Public Health	

Greene	Collaborates on prevention activities of Greene County obesity efforts
	Provides resources and links for prevention and health promotion to schools and community groups
	Facilitates action-oriented planning meetings with community partners
	Provides education on obesity and diabetes-related subjects
	Participates in Greene County Worksite Wellness Committee
Greene County Rural Health Network	
Greene	Provides seed money to local organizations in support of health programs that improve the health of Greene County residents.
	Administers obesity prevention programs, including Biggest Loser and the Greene Walks Program
	Promotes compliance with Health Screening Guidelines for Breast Cancer and Diabetes.
Hannaford Supermarket Eventbrite Classes	
Columbia & Greene	Hannaford offers free in-store and online Dietitian services, including classes that offer the latest nutrition trends and products or concerns about diabetes, heart health, food allergies or other nutrition needs. A team of registered and licensed dietitians can be found at hannaford.com/dietitians.
Hawthorne Valley	
Columbia	Programs focusing on cultivating reverence for life, respect for earth, practical skills, and more are available through: Parent Child Classes: Birth to Age 3, Nursery & Kindergarten, Grades 1-5, 6-8 and 9-12, EARTH: Education and Renewal Through Hands, After School Program and Extended Care, Summer Camps and Homeschool Student Opportunities
Hudson Out of School Time	
Columbia	Large group of collaborating local organizations providing out of school time experiences for school aged children and families within the Hudson City School District, H.O.S.T. provides high quality programs teaching sustainable life skills and
Perfect Ten	
Columbia	Independent non-profit organization helping girls to building respect, dignity, fairness, caring, equality, and self-esteem through programs focusing on developing sustainable life skills, financial literacy and job training.
Philmont/Mellenville Food Pantry	
Columbia	Tuesday 3-6 & Saturday 10:30am-1pm
Independent Living Center of the Hudson Valley	
Columbia & Greene	Staff provide activities that support living healthy. Activities include smoking cessation classes, living healthy with chronic disease, exercise classes, Zumba, meditation, chair yoga, and Diabetes Prevention classes.
Matthew 25 Food Pantry	
Greene	Emergency 3 day food pantry open Sundays 1-3pm; Fridays 1-4pm
Prabhuji Mission Food Pantry	
Greene	Food distribution Fridays 11am
Rock Solid Church Food Pantry	
Columbia	Thursday 11:30am-1:30pm; visit www.rocksolidchurch.net for summer schedule
Roe Jan Food Pantry	
Columbia	Friday 10am-12pm

Rolling Grocer 19	
Columbia	Year round, full-service grocery store located down street in Hudson, NY, offering fresh produce, dairy, bread, grains, meat, seafood, non-perishables, toiletries and other miscellaneous products. Also, operate a grocery store on wheels serving the broader Columbia County. Made affordable through a fair pricing system, similar to sliding scale.
Salvation Army	
Columbia	Monday & Friday 8am-10am
St. Mark's Lutheran Food Pantry	
Columbia	Monday, Wednesday & Saturday 9am-12pm
Sylvia Center	
Columbia	Serves youth, teens, adults, families, and community members on Katchkie Farm's through community-based programs. Full-day programs include tours of the greenhouses and farm, youth planting seeds, harvesting vegetables and creating a healthy meal using what they picked. In addition, programs training teachers in healthy cooking curriculums are available.
Valatie Ecumenical Food Pantry	
Columbia	Monday 12-2pm; 1st, 3rd & last Wednesday 6-8pm; 2nd & 4th Saturday 9-11am
YMCA	
Greene	Provides physical education to seniors (e.g. Silver Sneakers)
	Provides Chronic Disease Programs (e.g. Livestrong at the YMCA, Pedaling for Parkinsons, Moving for a Better Balance, Enhance Fitness)
	Provides General Health & Weight Loss Programs (e.g. Introduction to Weightlifting, Boot Camp, Yoga, etc.)
Zion Community Pantry	
Columbia	2nd & 4th Tuesday 5:30-6:30pm; 1st & 4th Friday 12-1pm

Assets related to Priority Area # 2: Promote Well-Being and Prevent Mental and Substance Use Disorders

Alliance for Better Health	
Columbia & Greene	The Alliance for Positive Health's Syringe Exchange Program provides new, sterile syringes and other injection supplies, safe disposal of used syringes, opioid overdose prevention, Buprenorphine stabilization services in our Drug User Health Hub, and case management around HCV care and treatment in our HCV Patient Navigation Program. Services also include education and information on safer injection techniques, referrals to HIV/STI/Hepatitis testing, health care, wound care, and substance use treatment programs.
American Foundation for Suicide Prevention-Capital Region Chapter	
Columbia & Greene	Education, Training, and Advocacy
Apogee Center	
Columbia	Individual Peer to Peer Support Peer Led Group Support Advocacy Wellness Recovery Action Plan (WRAP)™ development Benefits Advisement Wellness and Recovery Events Community Participation Opportunities
Berkshire Farms	
Columbia	Prevention Services and Residential Treatment Center
Catholic Charities of Columbia and Greene Counties	
Columbia	OASAS-contracted Prevention Providers for Columbia County, providing substance abuse education in schools and community Care management services through Adult Health Homes
Columbia County Community Services Board (CCCSB)	
Columbia	The fifteen-member Community Services Board (CSB) and its subcommittees are nominated through board consensus and appointed by the County Board of Supervisors to four year terms. The CSB was designed and established through New York State Mental Hygiene Law. As Director of Community Services, Dan Alamasi is responsible for the administration of a comprehensive planning process for local mental hygiene services. The Community Services Board, under the leadership of Chair, Beth Schuster, assists in this planning process. Subcommittees, which report directly to the Community Services Board, focus on identifying county needs as they relate to the three mental hygiene disability areas: alcoholism and substance abuse, mental health, and developmental disabilities. Through the work of the CSB and the Columbia County Department of Human Services, annual plans are submitted to the New York State Offices of Alcoholism and Substance Abuse Services (OASAS), Mental Health (OMH), and People with Developmental Disabilities (OPWDD). Subcommittee reports and recommendations are included in these annual plans which are required for localities to be eligible for State Aid funding.

Columbia County Department of Health	
Columbia	Promote opioid overdose prevention programs through collaboration with community partners Project Needle Smart is a community safe sharps collection program Certified Community Opioid Overdose Prevention Program Promote medication take back initiatives Provide public health education in the community
Columbia County Department of Human Services	
Columbia	Adult and Children's OMH Outpatient Mental Health Clinic Adult and Children's DOH Health Home Care Coordination
Columbia County Mental Health Center	
Columbia	Comprehensive Case Management, Care Coordination and Health Promotion, Comprehensive Transition Care, Patient and Family Support, Referrals to Community and Social Support Services for adults with two chronic conditions including substance use disorders. Adult and Children's OMH Outpatient Mental Health Clinic. Adult and Children's DOH Health Home Care Coordination, adult housing Single Point of Access Coordination, children's services Single Point of Access Coordination , 24/7 Crisis Services, forensic coordination, Assisted Outpatient Treatment Coordination, behavioral health planning and advocacy.
Columbia County Pathways to Recovery (CCPR)	
Columbia	Comprehensive resources for individuals and families impacted by substance abuse disorders Helpline Hotline
Columbia County Sheriff's Office	
Columbia	DARE (prevention programming)
	S.T.A.R. Dorm (Sheriff's Treatment and Recovery Dorm) in the Jail
	School Resource Officers
	Correctional Services Coordinator
	Medication Assisted Treatment (Vivitrol, Buprenorphine, and Methadone) available in the jail
	Incarcerated Individuals have access to a " Recovery Peer Advocate " and that we continually conduct Narcan Training for our and Employees and incarcerated.
Columbia Memorial Health (CMH)	
Columbia & Greene	Columbia Memorial Health (CMH) includes a 192-bed hospital where it provides emergency, inpatient, surgical, lab, and imaging services. The health system also includes three urgent care centers, and an extensive network of outpatient primary and specialty care providers. With regard to behavioral health services, CMH has a 22-bed inpatient psychiatric unit, and an outpatient clinic that has recently expanded its capacity by contracting with a provider of telehealth services. It has also integrated behavioral health into the primary care setting in a couple of key ways. For instance, CMH providers in the primary care setting conduct depression screening, which includes identifying people with suicidal ideation, as well as drug abuse screening for adolescents and adults. Furthermore, behaviorists (typically social workers or psychiatric nurses) are co-located in various Family Care Centers in order to provide MH/SUD screening, crisis intervention, short-term counseling and connection to long-term counseling, goal-setting and lifestyle interventions. Behaviorists also coordinate consultation between primary care providers and psychiatrists to address difficult cases, solicit recommendations for treatment, and co-manage medications. Additionally, CMH provides Medication Assisted Treatment, both in the emergency department where physicians will induce Buprenorphine (3-day dose) in order to manage detoxification and “bridge” patients to appointments, and in the outpatient setting, where a

	number of Buprenorphine prescribers are employed. It also partners with Greener Pathways, a program of Twin County Recovery Services, to host peer recovery specialists in its Hospital to facilitate linkages to treatment. Finally, CMH patients also have access to addiction services elsewhere in the Albany Med Health System of which CMH is a part. CMH also has a Controlled Substance Committee, a multidisciplinary group that includes psychiatry, addiction, pain management, pharmacy, primary care, ER and hospitalists. The committee convenes for case presentations by primary care providers who have challenging controlled substance patients and are looking for input from the various specialties and ways to improve the individual management of that patient. Cases are presented at least quarterly but can be convened with short notice as requested.
Columbia-Greene Addiction Coalition (CGAC)	
Columbia & Greene	Formerly known as the Columbia-Greene Controlled Substance Awareness Task Force, this two-county coalition was formed in 2013 to address the use, misuse and abuse of prescription drugs, with a focus on opiates. More recently, the group was renamed to the Columbia-Greene Addiction Coalition to broaden its focus on the issue of addiction, rather than any one particular drug of abuse. It has been populated by health and human service providers, representatives from law enforcement and criminal justice, grassroots community groups and others, and has been co-chaired by the Directors of Community Service from each county. In the Fall of 2022, the Coalition hired a Coordinator, who is expected to pursue incorporation.
Columbia-Greene Suicide Prevention Coalition	
Columbia & Greene	Planning, coordination, education, and advocacy
Community Action of Greene County	
Greene	Community Action provides services and programs for low-income and vulnerable individuals. Services include: Domestic violence program, wheels for work, housing and homelessness prevention, Crime Victims Advocacy Program
Greene County Department of Social Services	
Greene	Offers preventative services Makes referrals for treatment involving drug abuse, alcohol addiction, and emotional problems
Greene County Family Planning	
Greene	MAT provider
Greene County Mental Health Center (GCMHC)	
Greene	• GCMHC currently has therapists located in the following school districts: Cairo-Durham, Coxsackie-Athens, Hunter-Tannersville, and Windham, Ashland, Jewett. School-based services increase access to services families would not be able to easily utilize. Services provided include: 1). Information and referral, medication management, case management, and crisis management and 2). Other requested school related mental health preventive services or groups for students as needed. GCMHC continues to collaborate with school staff in districts not participating in the school-based program to accommodate referrals, manage crisis, communicate about high risk students, and provide trainings when requested. • GCMHC currently has therapists located in the following Primary Care Offices: Windham Medical Care, Jefferson Heights Family Care, and Coxsackie Medical Care. GCMHC maintains three satellite offices in Greene County. Therapists provide mental health assessment and treatment services directly to clients at the satellite locations, as well as linkage and referral

	to other programs and services. A screening instrument, brochures, and mental health educational materials are made available to the PCP satellite locations.

Greene County Public Health Department	
Greene	Promotes opioid overdose prevention programs through collaboration with community partners
	Project Needle Smart is a community safe sharps collection program
	Promotes medication take-back initiatives
	Provides public health education in the community
Greene County Rural Health Network	
Greene	Provides seed money to local organizations in support of innovative drug and alcohol abuse prevention programs Provides medication drop boxes around Greene County
Mental Health Association of Columbia-Greene Counties (MHA)	
Columbia & Greene	MICA enhancement offers additional assistance to those struggling with alcohol and/or substance use issues and is available to individuals living within a residential program
Mobile Crisis Assessment Team (MCAT), a program of the Mental Health Association	
Columbia & Greene	Provides effective crisis intervention designed to reduce hospitalization rates, minimize police interventions, and link crisis callers to long-term service providers in the community
National Alliance on Mental Illness (NAMI)	
Columbia	Information Help Line: Early identification and intervention can sharply improve outcomes and result in a substantially shorter and less disabling course of illness.
	Family Support Groups: Virtual Support Groups 1st & Third Wednesdays each month
	Family to Family (F2F): An educational program for families and caregivers of adults with mental illness
Greene	Family Support Groups: Virtual Support Groups, Thursdays, 5:30pm
	Basics Class NAMI Basics is a free, 6-week education program for parents and family caregivers of children and teens who are experiencing symptoms of a mental illness or who have already been diagnosed.
	Family to Family (F2F): An educational program for families and caregivers of adults with mental illness
Northeast Career Planning	
Columbia & Greene	Programs are specialized to meet the specific needs of those with addictions and substance abuse and other barriers to employment.
	Provides individualized career services, including: job readiness screening; vocational assessment; vocational counseling; career exploration; job readiness preparation; job seeking skills; job development and placement; job retention and support; and referrals to additional service providers.

Project Safe Point (a program of Catholic Charities Care Coordination Services, Albany)	
Columbia & Greene	Naloxone training Risk Reduction Services Harm Reduction Case Management HIV/HCV Screening Syringe Exchange

Twin County Recovery Services (TCRS)	
Columbia & Greene	Twin County Recovery Services (TCRS) is the sole OASAS-licensed treatment provider located in and serving Columbia and Greene Counties. It provides school-based prevention programming in Greene County, and clinical, residential and peer services in both Columbia and Greene Counties. Greener Pathways, a program of TCRS, provides off-site treatment and mobile services, including: • Peer-to-peer support networks that help build recovery and social supports via Certified Recovery Peer Advocates (CRPA) • Assistance with Transportation- available for any resident in Greene or Columbia Counties who are affected by substance use disorder • Live Video Telemedicine Sessions- Providing expanded clinical services beyond the traditional clinical setting via video and multimedia technology • Outreach services- Narcan training, information outreach and community events for promoting the culture of recovery • Personalized Treatment Program- mobile counseling services providing screening, brief intervention and referral to treatment (SBIRT) via mobile clinician and therapeutic team • Medications to help prevent relapse- linkages and services for medication assisted treatments (MAT) including Vivitrol, Suboxone and methadone TCRS also offers the Impaired Driver Program.
Water Street Studio (a program of MHA)	
Greene	Individual Peer to Peer Support Peer Led Group Support Advocacy Wellness Recovery Action Plan (WRAP)™ development Benefits Advisement Wellness and Recovery Events Community Participation Opportunities

Youth Clubhouses (a program of MHA)	
Columbia & Greene	Hudson and Catskill locations. Programs offered and target audience: Youth Clubhouses (Columbia and Greene Counties) - Drop in center for youth ages 12-17 Young Adult Group (Columbia and Greene Counties) - Drop in center for young Adults 18+ In addition, the Clubhouses host space for Youth Voices Matter, Refuge Recovery, NarAnon, and other meetings/events that support recovery The YCH mission is to provide recovery resources to all young individuals within the community who are in recovery, who are seeking recovery, or who have been impacted by Substance Use Disorder (SUD). It welcomes all young allies in the community who have been impacted by SUD and who support recovery.

Assets related to Priority Area # 3: Prevent Communicable Diseases

Columbia County Department of Health	
Columbia	Administers vaccination program for Columbia County Provision of vaccinations to homebound individuals Case management Testing Provision of and connection to resources for positive cases Daily reporting of number of total cases, new cases, hospitalized cases, cases being treated in the Intensive Care Unit Public Education
Greene County Public Health	
Greene	Administers COVID vaccination program for Greene County
Columbia Memorial Health (CMH)	
Columbia & Greene	Participates in regional network of hospitals as COVID volumes shift Timely and complete daily reporting to NYSDOH (e.g. IP or observation infection #'s for staff and patients, # in ICU, # vented, # vax administered, total adjusted daily rates, complications, reasons for admission, fully/partially vaxed, unvaxed, unknown vax status, etc) Weekly reporting on PPE status Daily report to HHS Weekly report to National Safety Network (CMS)
A.B. Shaw Fire Department	
Columbia & Greene	Serves as a host site for a weekly COVID vaccination clinic
Columbia-Greene Community College (CGCC)	
Columbia & Greene	Serves as a host site for vaccination clinics
Pharmacies (Various)	
Columbia & Greene	Provides all available COVID-19 vaccine manufacturers, any eligible dose in the recommended series, to eligible ages during operating hours. These include community locations of Shop Rite, CVS, Walgreens, Hannaford, Kelly's pharmacy.
Vaccination POD Host Sites (Various)	
Columbia & Greene	Multiple businesses, organizations, places of worship, etc. throughout the two counties served as "hosts" for vaccination events organized and managed by the LHDs. While many of these sites are not currently active, they could be reactivated should the need arise

D. Community Health Improvement Plan/Community Services Plan

1. Identification of Priorities – Process, Criteria, Community Engagement

The process for identifying health priorities in Columbia and Greene Counties began with an agreement among the key parties involved to approach community health planning in the most collaborative way possible. The Columbia County Department of Health, Greene County Public Health Department, and Columbia Memorial Hospital--hereinafter, the "Planning Partners"—recognized the many structural links between the counties, including the bridge that connects them, the community college that educates them, the hospital that cares for them, and the many other organizations dedicated to serving them. Countless friendly, familial, and professional relationships regularly cross the little river between the "Twin Counties," making a joint effort seem both efficient and appropriate.

The Columbia-Greene Planning Partners scheduled one partner meeting bringing all partners together to identify priorities and focus areas. This was a hybrid meeting taking place both virtually and in-person at Columbia-Greene Community College on March 10, 2022. An effort was made to "cast the net widely"—that is, to engage a diverse, multidisciplinary stakeholder group that represents the community's interests, including the interests of the uninsured, low-income and minority groups, as well as those with special knowledge of or expertise in public health. Consequently, meeting invitations were sent to an extensive email distribution list. The organizations that ultimately participated in these two prioritization meetings included:

- Catholic Charities of Columbia and Greene Counties
- COARC
- Columbia County Board of Supervisors
- Columbia County Department of Health
- Columbia County Department of Human Services
- Columbia County Department of Social Services
- Columbia County Human Resources
- Columbia County Office for the Aging
- Columbia-Greene Community College
- Columbia Memorial Hospital
- Community Action of Greene County
- Cornell Cooperative Extension
- Eddy Visiting Nurses- St. Peter's Health Partners
- Greater Hudson Promise Neighborhood
- Greene County Family Planning
- Greene County Mental Health
- Greene County Paramedics
- Greene County Public Health
- Greene County Rural Health Network
- Greene County Department of Human Services
- Healthcare Consortium

- Healthcare Consortium (Tobacco-Free Action Program)
- Healthy Capital District
- Hudson Valley Long Term Care Ombudsman Program
- Sun River Healthcare
- Hudson Valley Pediatrics
- Mobile Crisis Assessment Team of Columbia-Greene
- ReEntry Columbia
- St. Peter's Health Partners (Health Program and Promotion)
- St. Peter's Health Partners (Cancer Services Program)
- Twin County Recovery Services
- Twin County Recovery Services (Prevention Program)
- Twin County Recovery Services (Greener Pathways)
- Upper Hudson Planned Parenthood
- W Group (Home Sweet Home on the Hudson/Home Sweet Home in Athens)

The content for the meeting was supported by staff at the Healthy Capital District (HCD), the entity contracted to conduct the Community Health Needs Assessment for the region. At these meetings, the Planning Partners presented data on a total of 10 health issues related to four Prevention Agenda Priority Areas. Available data on prevalence, emergency department visits, hospitalizations, mortality, and trends were included for each indicator. Equity data for gender, age, race/ethnicity, and neighborhood groupings were presented as available.

After the presentation of data on each health issue, participants had an opportunity to ask questions and also share their own insights about the impact these health issues have on residents in the community. The discussion was often rich, with many of the participants adding context, perspective, and generally enhancing the whole group's understanding of the issue. Participants were provided with a survey to measure their thoughts on the local experience, community value, and potential opportunity regarding each health issue.

After the presentation of data on all health issues was complete, participants were encouraged to consider the relative importance of each health issue in the community based on two qualitative dimensions: what the data and organizational experiences suggested the degree of need in the community; and, the opportunity to prevent or reduce the burden of this health issue on the community. Participants were also given an opportunity to advocate for the health issue(s) they believed were most deserving of our collective efforts.

The issues of the COVID-19 Pandemic, substance use disorders, and chronic disease received the most attention and advocacy by far, likely because they impacted the largest number of people in the most significant ways, both directly and indirectly, through their influence on other health conditions, and also contributed most significantly to the cost of health care. It is perhaps no surprise, then, that when the group voted to select the Prevention Agenda Priorities for Columbia and Greene Counties, these were ***Prevent Chronic Diseases**, **Promote Well-Being and Prevent Mental and Substance Use Disorders,*** *and* ***Prevent Communicable Diseases.*** The following key considerations informed their selection:

- Diabetes is in the top five causes of premature death for both Columbia and Greene Counties. In the Capital Region, Diabetes Adult prevalence was highest in Greene County. The age-adjusted percentage of adults with diabetes has shown large increases in both Columbia (4.4% in 2016; 7.6% in 2018) and Greene (5.5% in 2016; 13.2% in 2018) Counties. In the Capital region, diabetes short-term complications hospitalization rates were 2.3 to 5.9 times higher for Black non-Hispanic residents compared to White non-Hispanic residents. Diabetes hospitalizations in the Capital Region for Black non-Hispanic were 2.0 to 4.1 times the rate of White non-Hispanic residents. Black non-Hispanic residents also suffered diabetes mortality rates 0.8 to 2.8 times compared to those White non-Hispanic.

- Obesity rates in the Capital Region were highest in Greene County (34.5%). Greene (42.6%) had the 3rd highest low-income obesity rates in the Capital Region. Obesity is the primary cause of type 2 diabetes. In 2018 Columbia County was the only in the Capital Region to see a decrease in adult obesity from 2016 BRFSS, but has not met the Prevention Agenda 2024 objective. Among children and adolescents obesity rates were highest in Greene County (23.0%). Among children (aged 2-4 years) in WIC, obesity rates were highest in Greene (19.5%) and Columbia (19.6%) counties.

- Both counties saw a decrease in physical activity between 2016 and 2018. A lack of physical activity can lead to many chronic diseases or conditions, including hypertension, heart disease, stroke, type 2 diabetes, and some cancers.

- In the Capital region, Opioid overdose deaths were highest in Greene (29.9) and Columbia (21.4) counties from 2016-2018. Opioid overdose ED visits were highest in Greene (84.6) county in 2018, but had shown a decrease since 2016 (113.1).

- In 2018, Columbia County had the highest rate of newborns with neonatal withdrawal symptoms and/or affected by maternal use of drugs of addiction (27.8).

- Columbia County was 2nd highest in adult binge drinking rate (21.1). Mortality rate was highest in Columbia County for Cirrhosis (8.9). For the Capital region, hospitalization rates for Cirrhosis were highest in Greene County (3.9).

- The COVID-19 pandemic posed a significant series of challenges to the health and well-being of Columbia & Greene County residents. Mortality rates were highest in the Twin Counties when compared to the rest of the Capital District (Columbia, 98.5; Greene, 124.2). Columbia and Greene counties also suffer some of the lowest vaccination rates in the capital region with the lowest (Greene, 55.6) and 3rd lowest (Columbia, 63.8) rate of residents completing the full series, lower than both the Capital Region (66.5) and the Rest of NYS (65.7).

Through the COVID-19 Pandemic, the constraints of virtual meetings posed several challenges to our collaborative process. Lack of in person meetings made evident significantly less participation and discussion of which this process requires. With proper COVID-19 protections in place, The Planning Partners were determined to overcome the identified shortcoming of entirely virtual meetings and to bring as many partners to the table whichever way they felt most comfortable. The Planning Partners decided to host a hybrid style meeting on March 10, 2022 allowing many to attend in person and also several to join virtually. The meeting was held at our shared Columbia-

Greene Community College which provided us the technology to support those attending virtually as well as plenty of space for those opting for in person attendance to still feel the protection of appropriate COVID-19 mitigation strategies.

The purpose of this meeting was to gather input from a broad stakeholder group on the focus areas, goals, objectives, and interventions related to the Prevention Agenda Priorities nominated by The Planning Partners. The broad stakeholder group, which hereinafter will be referred to as the Columbia-Greene Healthy People Partnership, ultimately identified focus areas directly drawn from and using the language of the NYS Prevention Agenda for 2019-2024, 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 area: Vaccine Preventable Diseases (COVID-19)

After these Priority Issues and the Focus Areas were selected by the group, the work of selecting goals, objectives and interventions fell largely to the Planning Partners. Throughout that work, the Planning Partners frequently referenced and were strongly influenced by the discussions that occurred in the Columbia-Greene Healthy People Partnership meeting. Furthermore, the Planning Partners continued to provide opportunities for members of the Healthy People Partnership to review and comment on its work, including this plan.

2. Goals, Objectives, Intervention Strategies, Process Measures

As noted, the Planning Partners relied on the input gleaned from the Columbia-Greene Healthy People Partnership to inform the selection of goals, objectives and intervention strategies within each focus area. 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. These goals, objectives, intervention strategies, process measures are outlined, by Priority Area, in the tables below:

<table>
<tr><th colspan="3">PRIORITY AREA #1: PREVENT CHRONIC DISEASE</th></tr>
<tr><th colspan="2">Focus Area 1</th><th>Healthy Eating and Food Security</th></tr>
<tr><th colspan="2">Goal 1.0</th><th>Reduce obesity and the risk of chronic disease</th></tr>
<tr><td rowspan="3">Hospital</td><td>Objective 1.6</td><td>Decrease the percentage of adults ages 18 years and older with obesity (among adults living with a disability)</td></tr>
<tr><td>Intervention</td><td>Provide nutritional education in one-on-one and group settings to patients in the inpatient psychiatric unit at Columbia Memorial Hospital</td></tr>
<tr><td>Process Measures</td><td>● Number of patients receiving nutrition education one-on-one
● Number of patients receiving nutrition education in groups</td></tr>
<tr><th colspan="2">Focus Area 2</th><th>Physical Activity</th></tr>
<tr><th colspan="2">Goal 1.0</th><th>Reduce obesity and the risk of chronic diseases</th></tr>
<tr><td rowspan="3">Local Health Dept(s)</td><td>Objective 1.4</td><td>Decrease the percentage of adults age 18 years and older with obesity (among all adults)</td></tr>
<tr><td>Intervention</td><td>Expand access to the Biggest Loser Contest, a 16 week, independent weight loss program</td></tr>
<tr><td>Process Measures</td><td>● Number of registrants
● Number of participants initiating the program
● Number of participants completing the program
● Percent of participants completing the program
● Number of participants who have lost at least 5% of their beginning weight</td></tr>
<tr><td rowspan="3">Hospital</td><td>Objective 1.6</td><td>Decrease the percentage of adults age 18 years and older with obesity (among adults living with a disability)</td></tr>
<tr><td>Intervention</td><td>Provide an exercise program to patients in the inpatient psychiatric unit at Columbia Memorial Hospital</td></tr>
<tr><td>Process Measures</td><td>● Number of patients who participate in the program when offered
● Percent of patients who participate in the program when offered</td></tr>
</table>

	Focus Area 4	Chronic Disease Preventive Care and Management
	Goal 4.3	**Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity**
Hospital	Objective 4.3.1	By December 31, 2024, decrease the percentage of adult patients with diabetes whose most recent HbA1c level indicated poor control (>9%)
	Intervention	Promote evidence-based medical management in accordance with national guidelines
	Process Measures	Track a variety of measures related to diabetes control in the outpatient setting: ● the number 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 ● number of nephropathy screenings, with the aim to improve the number of diabetics who have nephropathy screening with a microalbumen to creatinine test annually ● blood pressure control ● Statin use in patients with diabetes, with the aim of increasing its use
Hospital	Objective	By December 31, 2024, increase the percentage of adults (18+) who were given a diabetes action plan by a health professional by 10%
	Intervention	Utilizing a diabetes educator, provide nutrition education and dietary consults to patients of the family care centers (i.e. outpatient) with a diabetes diagnosis
	Process Measures	● Number of patients with a diabetes diagnosis who meet with a diabetes educator ● Percent of patients with a diabetes diagnosis who meet with a diabetes educator
	Goal 4.4	**In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes, and obesity**
Local Health Dept(s)	Objective 4.4.1	By December 31, 2024, increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or classes to learn how to manage their condition by 25 % from 6.0 to 7.5 (Columbia), 5.3 to 6.6 (Greene).
	Intervention 4.4.3	Expand access to the National Diabetes Prevention Program (National DPP), a lifestyle change program for preventing Type 2 Diabetes.
	Process Measures	● Number of health systems that have policies/practices for identifying and referring patients to the National DPP programs ● Number of National DPP programs in the community setting ● Number of patients referred to the National DPP ● Number of patients who participate in the National DPP ● Percentage of patients who complete the National DPP

Local Health Dept(s)	Objective 4.4.1	By December 31, 2024, increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or classes to learn how to manage their condition by 25 % from 6.0 to 7.5 (Columbia), 5.3 to 6.6 (Greene)..
	Intervention	Increase knowledge and awareness of Type 2 Diabetes through a media campaign.
	Process Measures	● Number of awareness campaigns ● Number of mediums used to reach the public ● Number of impressions ● Number of clicks to webpage ● Number of ads run ● Number of post-engagements

PRIORITY AREA #2: PROMOTE WELL-BEING AND PREVENT MENTAL/SUBSTANCE USE DISORDERS		
	Focus Area 2	**Mental and Substance Use Disorders Prevention**
	Goal 2.2	**Prevent opioid and other substance misuse and deaths**
Local Health Dept(s)	Objective 2.2.1	Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.3 per 100,000 population
	Intervention 2.2.2	Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers.
	Process Measures	● Number of trainings ● Number of kits provided ● Number of agencies able to provide overdose reversal trainings to their staff and community ● Number of staff who complete naloxone administration training
Hospital	Objective 2.2.1	Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.3 per 100,000 population
	Intervention 2.2.4	Build support systems to care for opioid users or others at risk of an overdose
	Process Measures	● Number of individuals educated about the availability of peer support ● Number of patients referred to peer support ● Number of patients served by peers ● Number of individuals who engage with peers, harm reduction strategies, and/or traditional treatment with 90 days
Local Health Dept(s)	Objective 2.2.1	Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.3 per 100,000 population
	Intervention 2.2.5	Establish additional permanent safe disposal sites for prescription drugs and organize take-back days
	Process Measures	● Number of new medication disposal sites ● Number of take-back days

Hospital	Objective 2.2.1	Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.3 per 100,000 population
	Intervention	Embed behaviorists in the outpatient setting to assist patients with goal-setting, MH/SUD screening and referrals, as well as coordinate consultation between Primary Care prescribers and psychiatry
	Process measures	• Number of behaviorists working in the outpatient setting • Number of patients referred to behaviorists • Number of patient contacts with behaviorists
Hospital	Objective 2.2.1	Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.3 per 100,000 population
	Intervention	Expand mental health service capacity by contracting with a third-party virtual provider
	Process Measures	Number of patient contacts with third party provider
Local Health Dept(s)	Objective 2.2.2	Increase the age-adjusted rate of patients who received at least one Buprenorphine prescription for opioid use disorder by 20% to 415.6 per 100,000 population.
	Intervention 2.2.1	Increase availability of/access and linkages to medication-assisted treatment (MAT) Including Buprenorphine
	Process Measures	Number and percent initiating pharmacotherapy upon new episode of opioid dependence

PRIORITY AREA #3: PREVENTING COMMUNICABLE DISEASE		
	Focus Area 1	**Vaccine Preventable Diseases**
	Goal 1.1	**Improve COVID-19 Vaccination Rates**
Local Health Dept(s)	Objective	By December 31, 2024, increase the percentage of people with an up to date COVID-19 vaccination status, per CDC definition, by 10% from baseline of 56% as provided by local health departments
	Intervention 1.1.3	Implement and promote use of standing orders for vaccine administration
	Process Measures	• Number of vaccinations provided • COVID-19 vaccination rates • Number of vaccination clinics provided • Rate of fully immunized (eligible ages) residents
Hospital	Objective	By December 31, 2024, increase the percentage of people with an up to date COVID-19 vaccination status, per CDC definition, by 10% from baseline of 56% as provided by local health departments
	Intervention	Promote vaccination at CMH’s clinical service sites
	Process Measures	• Number of flyers and posters developed for posting in primary and rapid care settings • Number of 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

		Goal 1.2	**Reduce COVID-19 vaccination coverage disparities**
Local Health Dept(s)	Objective	By December 31, 2024, increase the percentage of county residents residing in rural areas completing their COVID-19 vaccination series by 10% from 70.2% to 77.2% (Columbia), 62.2% to 68.4% (Greene).
	Intervention 1.2.2	Offer 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
	Process Measures	Number of vaccine clinics in rural areas
	Focus Area 5	**Healthcare-Associated Transmissions**
	Goal 5.1	**Improve infection control in healthcare facilities**
Hospital	Objective	Reduce the spread of COVID-19 in clinical settings
	Intervention	Prevent and mitigate COVID-19 transmission among the CMH workforce and patients by providing COVID testing and the use of PPE / masking in public and clinical areas
	Process measures	● Number of staff who are educated on infection prevention and control measures ● COVID-19 infection rates among CMH staff

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

a. Local Health Department Actions and Impact

As it pertains to the **Priority Area #1: Prevent Chronic Disease**, the local health departments will have two areas of focus: ***Physical Activity*** and ***Chronic Disease Preventive Care and Management.***

In the realm of ***Physical Activity***, the Local Health Departments (LHDs) will collaborate to expand access to the Biggest Loser Contest, a 16-week independent weight loss program. The Biggest Loser Contest has been administered for 10 years by the Greene County Rural Health Network, a private, not-for-profit organization that aims to develop coordinated solutions to Greene County's community health problems. The LHDs will promote and support participation in the Contest, including its expansion into Columbia County.

In the realm of ***Chronic Disease Preventive Care and Management***, the LHDs will pursue the goal of improving the self-management skills of individuals with obesity, prediabetes and diabetes in the community setting. To do so, they will expand access to the National Diabetes Prevention Program (National DPP), a lifestyle change program for preventing Type 2 Diabetes. The LHDs will also increase the public's knowledge and awareness of Type 2 Diabetes through a media campaign, which will again be coordinated across county lines and agencies with the goal of reinforcing and amplifying the core messages.

Within **Priority Area #2: Promote Well-being and Prevent Mental and Substance Use Disorders,** the LHDs will have ***Mental and Substance Use Disorders Prevention*** as their area of focus.

The LHDs will pursue the goal of preventing opioid and other substance use misuse and deaths. To do so, they will increase the availability of and access to overdose reversal (Naloxone or Narcan) training to prescribers, pharmacists and consumers (Intervention 2.2.2). This intervention is closely aligned with existing activities currently being pursued by both Departments of Health. These include conducting community Opioid overdose reversal trainings as each County LHD is a registered New York State Community Opioid Overdose Prevention Program (COOP). This designation allows educators to train the public in naloxone administration and provides free naloxone kits to those who complete the training. In year one, each LHD will continue this work and track success through the number of trainings, and the number of kits provided to attendees. This work will continue through all three years of implementation. During year two the LHDs will create and disseminate a survey to local pharmacists to determine their awareness levels of the NYS Naloxone Co-Payment Assistance Program (N-CAP). During year three the Planning Partners will disseminate education material regarding N-CAP to pharmacists in the Twin Counties. Success for this initiative will be measured by the number of surveys completed and the number of interactions with pharmacists.

The LHDs will also work to establish additional permanent safe disposal sites for prescription drugs and organize take-back days. This work is consistent with and builds upon work that both LHDs have been intimately involved with for several years.

Finally, the LHDs will aim to increase the access to and linkages with providers of medication-assisted treatment (MAT), including Burprenorphine. Happily, as the assets, facilities and resources lists of Section C-3 demonstrates, the Twin Counties already has a number of ways in which individuals can access MAT, including Twin County Recovery Services, Greene County Family Planning, and multiple providers throughout the primary care network. Nevertheless, efforts to increase the number of providers of MAT services will be ongoing.

With regard to **Priority Area #3: Prevent Communicable Disease,** the Planning Partners identified Vaccine Preventable Diseases–and specifically, COVID-19–as their focus, and two goals: improving COVID-19 vaccination rates, and reducing COVID-19 vaccination coverage disparities. Naturally, the LHDs will be absolutely central to these efforts. Specifically, the LHDs will do the following:

- Implement and promote the use of standing orders for vaccine administration
- Offer 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

Both of these activities consume a considerable amount of time and energy for the LHDs, but remain absolutely necessary to the ongoing maintenance and control of the COVID-19 endemic.

b. Local Health Department Resources to be Committed

Public Health Educators will provide coordination for meetings and activities of the Columbia-Greene Healthy People Partnership. Public Health Educators will provide training and support to the Healthy People Partnership and other community partners in pursuance of the identified goals and interventions. Public Health Educators will support and assume tracking responsibilities for the process measures identified.

c. Hospital Actions and Impact

The mission of Columbia Memorial Health (CMH), the hospital-based health system serving the residents of Columbia and Greene Counties, is to provide the communities it serves with safe, high-quality, comprehensive health care services in a dignified and compassionate environment. It maintains the following vision: "We will strive for excellence, innovation and forward-thinking while preserving our special culture of ownership and empathy, never forgetting that we are family and friends caring for family and friends. Our financial foundation will be strengthened. Our facilities will be modernized and renewed. We will nurture a work environment that promotes job satisfaction, wellness, productivity and pride in meeting the many challenges of an ever-changing environment."

CMH is committed to making a meaningful contribution to collaborative community health improvement efforts. Toward that end, it has identified a number of activities that it will pursue during the performance period to address the priority health issues that have been identified.

To address the **Prevention Agenda Priority #1: Prevent Chronic Disease,** CMH will have three areas of focus: ***Healthy Eating and Food Security, Physical Activity,*** and ***Chronic Disease Preventive Care and Management.***

With regard to ***Healthy Eating and Food Security*****,** CMH will provide nutritional education in one-on-one and group settings to patients in the inpatient psychiatric unit at Columbia Memorial Hospital. Dietitians from the Hospital's food service company will work with the patients on supporting wellness through diet.

With regard to ***Physical Activity***, CMH will provide an exercise program two (2) times per week to patients in the inpatient psychiatric unit at Columbia Memorial Hospital. The exercise program is through an arrangement with KS Fitness, which provides a fitness instructor to the Unit every Tuesday and Saturday for a one hour fitness class in two parts. There is a 30-minute low impact group followed by a more vigorous or high impact class for 30 minutes. The fitness classes have been held since June of 2019 and have been very well-received by the patients. Participation data (# patients attending each session) will be tracked and reported.

With regard to ***Chronic Disease Preventive Care and Management***, CMH will pursue two strategies. The first is to promote evidence-based medical management in accordance with national guidelines. This will entail tracking a variety of measures related to diabetes control in the outpatient setting, including, but not limited to, diabetic eye exams, A1c levels, nephropathy screenings, blood pressure control, and statin use. A second strategy will be to utilize a diabetes educator to provide nutrition education and dietary consults to patients of the family care centers (i.e. outpatient) with a diabetes diagnosis

With regard to **Priority Area #2: Promote Well-being and Prevent Mental/Substance Use Disorders**, the Planning Partners selected the ***Mental and Substance Use Disorders Prevention*** as their area of focus,with the goal of preventing opioid and other substance misuse and deaths.

To advance this goal, CMH will help build 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.

Additionally, CMH will embed behaviorists in its outpatient setting to assist patients with goal-setting, Mental and Substance Use Disorder screening and referrals, as well as coordinate consultation between Primary Care prescribers and psychiatry.

Finally, CMH will ensure that it has sufficient capacity to meet the mental health needs of the community it serves by contracting with a third-party virtual provider of mental health services to supplement the capacity of its outpatient psychiatric clinic.

With regard to **Priority Area #3: Prevent Communicable Disease,** and the focus on ***Vaccine Preventable Diseases***–specifically, COVID-19–CMH will do the following:

- Continue to promote vaccination, and improve vaccine rates, at its clinical service sites
- Prevent and mitigate COVID-19 transmission among the CMH workforce and patients by providing COVID testing and the use of PPE / masking in public and clinical areas

d. Hospital Resources to be Committed

CMH is committed to providing adequate resources to support all the activities noted above.

For instance, to support the activities related to Priority Area #1, Prevent Chronic Disease, CMH will do the following:

- contract with outside providers in order to deliver nutrition education and physical activity to patients in the Psychiatric Unit
- provide education, direction, and oversight to providers and nursing staff to ensure they are educated about the national guidelines for evidence-based medical management of obesity, prediabetes, and diabetes and deliver care accordingly
- employ a diabetes educator
- provide staff to serve as points of contact, sources of referral, and generally coordinate activities with the Certified Peer Recovery Advocate (CRPA) working on behalf of Greener Pathways; also, CMH will provide office space to the CRPA
- employ multiple behaviorists throughout the primary care system
- contract with a third-party to provide telemental health services

All of these efforts will require some measure of stewardship, including periodic meetings and less formal, ongoing communication to establish policies and procedures, evaluate performance, make mid-stream corrections as needed, and collect and report utilization data. CMH will support that stewardship, both by deploying its own staff to the efforts, as well as contracting for services to manage its obligations under the Community Services Plan, including ongoing collaboration with the Columbia-Greene Planning Partners and the Healthy People Partnership, the collection of data related to implementation and performance of these activities, and reporting to NYSDOH and other entities.

e. Roles and Resources of Others

There are a number of entities that are key to the successful implementation of the interventions noted above. Chief among these are the Greene County Rural Health Network, which will be instrumental as a partner in the activities that address obesity and obesity-related illnesses, and the Greener Pathways Program of Twin County Recovery Services, which provides CRPA services to CMH's Emergency Department and Inpatient Setting.

Additionally, the Planning Partners will rely heavily on all the individuals and agencies that have and will continue to participate in the Healthy People Partnership, who will continue to meet to monitor progress on the Plan.

f. How Activities Address a Disparity

As the reader knows, the residents of rural areas tend to be older, sicker and poorer than their urban and suburban neighbors, and the residents of Columbia and Greene Counties are no exception to that sad rule. Consequently, it could be argued that ALL the activities outlined in this Plan address the disparities in healthcare access and health outcomes that our rural residents experience. Nevertheless, the Planning Partners have chosen to narrow the focus of our efforts on reducing disparities and achieving health equity to vaccination coverage.

3. Process to Maintain Partner Engagement, Progress Tracking, & Mid-course Corrections

In order to maintain the engagement of the broader stakeholder group that was so instrumental in shaping this plan, the Planning Partners intend to convene the Columbia-Greene Healthy People Partnership on a regular basis throughout the next three years. This approach reflects an ongoing commitment to working jointly—both across agencies and county lines--throughout the entire CHIP cycle. (Note that this is a departure from the previous cycle, when each county convened one or more separate workgroups. This team recognizes that those workgroups were populated by the same people, often working in both counties, and therefore has restructured how we ask our colleagues to both get and stay engaged.) The Partnership will be charged with reviewing reports, monitoring progress, and providing feedback. At this time, the intention is to convene on a quarterly basis. Should there be a need to meet in smaller groups by county and/or focus area, breakout sessions during the larger group meeting will be utilized.

Formally, the Planning Partners intend to convene on a quarterly basis, likely between meetings of the larger Partnership, in order to track progress on the implementation of this plan and determine the need for mid-course corrections, if any. Additionally, the Planning Partners have excellent working relationships marked by constant communication and collaboration, so there will be innumerable less formal opportunities for troubleshooting and information exchange.

4. Dissemination of Executive Summary

The Executive Summary of this Community Health Improvement Plan/Community Service Plan/Implementation Strategy ("the Plan") and the full document, including the multi-county Community Health Needs Assessment, will be made widely available to the public.

Electronic copies of the Executive Summary and full document will be distributed to all members of the Columbia-Greene Healthy People Partnership, who will be encouraged to further redistribute the information to their supporters, staff, volunteers, and program participants, as well as post the Plan or a link to it on their own websites.

Electronic copies will also be distributed to local elected officials and to state elected officials representing Columbia and/or Greene Counties.

The entire document, including the Community Health Needs Assessment, will be posted on the website of each of the Planning Partners, as follows:

Columbia County Department of Health:
https://www.columbiacountynyhealth.com/news

Greene County Public Health Department:
https://www.greenegovernment.com/departments/public-health

Columbia Memorial Hospital:
https://www.columbiamemorialhealth.org/community-health/

Paper copies of the Plan will be available for inspection by the public at the main offices of the Columbia County Department of Health, Greene County Public Health, and Columbia Memorial Hospital.

Lastly, an electronic copy of the Community Health Needs Assessment is available at https://www.healthycapitaldistrict.org/CHNA2022.

Columbia - Greene Community Partner Meeting

Thursday, March 10, 2022
Columbia-Greene Community College

Meeting Agenda

Welcome and Introductions

--Who are the Columbia-Greene Planning Partners?

--Who is our data partner?

--Who are the individuals and agencies in the room?

Why we're here and what we're doing today

--What is the Prevention Agenda?

--Assessment and Planning Processes related to the Prevention Agenda

--Where are we in this process?

The Community Health Needs Assessment

--It's all about the data!

--Health issues and measures

--Review of the data for top ten health issues

--Your input and scoring

Who are the Columbia-Greene Planning Partners?

Who is our Data Partner?

The work of the Columbia-Greene Planning Partners is very ably supported by our data partner, Healthy Capital District.

Healthy Capital District prepares the data analysis and regional Community Health Needs Assessment for us and also supports our Prevention Agenda work.

Visit www.hcdny.org to learn more about the Prevention Agenda and access regional health data.

Who are YOU?

- Name
- Agency affiliation (if any)
- Familiarity/past experience with this process

What is the Prevention Agenda?

The Prevention Agenda is New York State's health improvement plan,
the blueprint for state and local action to improve the health and well-being
of all New Yorkers
and promote health equity across populations experiencing health disparities.

It outlines evidence-based strategies to reduce the number of people who suffer or die from disease, with the goal to improve the quality of life and extend it.

Every six years, the New York State Department of Health (NYSDOH) creates a Prevention Agenda. The current Prevention Agenda is for **2019-2024.**

Assessment and Planning Processes Related to the Prevention Agenda

NYSDOH requires local departments of health and hospitals to engage in periodic assessment and planning activities, the products of which are …

The Community Health Needs Assessment (CHNA)
…and…
The Community Health Improvement Plan (CHIP)

The first informs the second. In other words, the CHNA is meant to describe a community's health status and identify its chief health issues, two (or more) of which become the focus of the CHIP.

Where are we in this process?

The CHIPs cover three-year periods.

The most recent CHIP, which was submitted jointly by the three planning partners for the two-county area, covers the period **2019-2021**.

We are currently completing the CHNA to inform the CHIP for **2022-2024**.

The CHIP must be written and submitted to NYSDOH by December 31, 2022.

CHNA: It’s all about the data!

The process for assessing a community’s health needs begins with **data.**

Data is gathered from a variety of sources, including:

- Public use data sets
- Community member surveys
- And the input and insights of partners like you!

Today, we’ll present the findings from public use data sets and the community member surveys, and then ask YOU to help add to our understanding of these issues.

Health Issue & Measure Selection

- **25 Health Issues** and around **140 Health Measures** were selected from over 700 health measures located in the following data collections:
  - Prevention Agenda Dashboard
  - Community Health Indicator Reports (CHIRS) Dashboard
  - County Health Indicators by Race/Ethnicity (CHIRE)
  - SPARCS data – via Common Ground Health Portal
  - NYS Opioid Data Dashboard
  - NYS Behavioral Risk Factor Surveillance Survey (BRFSS)
  - Division of Criminal Justice Services (DCJS) Index Crimes
  - NYS DOH COVID-19 Tracker
  - NYS DOH Cancer Registry
  - County Health Rankings and Roadmaps

#	Health Issue
1	COVID-19
2	Colorectal Cancer
3	Breast Cancer
4	Obesity
5	Asthma
6	Diabetes
7	Heart disease
8	Stroke
9	Violence
10	Injuries & falls
11	Motor vehicle injuries
12	Poor birth outcomes
13	Prenatal care
14	Breast feeding
15	Tobacco use
16	Drug misuse
17	Alcohol misuse
18	Mental illness including suicide
19	Sexually transmitted infections
20	Teen pregnancy
21	Childhood lead exposure
22	Tick-borne disease
23	Immunization & related disease
24	Social Determinants of Health
25	Oral Health

Capital Region Public Health Data Matrix

171 Health Indicators

including 62 Prevention Agenda Tracking Indicators

Link: http://www.hcdiny.org/content/sites/hcdi/resource_library_additions/HCD-County-PH-Indicator_Matrix.pdf

Prevent Chronic Diseases

Indicator		Prevention Agenda 2017 or 2024 Objective	NYS	NYS excl. NYC (Upstate)	Capital Region (6 County) Summary	Albany County	Schenectady County	Rensselaer County	Saratoga County	Columbia County	Greene County
	YEAR	Rate	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #
Percentage of adults who are obese	2018	24.2	27.6	29.1	29.6	26.9	33.7	30.9	30.1	24.3	34.5
Number :					228,428	67,268	41,075	39,584	54,786	12,082	13,633
Percentage of adults who are obese-income <$25,000	2018	29.0	31.8	34.4	38.8	33.2	54.2	39.6	44.8	18.6	42.6
Percentage of children and adolescents who are obese	2017-19	16.4	na	17.3	16.5	16.3	18.8	18.7	13.1	17.3	23.0
Number :					22,901	6,735	4,591	4,263	4,557	1,400	1,355
% of children (aged 2-4 yrs.) enrolled in WIC who are obese	2017	13.0	13.9	na	15.2	13.4	15.6	14.1	17.0	21.3	19.9
Number :					820	262	171	156	118	70	43
Age-adjusted % Adults not engaged in some type of leisure time physical activity	2018	22.6	23.8	22.4	19.7	18.9	19.0	23.4	14.0	20.1	25.7
# no leisure time PA					146,028	47,263	23,158	29,976	25,482	9,994	10,155
% Adults 65+ with no leisure time physical activity	2018	24.1	31.1	31.1	29.9	26.2	30.1	32.9	21.8	25.5	35.6
% adults with disability with no leisure time physical activity	2018	38.2	38.8	39.4	35.0	28.4	28.3	43.5	29.6	46.2	55.4
% Adults with <$25,000 income who consume 1+ sugary drinks daily	2018	28.5	31.0	34.1	30.3	27.0	33.1	24.5	40.6	25.8	15.9
Age-adjusted % Adults who consume <1 friut or vegetable daily	2018		28.1	na	26.4	24.0	30.8	27.6	24.8	24.9	22.5
Number:					199,324	60,016	37,541	35,357	35,028	12,880	8,891
Age-adjusted % Adults with physician diagnosed diabetes	2018		10.0	na	9.4	7.7	10.3	10.1	8.9	7.6	13.2

That’s a lot to think about! How do we choose?

With so many health issues and measures, the problem instantly becomes how to grapple with so much information in order to compare the issues and ultimately narrow them down to the two or so that will be the CHIP’s focus.

In order to do this, HCD devised a way to weigh the different issues, based on two dimensions--**NEED** and **OPPORTUNITY**--and relying on data, the input of community partners, and the input of the planning partners.

Weighing Health Issues

Need

Opportunity

Data

Community Partners

Hospitals and Health Depts.

What do we mean by “Need”?

Count
- Number of people impacted

Rate
- Compared to New York State, excl. NYC

Trend
- Change over time

Disparity
- Difference among sub-populations

Seriousness
- From behavior to mortality

Community Priority
- Survey results

Other Considerations
- e.g. more recent or local data

Community Partner Considerations

What do we mean by "Opportunity"?

- Aligned with Goals
- Effort Sustainability
- Resources & Expertise
- Support from other Organizations
- Measureable Impact Ability
- Other Considerations
- Community Partner Considerations

Health Issue Scoring

Opportunity
Health issue aligns with organizations' strategic goals
If already invested in addressing this need, are efforts working sustainably
If not already working on this need, do we have resources and expertise to lead the effort
Are there organizations that would be interested in supporting efforts to address this need
Is it possible to make a measureable, positive impact
Other considerations
Community Partner considerations

The opportunity measures were derived from guidance documents from the American Hospital Association, the National Association of County and City Health Officials and other industry resources.

Need
Is this issue a major need in the community - **Total number** of cases
Is this issue worse in our region than throughout NY - **Rates**
Is this issue more common for some populations - **Disparities**
Is this issue getting better or worse - **Trend**
How **seriousl**y does this issue threaten mortality
Is this issue a **priority for the community** based on the survey
Other considerations about the data
Community Partner considerations

The need measures are determined by HCD methods, opportunity scores and other data considerations by the LDoHs and hospital, and community input comes through the LDoHs and hospital assessment of CBO capacity, a consumer survey, and your input.

Planning Partners Scores
Data-based Scores
Community Partners Scores

Health Issue Scoring Sheet

Opportunity	Max Score	Score
Health issue aligns with organizations' strategic goals	**3**	
If already working to address this need, are efforts working sustainably	**2**	
If not working on this need, do we have resources and expertise to lead effort	**1**	
Are there organizations interested in supporting efforts to address this need	**2**	
Is it possible to make a measureable, positive impact	**3**	
Other considerations	**3**	
Community Partner considerations	**3**	
Total Opportunity Score	**17**	

Need	Max Score	Score
Is this issue a major need in the community - **Total number** of cases	**2**	
Is this issue worse in our region than throughout NY - **Rates**	**2**	
Is this issue more common for some populations - **Disparities**	**2**	
Is this issue getting better or worse - **Trend**	**2**	
How **seriously** does this issue threaten mortality	**2**	
Is this issue a **priority for the community** based on the survey	**3**	
Other considerations about the data	**2**	
Community Partner considerations	**3**	
Total Need Score	**18**	

	Max Score	Score	Contribution to Total Score
Total Planning Partners Score	**14**		**40%**
Total Data-based Score	**10**		**29%**
Total Community Partners Score	**11**		**31%**
Total Priority Score	**35**		

Health Issue Scoring Sheet

Opportunity	Max Score	Score
Health issue aligns with organizations' strategic goals	**3**	
If already working to address this need, are efforts working sustainably	**2**	
If not working on this need, do we have resources and expertise to lead effort	**1**	
Are there organizations interested in supporting efforts to address this need	**2**	
Is it possible to make a measureable, positive impact	**3**	
Other considerations	**3**	
Community Partner considerations	**3**	
Total Opportunity Score	**17**	

Need	Max Score	Score
Is this issue a major need in the community - **Total number** of cases	**2**	
Is this issue worse in our region than throughout NY - **Rates**	**2**	
Is this issue more common for some populations - **Disparities**	**2**	
Is this issue getting better or worse - **Trend**	**2**	
How **serious**ly does this issue threaten mortality	**2**	
Is this issue a **priority for the community** based on the survey	**3**	
Other considerations about the data	**2**	
Community Partner considerations	**3**	
Total Need Score	**18**	

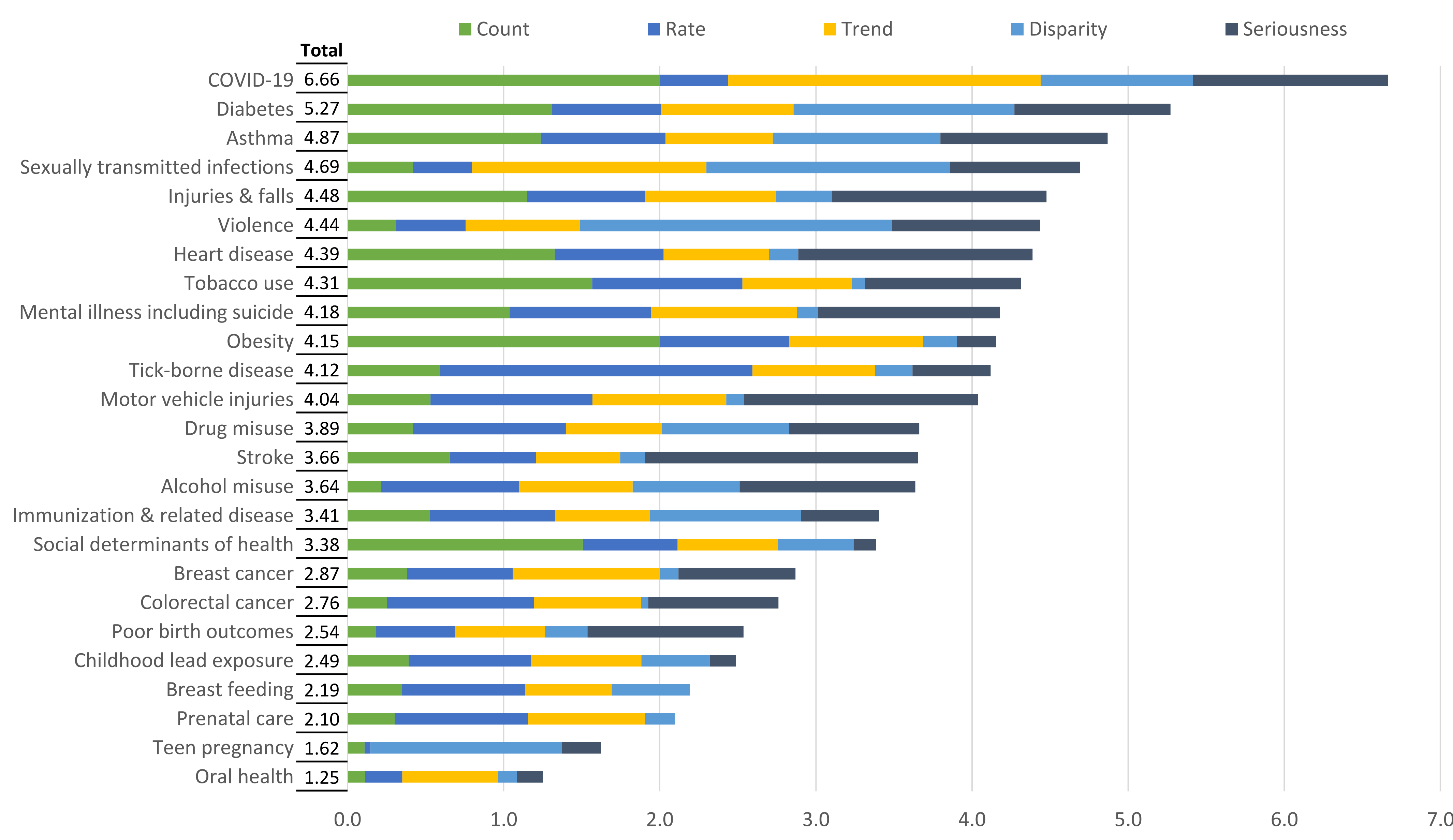
Today

	Max Score	Score	Contribution to Total Score
Total Planning Partners Score	**14**		**40%**
Total Data-based Score	**10**		**29%**
Total Community Partner Score	**11**		**31%**
Total Priority Score	**35**		

First step…

Data-based Need Scoring

Data-based Need Scores (out of 10) – Columbia & Greene Counties



Second step…

Adding Community Member Input to Data-based Scoring

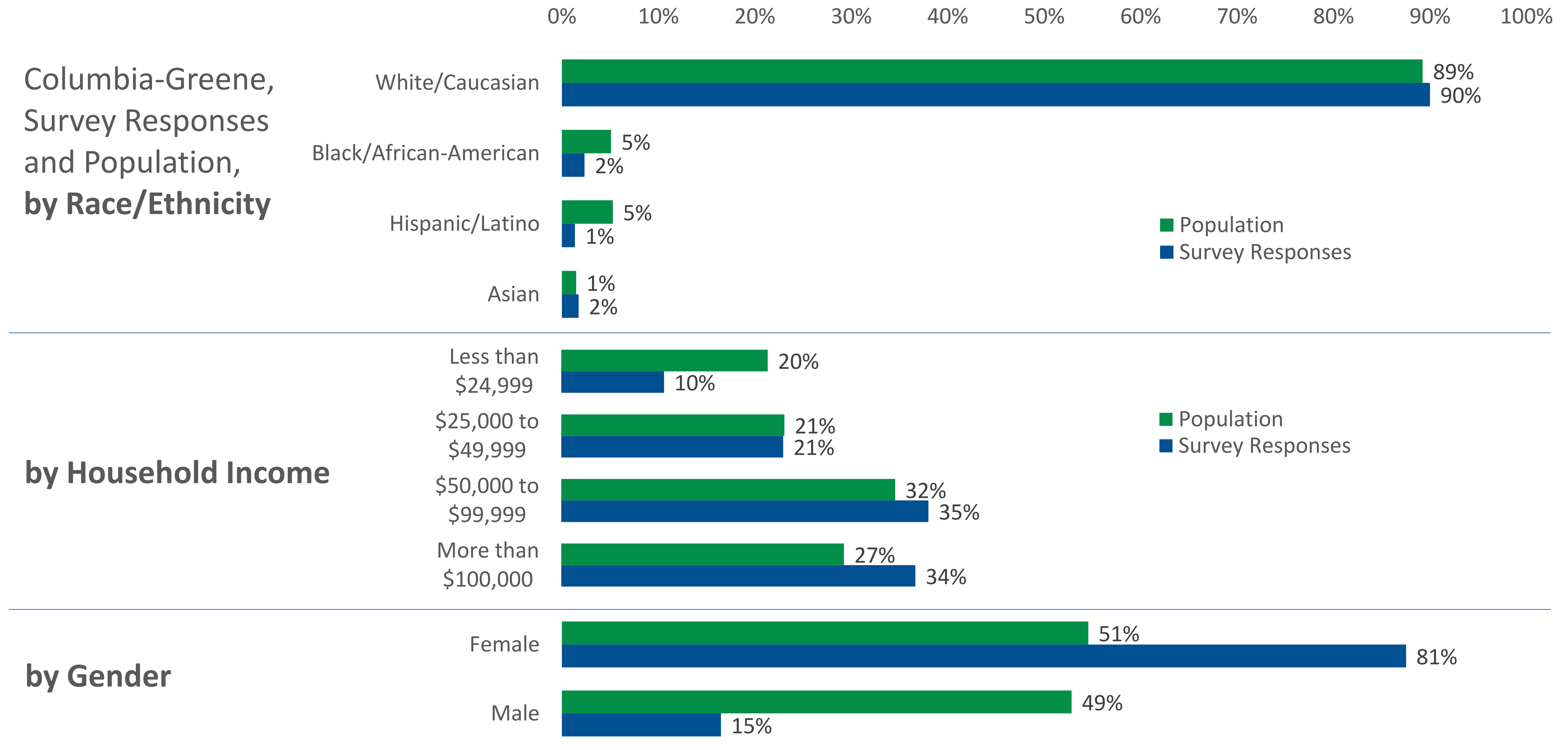
Community Member Survey, Fall 2021

	Responses	
Region/County	**(n)**	**(%)**
Capital Region	2,104	
Albany	547	26%
Rensselaer	268	13%
Schenectady	426	20%
Saratoga	194	9%
Columbia	387	18%
Greene	282	13%
Columbia-Greene	669	32%

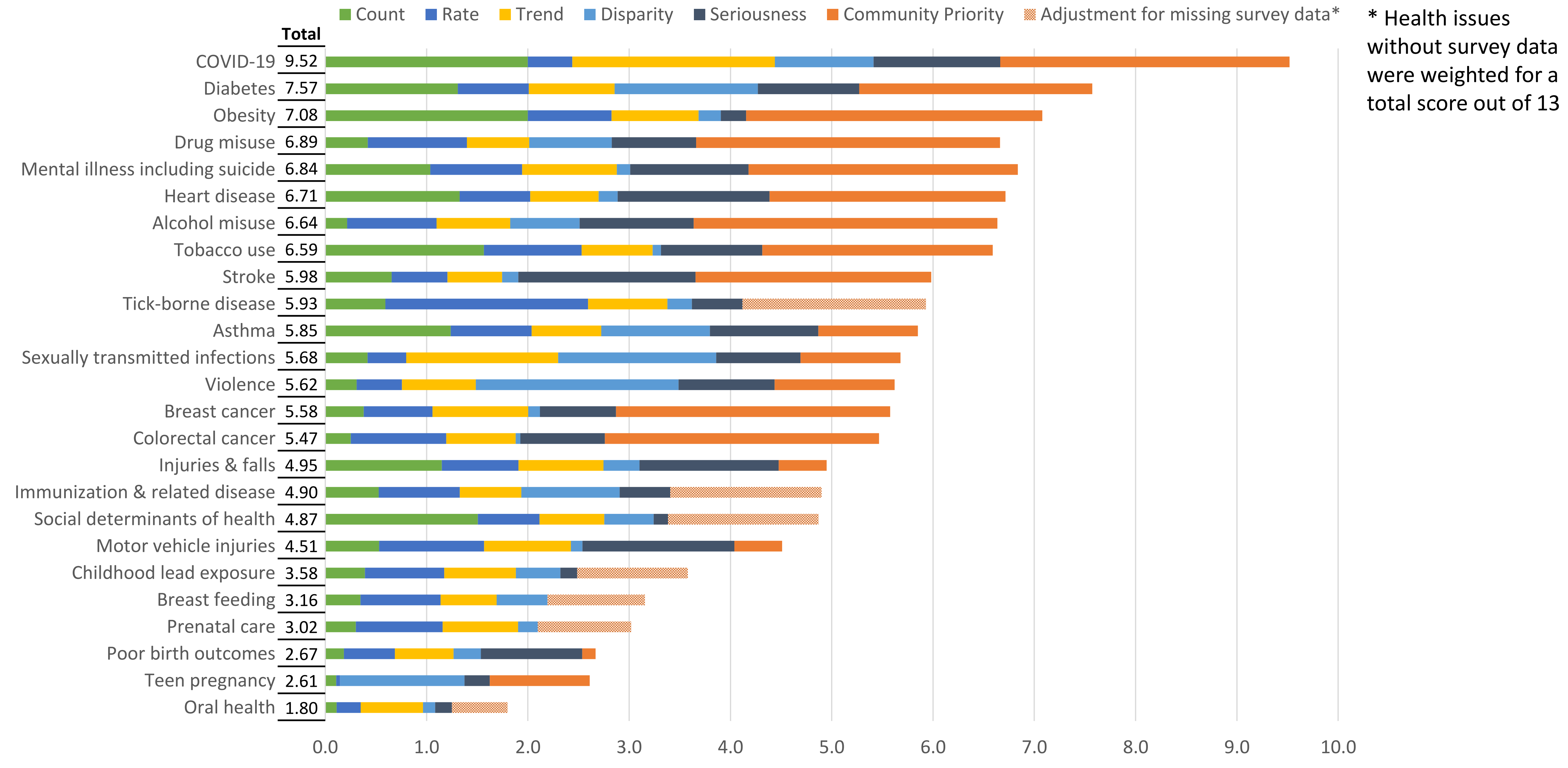
Survey Reports

- **Capital Region:** https://reporting.alchemer.com/r/505744_618158d6bb47d1.59744945
- **Columbia & Greene counties, combined:** https://reporting.alchemer.com/r/505744_618c3b72a5ddd2.37390934
- **Columbia County only:** https://reporting.alchemer.com/r/505744_6181582c96ee15.99916867
- **Greene County only:** https://reporting.alchemer.com/r/505744_618158929f6da8.55068397

Community Member Survey, Fall 2021



Data-based Need Score (out of 13) with Survey Data



* Health issues without survey data were weighted for a total score out of 13

Data + Survey Scores (out of 13) – Columbia & Greene

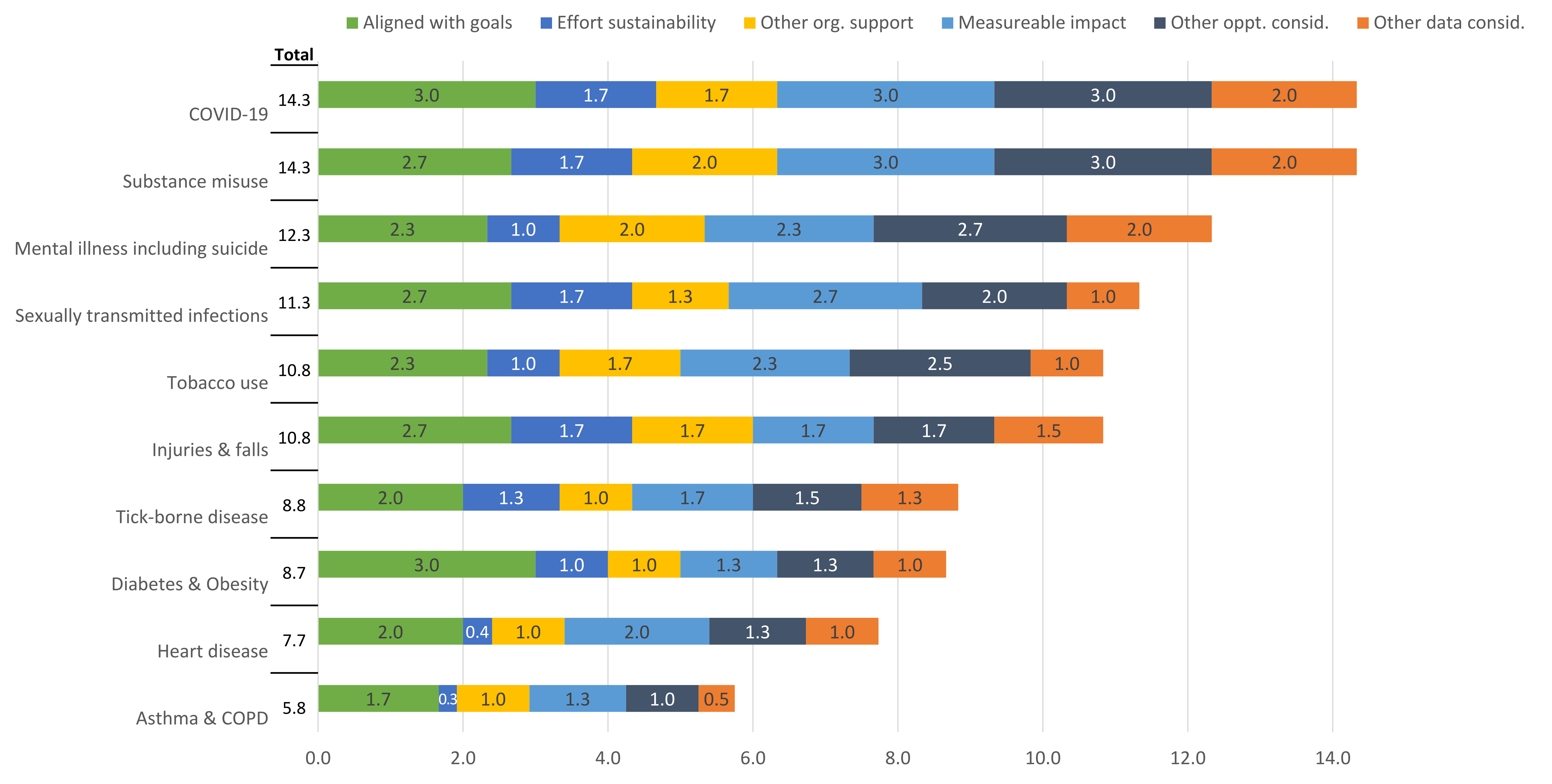
Third step…

Narrowing the list from 25 to 10 and adding Hospital and Local Health Department Scoring

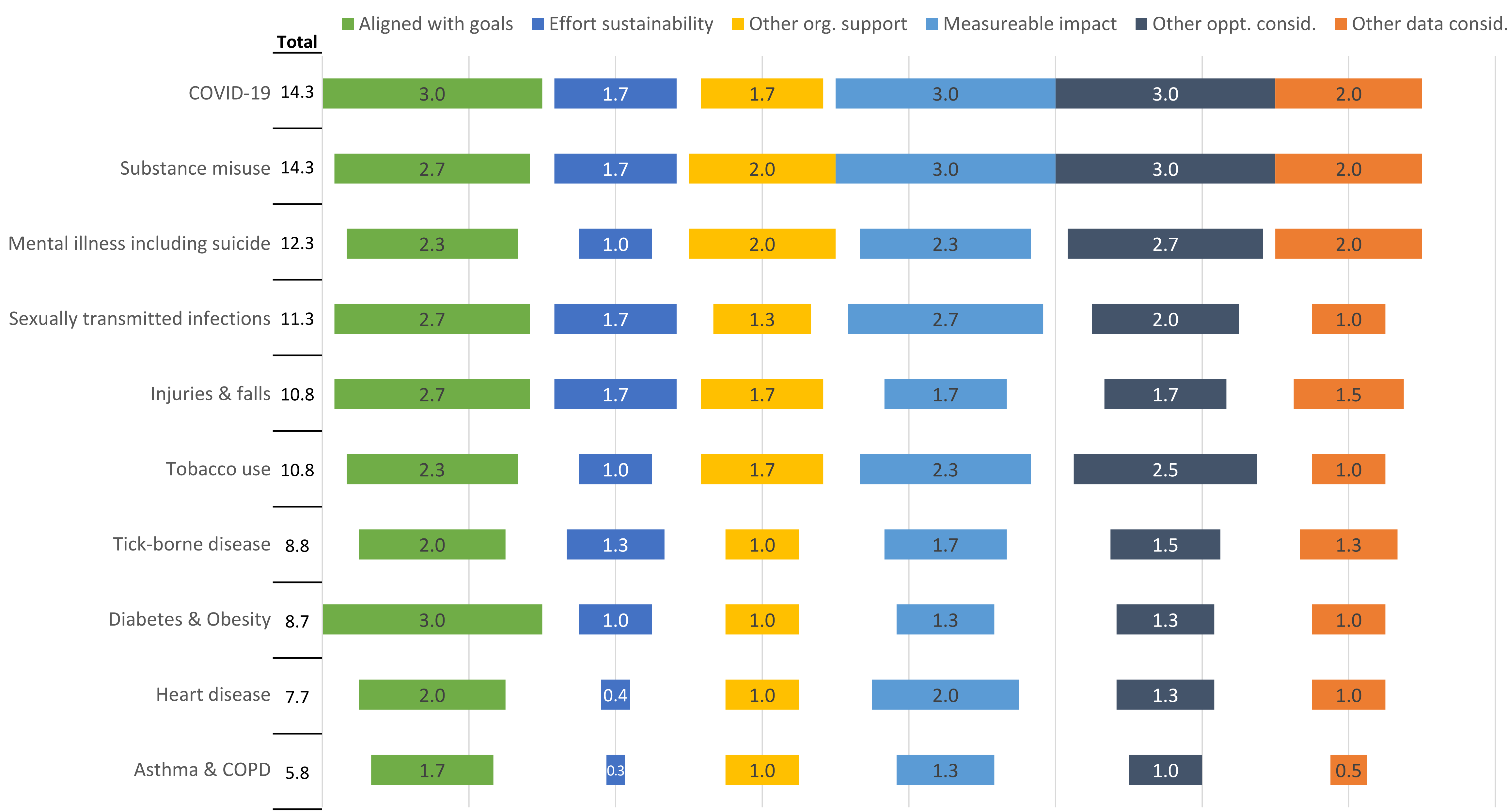
Data + Survey Scores
Columbia & Greene Counties

Rank	Health Issue	Data + Survey Score
1	COVID-19	9.52
2	Diabetes	7.57
3	Obesity	7.08
4	Drug misuse	6.89
5	Mental illness including suicide	6.84
6	Heart disease	6.71
7	Alcohol misuse	6.64
8	Tobacco use	6.59
9	Stroke	5.98
10	Tick-borne disease	5.93
11	Asthma	5.85
12	Sexually transmitted infections	5.68
13	Violence	5.62
14	Breast cancer	5.58
15	Colorectal cancer	5.47
16	Injuries & falls	4.95
17	Immunization & related disease	4.90
18	Social determinants of health	4.87
19	Motor vehicle injuries	4.51
20	Childhood lead exposure	3.58
21	Breast feeding	3.16
22	Prenatal care	3.02
23	Poor birth outcomes	2.67
24	Teen pregnancy	2.61
25	Oral health	1.80

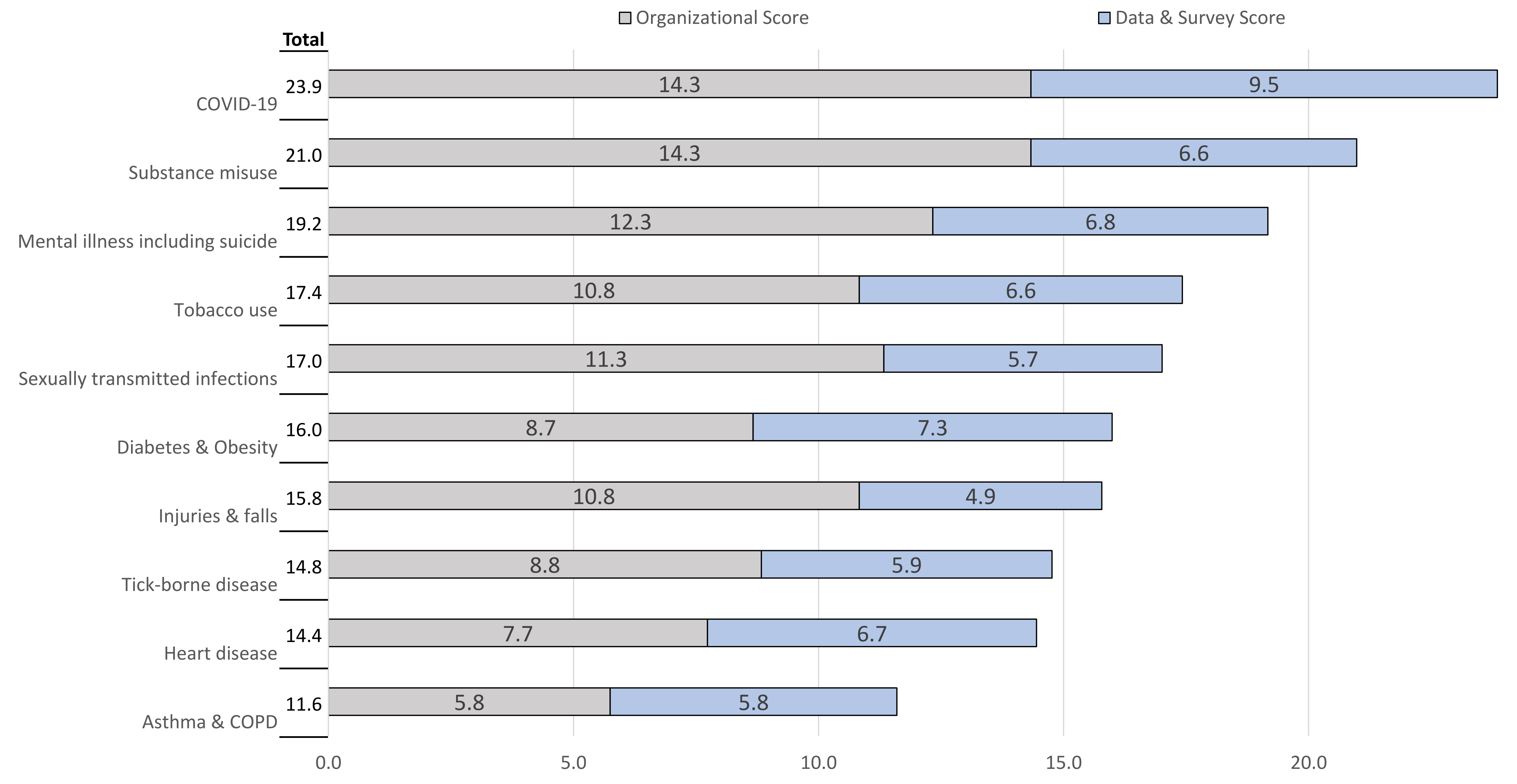
Columbia-Greene Planning Partners' Scores



Columbia-Greene Planning Partners' Scores



All Scores Thus Far: Data, Survey, and Planning Partner Scores (out of 29)



Remaining Work

Community Partner Scoring (that's where you come in!)

Health Issue Scoring Sheet

Opportunity	Max Score	Score
Health issue aligns with organizations' strategic goals	3	
If already working to address this need, are efforts working sustainably	2	
If not working on this need, do we have resources and expertise to lead effort	1	
Are there organizations interested in supporting efforts to address this need	2	
Is it possible to make a measureable, positive impact	3	
Other considerations	3	
Community Partner considerations	3	
Total Opportunity Score	**17**	

Need	Max Score	Score
Is this issue a major need in the community - **Total number** of cases	2	
Is this issue worse in our region than throughout NY - **Rates**	2	
Is this issue more common for some populations - **Disparities**	2	
Is this issue getting better or worse - **Trend**	2	
How **serious**ly does this issue threaten mortality	2	
Is this issue a **priority for the community** based on the survey	3	
Other considerations about the data	2	
Community Partner considerations	3	
Total Need Score	**18**	

	Max Score	Score	Contribution to Total Score
Total Planning Partners Score	14		40%
Total Data-based Score	10		29%
Total Community Partner Score	11		31%
Total Priority Score	**35**		

Today

Community Partner Scoring Process

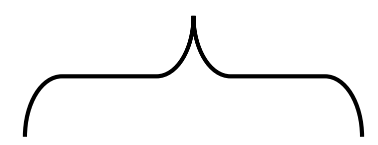
1. We'll review data about each of the 10 health issues
2. We'll discuss each health issue, guided by the following questions:
   - What about this data surprises you?
   - Are these data current and complete? Is there more recent data of which you are aware?
   - What are the implications/consequences of this health issue on our community?
   - What else do we need to know about this issue?
3. We'll ask you to score the health issue, using the scoring sheet that was distributed to those attending in person, and the following link for those attending remotely:

https://survey.alchemer.com/s3/6701386/Health-Issue-Prioritization-Community-Partner-Survey-Columbia-Greene

Community Partner Scoring

Let’s get started!

Asthma & COPD Measures



Indicator		Prevention Agenda 2024 Objective	NYS	NYS excl. NYC (Upstate)	Capital Region (6 County) Summary	Albany County	Schenectady County	Rensselaer County	Saratoga County	Columbia County	Greene County
	YEAR	Rate	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #
Age-adj. COPD/CLRD Mortality Rate per 100,000	2016-18		28.3	35.0	39.1	32.0	41.1	48.2	40.8	41.9	32.4
Number :	2018				520	130	85	106	127	35	37
Age-adj. COPD/CLRD Hospitalizations per 10,000	2016-18		27.1	24.0	23.2	23.8	25.0	23.3	18.4	30.0	28.1
Number :	2018				2,453	756	406	364	495	260	172
Age-adjusted % Adults with Current Asthma	2018		10.1	na	12.7	11.7	15.9	13.1	14.1	10.8	13.9
Number :					101,698	29,259	19,380	16,782	25,664	5,121	5,493
Asthma emergency department visit rate per 10,000-Ages 0-17 yrs	2018	131.1	122.5	64.3	55.8	79.1	72.0	52.6	19.9	45.4	57.6
Number :					1,034	446	240	164	92	47	47
Age-adj. Asthma Hospitalizations-Total per 10,000	2016-18		10.8	6.7	5.3	6.7	6.2	4.8	2.9	6.1	5.7
Number :	2018				473	195	100	57	62	36	23
Asthma Hospitalizations-0-17 years per 10,000	2016-18		21.9	12.8	8.1	11.4	8.6	8.7	4.1	4.4	8.0
Number :	2018				172	82	30	30	18	s	s

One of 5 Counties with Poorest Rates
Counties in the 4th Quartile (1=good; 4=bad)
Counties in the 3rd Quartile

Link:
http://www.hcdiny.org/content/sites/hcdi/resource_library_additions/HCD-County-PH-Indicator_Matrix.pdf

Health Issue Discussion: Asthma & COPD

What about this data surprises you?

Are these data current and complete? Is there more recent data related to this issue of which you are aware?

What are the implications/consequences of this health issue on our community?

What else do we need to know about this issue?

Health Issue Prioritization - Community Partner Survey - Columbia-Greene

Community Partner Consideration Scoring

Please rate the opportunity/need to address the following health issues, based on what you know or have seen, as well as the group discussion.

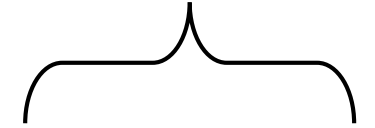
0 = very **little**

3 = very **high**

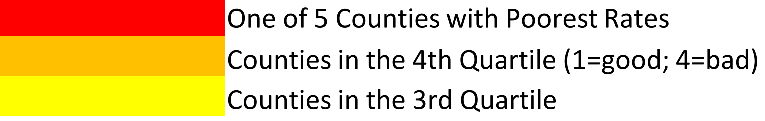
1. **Asthma & COPD**

	0	1	2	3
Opportunity	○	○	○	○
Need	○	○	○	○

Heart Disease Measures



Indicator		Prevention Agenda 2017 or 2024 Objective	NYS	NYS excl. NYC (Upstate)	Capital Region (6 County) Summary	Albany County	Schenectady County	Rensselaer County	Saratoga County	Columbia County	Greene County
	YEAR	Rate	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #
% Adults with physician diagnosed high blood presssure taking BP meds.	2016	80.7	76.9	77.6	73.3	71.3	71.6	76.8	71.9	83.8	72.3
Number not on meds. :					60,965	22,281	10,262	8,525	13,926	2,038	3,933
% Adults with cardiovascular disease (heart attack, CHD or stroke)	2018		7.0	na	7.7	6.9	6.3	8.3	8.3	7.2	7.8
Number:					58,067	17,255	8,410	10,633	15,107	3,580	3,082
Age-adjusted Heart Attack (Acute MI) Mortality per 100,000	2016-18		24.2	27.9	19.7	16.5	18.3	21.5	20.3	26.6	23.9
Number :	2018				246	63	33	43	43	27	21
Age-adjusted Heart Attack hospitalization rate per 10,000	2016-18		13.7	14.9	13.5	12.5	16.4	14.6	12.5	11.8	14.0
Number :	2018				1,542	433	308	231	373	109	88
Age-adj. Coronary Heart Disease Mortality per 100,000	2016-18		132.0	115.6	100.9	100.1	105.7	103.1	85.9	118.7	125.9
Number :	2018				1,310	376	231	208	260	129	106
Age-adj. Coronary Heart Disease Hospitalizations per 10,000	2016-18		25.8	25.3	20.8	19.0	24.9	21.4	20.3	18.4	23.5
Number :	2018				2,398	675	449	365	604	161	144
Age-adj.Congestive Heart Failure Mortality per 100,000	2016-18		12.0	16.7	17.2	18.4	17.9	19.4	11.9	19.1	22.2
Number :	2018				207	66	30	37	37	21	16



One of 5 Counties with Poorest Rates
Counties in the 4th Quartile (1=good; 4=bad)
Counties in the 3rd Quartile

Link:
http://www.hcdiny.org/content/sites/hcdi/resource_library_additions/HCD-County-PH-Indicator_Matrix.pdf

Health Issue Discussion: Heart Disease

What about this data surprises you?

Are these data current and complete? Is there more recent data related to this issue of which you are aware?

What are the implications/consequences of this health issue on our community?

What else do we need to know about this issue?

Health Issue Prioritization - Community Partner Survey - Columbia-Greene

Community Partner Consideration Scoring

Please rate the opportunity/need to address the following health issues, based on what you know or have seen, as well as the group discussion.

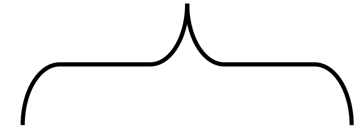
0 = very **little**

3 = very **high**

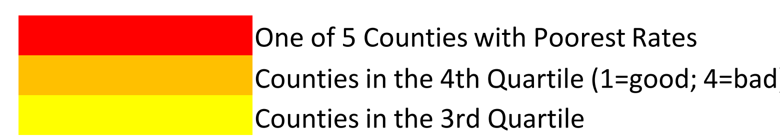
2. **Heart Disease**

	0	1	2	3
Opportunity	○	○	○	○
Need	○	○	○	○

Tick-borne Disease Measures



Indicator		Prevention Agenda 2017 or 2024 Objective	NYS	NYS excl. NYC (Upstate)	Capital Region (6 County) Summary	Albany County	Schenectady County	Rensselaer County	Saratoga County	Columbia County	Greene County
	YEAR	Rate	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #
Lyme Disease case rate per 100,000	**2016-18**		42.0	58.5	187.2	104.2	68.7	311.3	109.7	593.8	550.9
Number :	**2018**				1,367	349	87	358	192	251	130
Anaplasmosis case rate per 100,000	**2018**		4.6	7.6	47.8	23.6	10.3	63.2	37.0	170.0	90.6
Number :	**2018**				421	73	16	101	85	103	43
Babesiosis case rate per 100,000	**2018**		3.2	5.0	10.4	5.2	1.3	21.9	1.7	44.6	25.3
Number :	**2018**				96	16	2	35	4	27	12



Link:
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Health Issue Discussion: Tick-Borne Disease

What about this data surprises you?

Are these data current and complete? Is there more recent data related to this issue of which you are aware?

What are the implications/consequences of this health issue on our community?

What else do we need to know about this issue?

Health Issue Prioritization - Community Partner Survey - Columbia-Greene

Community Partner Consideration Scoring

Please rate the opportunity/need to address the following health issues, based on what you know or have seen, as well as the group discussion.

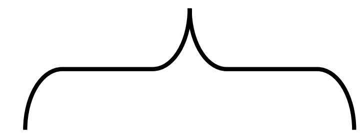
0 = very **little**

3 = very **high**

3. Tick-borne disease

	0	1	2	3
Opportunity	○	○	○	○
Need	○	○	○	○

Injuries & Falls Measures



Indicator		Prevention Agenda 2017 or 2024 Objective	NYS	NYS excl. NYC (Upstate)	Capital Region (6 County) Summary	Albany County	Schenectady County	Rensselaer County	Saratoga County	Columbia County	Greene County
	YEAR	**Rate**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**
Rate of hospitalizations due to falls per 10,000 - Ages 65+ years	**2017**	**173.7**	180.6	193.5	187.4	247.3	114.8	186.0	159.7	199.0	172.7
Number :					3,142	1256	301	490	641	277	177
Age-adjusted Unintentional Injury Mortality per 100,000	**2016-18**		34.6	45.8	25.5	23.4	21.3	25.8	22.3	42.7	51.1
Number :	**2018**				292	87	35	52	55	26	37
Age-adjusted Unintentional Injury Hospitalizations per 10,000	**2016-18**		58.1	61.5	60.3	69.3	48.7	62.4	51.6	62.4	79.1
Number :	**2018**				7,648	2,636	1,248	1,218	1,569	526	451

One of 5 Counties with Poorest Rates
Counties in the 4th Quartile (1=good; 4=bad)
Counties in the 3rd Quartile

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Health Issue Discussion: Injuries & Falls

What about this data surprises you?

Are these data current and complete? Is there more recent data related to this issue of which you are aware?

What are the implications/consequences of this health issue on our community?

What else do we need to know about this issue?

Health Issue Prioritization - Community Partner Survey - Columbia-Greene

Community Partner Consideration Scoring

Please rate the opportunity/need to address the following health issues, based on what you know or have seen, as well as the group discussion.

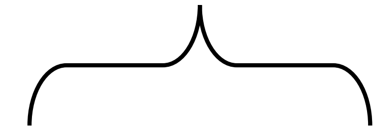
0 = very **little**

3 = very **high**

4. **Injuries & falls**

	0	1	2	3
Opportunity	○	○	○	○
Need	○	○	○	○

Diabetes Measures



Indicator	YEAR	Prevention Agenda 2017 or 2024 Objective	NYS	NYS excl. NYC (Upstate)	Capital Region (6 County) Summary	Albany County	Schenectady County	Rensselaer County	Saratoga County	Columbia County	Greene County
	YEAR	Rate	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #
Age-adjusted % Adults with physician diagnosed diabetes	2018		10.0	na	9.4	7.7	10.3	10.1	8.9	7.6	13.2
Number :					69,942	19,255	12,554	12,939	16,199	3,779	5,216
Age-adj. Diabetes Mortality Rate per 100,000	2016-18		17.2	15.9	16.3	16.3	21.2	17.3	14.0	14.2	13.0
Number :	2018				246	90	51	31	43	20	11
Age-adj. Diabetes (primary diagnosis) Hospitalizations per 10,000	2016-18		17.7	15.5	15.4	17.7	17.2	17.3	10.3	14.6	16.4
Number :	2018				1,710	591	324	323	293	95	84
Age-adj. Diabetes (any diagnosis) Hospitalizations per 10,000	2016-18		211.3	193.0	191.5	209.0	217.5	209.2	147.5	172.8	198.1
Number :	2018				23,718	7,801	4,283	4,102	4,620	1,549	1,363
Hospitalizations for short-term complications of diabetes - 18+ (potentially preventable)	2016-18		5.2	5.1	5.4	5.5	6.9	6.4	3.9	4.2	6.4
Number :	2018				553	178	124	117	89	23	22
% adults 45+ with test for diabetes in last 3 yrs.	2018	71.7	63.8	61.0	61.5	59.5	64.5	62.7	62.9	62.9	66.0
Number without test:					164,448	52,530	24,113	26,370	39,901	13,202	8,332

One of 5 Counties with Poorest Rates
Counties in the 4th Quartile (1=good; 4=bad)
Counties in the 3rd Quartile

Link:
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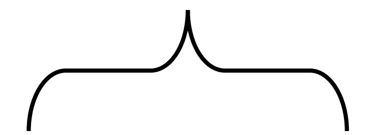
Obesity Measures



Indicator	YEAR	Prevention Agenda 2017 or 2024 Objective	NYS	NYS excl. NYC (Upstate)	Capital Region (6 County) Summary	Albany County	Schenectady County	Rensselaer County	Saratoga County	Columbia County	Greene County
	YEAR	Rate	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #
Percentage of adults who are obese	**2018**	**24.2**	27.6	29.1	29.6	26.9	33.7	30.9	30.1	24.3	34.5
Number :					228,428	67,268	41,075	39,584	54,786	12,082	13,633
Percentage of adults who are obese-income <$25,000	**2018**	**29.0**	31.8	34.4	38.8	33.2	54.2	39.6	44.8	18.6	42.6
Percentage of children and adolescents who are obese	**2017-19**	**16.4**	na	17.3	16.5	16.3	18.8	18.7	13.1	17.3	23.0
Number :					22,901	6,735	4,591	4,263	4,557	1,400	1,355
% of children (aged 2-4 yrs.) enrolled in WIC who are obese	**2017**	**13.0**	13.9	na	15.2	13.4	15.6	14.1	17.0	21.3	19.9
Number :					820	262	171	156	118	70	43
Age-adjusted % Adults not engaged in some type of leisure time physical activity	**2018**	**22.6**	23.8	22.4	19.7	18.9	19.0	23.4	14.0	20.1	25.7
# no leisure time PA					146,028	47,263	23,158	29,976	25,482	9,994	10,155
% Adults 65+ with no leisure time physical activity	**2018**	**24.1**	31.1	31.1	29.9	26.2	30.1	32.9	21.8	25.5	35.6
% adults with disability with no leisure time physical activity	**2018**	**38.2**	38.8	39.4	35.0	28.4	28.3	43.5	29.6	46.2	55.4
% Adults with <$25,000 income who consume 1+ sugary drinks daily	**2018**	**28.5**	31.0	34.1	30.3	27.0	33.1	24.5	40.6	25.8	15.9
Age-adjusted % Adults who consume <1 friut or vegetable daily	**2018**		28.1	na	26.4	24.0	30.8	27.6	24.8	24.9	22.5
Number:					199,324	60,016	37,541	35,357	35,028	12,880	8,891

One of 5 Counties with Poorest Rates

Counties in the 4th Quartile (1=good; 4=bad)

Counties in the 3rd Quartile

Link:

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Health Issue Discussion: Diabetes & Obesity

What about this data surprises you?

Are these data current and complete? Is there more recent data related to this issue of which you are aware?

What are the implications/consequences of this health issue on our community?

What else do we need to know about this issue?

Health Issue Prioritization - Community Partner Survey - Columbia-Greene

Community Partner Consideration Scoring

Please rate the opportunity/need to address the following health issues, based on what you know or have seen, as well as the group discussion.

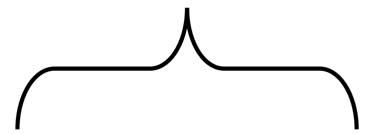
0 = very **little**

3 = very **high**

5. **Diabetes & Obesity**

	0	1	2	3
Opportunity	○	○	○	○
Need	○	○	○	○

Sexually Transmitted Infections Measures



Indicator		Prevention Agenda 2017 or 2024 Objective	NYS	NYS excl. NYC (Upstate)	Capital Region (6 County) Summary	Albany County	Schenectady County	Rensselaer County	Saratoga County	Columbia County	Greene County
	YEAR	**Rate**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**
Newly diagnosed HIV case rate per 100,000	**2016-18**	**5.2**	13.9	6.1	6.2	9.2	8.4	4.6	1.9	6.6	5.6
Number per yr :					60	28	13	7	4	4	3
Age adj. Gonorrhea case rate per 100,000	**2018**	**242.6**	195.8	106.9	123.5	162.5	181.6	152.7	35.0	54.5	34.9
Number :					1145	535	260	234	73	27	16
Age adj. Chlamydia case rate per 100,000	**2018**	**676.9**	633.4	443.7	465.9	543.5	564.1	515.3	271.1	434.9	352.1
Number :					4,447	1,932	817	804	547	201	146
Age adj. Early syphilis case rate per 100,000	**2018**	**79.6**	35.6	11.6	13.2	16.8	22.8	13.5	3.3	12.4	6.6
Number :					127	55	34	21	8	6	3

One of 5 Counties with Poorest Rates
Counties in the 4th Quartile (1=good; 4=bad)
Counties in the 3rd Quartile

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Healthy Capital District
Get Covered • Find Care • Stay Healthy

Health Issue Discussion: STIs

What about this data surprises you?

Are these data current and complete? Is there more recent data related to this issue of which you are aware?

What are the implications/consequences of this health issue on our community?

What else do we need to know about this issue?

Health Issue Prioritization - Community Partner Survey - Columbia-Greene

Community Partner Consideration Scoring

Please rate the opportunity/need to address the following health issues, based on what you know or have seen, as well as the group discussion.

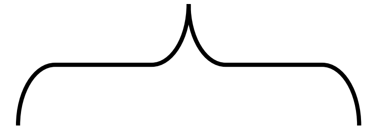
0 = very **little**

3 = very **high**

6. Sexually transmitted infections

	0	1	2	3
Opportunity	○	○	○	○
Need	○	○	○	○

Tobacco Use Measures



Indicator		Prevention Agenda 2017 or 2024 Objective	NYS	NYS excl. NYC (Upstate)	Capital Region (6 County) Summary	Albany County	Schenectady County	Rensselaer County	Saratoga County	Columbia County	Greene County
	YEAR	**Rate**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**
Percentage of cigarette smoking among adults	**2018**	**11.0**	12.8	13.9	14.0	11.6	11.3	17.3	12.8	16.2	18.5
Number :					103,606	29,008	13,733	22,162	23,298	8,055	7,310
Age-adj. Lung Cancer Incidence/100,000	**2015-17**		58.4	66.1	74.0	74.0	72.4	80.1	71.8	66.9	80.5
Number :	**2017**				926	286	133	155	207	80	65
Age-adj. Lung Cancer Mortality/100,000	**2015-17**		33.0	37.4	42.0	41.9	39.0	45.1	42.6	33.9	50.8
Number :	**2017**				505	156	75	93	108	31	42

One of 5 Counties with Poorest Rates
Counties in the 4th Quartile (1=good; 4=bad)
Counties in the 3rd Quartile

Link:

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Health Issue Discussion: Tobacco Use

What about this data surprises you?

Are these data current and complete? Is there more recent data related to this issue of which you are aware?

What are the implications/consequences of this health issue on our community?

What else do we need to know about this issue?

Health Issue Prioritization - Community Partner Survey - Columbia-Greene

Community Partner Consideration Scoring

Please rate the opportunity/need to address the following health issues, based on what you know or have seen, as well as the group discussion.

0 = very **little**

3 = very **high**

7. **Tobacco use**

	0	1	2	3
Opportunity	○	○	○	○
Need	○	○	○	○

Mental Illness including Suicide Measures

Indicator	YEAR	Prevention Agenda 2017 or 2024 Objective	NYS	NYS excl. NYC (Upstate)	Capital Region (6 County) Summary	Albany County	Schenectady County	Rensselaer County	Saratoga County	Columbia County	Greene County
	YEAR	Rate	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #
Age-adjusted mental disease/disorder primary dx ED visit rate per 10,000	**2016-18**		na	167.0	175.6	175.7	245.0	166.5	148.1	209.2	126.4
Number:	**2018**				15,964	5,085	3,537	2,366	3,303	1475	198
Age-adj. mental disease/disorder primary dx hospitalization rate per 10,000	**2016-2018**		na	83.7	97.7	101.0	125.2	109.6	68.8	115.9	95.0
Number:	**2018**				9,719	3,400	1,858	1,794	1,569	781	317
Age-adjusted Suicide Mortality rate per 100,000	**2016-18**	**7.0**	8.2	9.9	11.3	9.7	10.2	11.8	11.5	15.9	15.7
Number :	**2016-18 av.**				110	31	16	18	27	11	7
Suicide Mortality (15-19yrs) rate per 100,000	**2016-18**		5.9	7.2	6.3	4.4	10.3	6.2	7.1	10.0	0.0
Number :	**2016-18**				12	3	3	2	3	1	0
Age-adjusted Self-inflicted Injury Hospitalizations per 10,000	**2016-18**		3.6	4.4	4.9	5.0	5.6	5.0	4.3	4.2	6.3
Number :	**2018**				574	216	107	79	115	22	35
Mental health provider to pop. ratio	**2020**		330:1	na	na	270:1	430:1	590:1	550:1	570:1	1150:1

One of 5 Counties with Poorest Rates
Counties in the 4th Quartile (1=good; 4=bad)
Counties in the 3rd Quartile

Link:
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Health Issue Discussion: Mental Illness (incldng Suicide)

What about this data surprises you?

Are these data current and complete? Is there more recent data related to this issue of which you are aware?

What are the implications/consequences of this health issue on our community?

What else do we need to know about this issue?

Health Issue Prioritization - Community Partner Survey - Columbia-Greene

Community Partner Consideration Scoring

Please rate the opportunity/need to address the following health issues, based on what you know or have seen, as well as the group discussion.

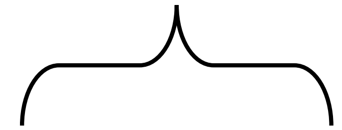
0 = very **little**

3 = very **high**

8. **Mental illness including suicide**

	0	1	2	3
Opportunity	○	○	○	○
Need	○	○	○	○

Drug Misuse Measures

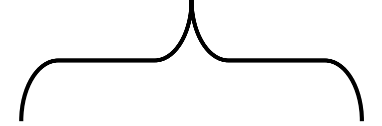


Indicator	YEAR	Prevention Agenda 2017 or 2024 Objective	NYS	NYS excl. NYC (Upstate)	Capital Region (6 County) Summary	Albany County	Schenectady County	Rensselaer County	Saratoga County	Columbia County	Greene County
		Rate	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #
Newborns with neonatal abstinence symptom and/or affected by maternal use of drugs of addiction per 1,000 newborn discharges	**2018**		9.0	14.0	12.2	16.6	8.9	9.4	9.7	27.8	s
Number :					71	21	13	8	16	8	s
Age-adjusted Opioid Analgesic Prescription rate per 1,000 pop.	**2019**	**350.0**	298.6	372.7	364.4	316.5	395.0	417.3	332.6	413.5	492.3
Number prescriptions:					414,705	110,322	71,039	77,641	93,280	32,233	30,180
Opioid burden (ED/hosp./death) due to opioids per 100,000	**2018**		279.2	256.1	305.7	336.4	286.4	400.8	182.5	340.5	404.3
Number:					2,933	1,033	445	639	420	204	192
Age-adj. Opioid Overdose ED visits per 100,000	**2018**	**53.3**	55.2	71.9	56.9	64.7	51.3	74.1	31.7	66.8	84.6
Number:					521	193	76	116	67	35	34
Opioid Overdose Hospitalizations per 100,000 (crude rate)	**2018**		15.6	15.3	13.0	20.2	11.6	11.3	5.2	13.4	14.7
Number:					125	12	18	18	12	8	7
Age-adj. Opioid Overdose Mortality Rate per 100,000	**2018**	**14.3**	15.0	18.5	15.2	15.5	17.5	14.5	12.1	9.9	27.5
Number:					135	45	25	21	26	6	12
Patients who received at least one buprenorphine prescription for opioid use disorder, age-adjusted rate per 100,000	**2019**	**415.6**	414.3	621.1	592.3	500.3	723.6	580.2	475.8	891.2	1106.5
Number patients:	**2019**				5,195	1,386	1,040	871	994	443	461

One of 5 Counties with Poorest Rates
Counties in the 4th Quartile (1=good; 4=bad)
Counties in the 3rd Quartile

Link:
http://www.hcdiny.org/content/sites/hcdi/resource_library_additions/HCD-County-PH-Indicator_Matrix.pdf

Alcohol Misuse Measures



Indicator		Prevention Agenda 2017 or 2024 Objective	NYS	NYS excl. NYC (Upstate)	Capital Region (6 County) Summary	Albany County	Schenectady County	Rensselaer County	Saratoga County	Columbia County	Greene County
	YEAR	Rate	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #	Rate & #
Age-adj.Adult binge drinking during the past month	**2018**	**16.4**	17.5	18.4	18.5	19.2	15.8	23.5	19.5	21.1	16.1
Number :					149,721	48,013	19,258	30,104	35,493	10,491	6,362
Age-adj. Cirrhosis mortality rate per 100,000	**2016-18**		6.9	7.9	7.4	5.6	8.6	8.0	8.1	8.9	6.9
Number :	**2018**				94	22	19	10	30	5	8
Age-adj. Cirrhosis Hospitalizations per 10,000	**2016-18**		3.2	3.0	2.8	3.3	2.8	2.3	2.6	2.1	3.9
Number :	**2018**				366	136	58	45	86	14	27
Alcohol-related motor vehicle injuries and deaths per 100,000	**2016-18**		30.1	36.5	38.1	35.4	34.0	33.5	41.4	48.6	54.0
Number :	**2018**				357	98	59	58	91	22	29

- (Red) One of 5 Counties with Poorest Rates
- (Orange) Counties in the 4th Quartile (1=good; 4=bad)
- (Yellow) Counties in the 3rd Quartile

Link:
http://www.hcdiny.org/content/sites/hcdi/resource_library_additions/HCD-County-PH-Indicator_Matrix.pdf

Health Issue Discussion: Substance Misuse

What about this data surprises you?

Are these data current and complete? Is there more recent data related to this issue of which you are aware?

What are the implications/consequences of this health issue on our community?

What else do we need to know about this issue?

Health Issue Prioritization - Community Partner Survey - Columbia-Greene

Community Partner Consideration Scoring

Please rate the opportunity/need to address the following health issues, based on what you know or have seen, as well as the group discussion.

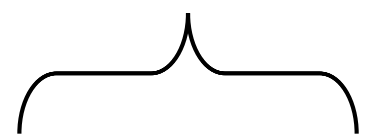
0 = very **little**

3 = very **high**

9. **Substance misuse**

	0	1	2	3
Opportunity	○	○	○	○
Need	○	○	○	○

COVID-19 Measures



Indicator		Prevention Agenda 2024 Objective	NYS	NYS excl. NYC (Upstate)	Capital Region (6 County) Summary	Albany County	Schenectady County	Rensselaer County	Saratoga County	Columbia County	Greene County
	YEAR	**Rate**	**Rate**	**Rate**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**	**Rate & #**
COVID-19 Cases per 1,000	**Jan, 12 2021**		160.9	146.1	117.6	110.3	123.0	121.2	126.8	100.4	111.6
Number :	**- Jan, 11 2022**				112,802	33,877	19,318	19,112	29,181	6,015	5,299
COVID-19 Mortality per 100,000	**Jan, 12 2021**		91.8	94.4	88.3	69.4	108.1	80.9	95.1	98.5	124.2
Number :	**- Jan, 11 2022**				847	213	59	59	129	219	168

One of 5 Counties with Poorest Rates
Counties in the 4th Quartile (1=good; 4=bad)
Counties in the 3rd Quartile

Link:

http://www.hcdiny.org/content/sites/hcdi/resource_library_additions/HCD-County-PH-Indicator_Matrix.pdf

Health Issue Discussion: COVID-19

What about this data surprises you?

Are these data current and complete? Is there more recent data related to this issue of which you are aware?

What are the implications/consequences of this health issue on our community?

What else do we need to know about this issue?

Health Issue Prioritization - Community Partner Survey - Columbia-Greene

Community Partner Consideration Scoring

Please rate the opportunity/need to address the following health issues, based on what you know or have seen, as well as the group discussion.

0 = very **little**

3 = very **high**

10. **COVID-19**

	0	1	2	3
Opportunity	○	○	○	○
Need	○	○	○	○

Next Steps

The Planning Partners will…

…review the Community Partner Scoring

…finalize the selection of health priorities

…develop and submit the 2022-2024 CHIP

Thank you for joining us and providing valuable input!

The Columbia-Greene Planning Partners

Columbia County Department of Health
Greene County Public Health
Columbia Memorial Health

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Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives through 2024	Disparities	Interventions	Family of Measures	By December 2023, we will have completed . . .	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 1.0 Reduce obesity and the risk of chronic disease	Objective 1.4: Increase the percentage of adults age 18 years and older with obesity (among all adults)	N/A	Expand access to the Biggest Loser Contest, a 16 week, independent weight loss program.	Number of registrants; Number of participants initiating the program; Number of participants completing the program; Number of participants who have lost at least 5% of their beginning weight	...recruiting participants and implementing one 16-week cycle of Biggest Loser Contest	Community-based organizations	Staff experience and support initiating and maintaining engagement of participatns for Biggest Loser Contest
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.0 Reduce obesity and the risk of chronic disease	Objective 1.6: Decrease the percentage of adults ages 18 years and older with obesity (among adults living with a disability)	N/A	Provide nutritional education in one-on-one and group settings to patients in the inpatient psychiatric unit at Columbia Memorial Hospital	Number of patients receiving nutrition education one-on-one; Number of patients receiving nutrition education in groups	Developing a mechanism for referring to/engaging patients in nutrition education, whether one-on-one or in the group setting, and tracking their participation	Other (please describe partner and role(s) in column D)	The Hospital will rely upon the nutritionists from its contracted food service agency to deliver the nutrition education
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 1.0 Reduce obesity and the risk of chronic disease	Objective 1.6: Increase the percentage of adults age 18 years and older with obesity (among adults living with a disability)	N/A	Provide an exercise program to patients in the inpatient psychiatric unit at Columbia Memorial Hospital	Number of patients who participate in the program when offered; Percent of patients who participate in the program when offered	...developing a mechanism for referring to/engaging patients in the exercise program and tracking their participation	Other (please describe partner and role(s) in column D)	The Hospital will contract with a third-party to provide an exercise program
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Objective 4.3.1: Decrease the percentage of adult patients with diabetes whose most recent HbA1c level indicated poor control (>9%)	N/A	Promote evidence-based medical management in accordance with national guidelines	Track a variety of measures related to diabetes control in the outpatient setting, including diabetic eye exams, HgbA1C, nephropathy screenings, blood pressure control, and Statin use	...an inventory of staff needing education on evidence-based medical management of obesity, prediabetes and diabetes; training of staff; the development of a mechanism for collecting and reporting these data points	Providers	The Hospital will rely upon its network of primary care providers and nursing staff to deliver the appropriate care; staff engaged in quality assurance and the management and monitoring of performance of value-based payment arrangements with a variety of health plans will also be engaged
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	By December 31, 2024, increase the percentage of adults (18+) who were given a diabetes action plan by a health professional by 10%	N/A	Utilizing a diabetes educator, provide nutrition education and dietary consults to patients of the family care centers (i.e. outpatient) with a diabetes diagnosis	Number of patients with a diabetes diagnosis who meet with a diabetes educator; Percent of patients with a diabetes diagnosis who meet with a diabetes educator	...hiring of the diabetes educator; establishing patient referral protocols; a mechanism for tracking referrals; a mechanism for tracking completed consultations between the educator and patients	Providers	The Hospital will rely upon its network of primary care providers and nursing staff to develop protocols for identifying and referring appropriate patients to the educator
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Objective 4.4.1: By December 31, 2024, increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or classes to learn how to manage their condition by 25 % from 6.0 to 7.5 (Columbia), 5.3 to 6.6 (Greene).	N/A	Expand access to the National Diabetes Prevention Program (National DPP), a lifestyle change program for preventing type 2 diabetes.	Number of health systems that have policies/practices for identifying and referring patients to the National DPP programs; Number of National DPP programs in the community setting; Number of patients referred to the National DPP; Number of patients who participate in the National DPP; Percentage of patients who complete the National DPP	....recruiting participants and initiating the National DPP Program in a community setting	Community-based organizations	Assist in hosting and coordinating National DPP program
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Objective 4.4.1: By December 31, 2024, increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or classes to learn how to manage their condition by 25 % from 6.0 to 7.5 (Columbia), 5.3 to 6.6 (Greene).	N/A	Increase knowledge and awareness of Type 2 Diabetes through a media campaign.	Number of awareness campaigns; Number of mediums used to reach the public; Number of impressions; Number of clicks to webpage; Number of ads run; Number of post-engagements	...creating and implementing digital media campaign for diabetes education and awareness, which will be focused during November 2023, National Diabetes Awareness month	Community-based organizations	Assist in creation and promotion of Diabetes education and awareness materials through earned media and local media partners

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Priority	Focus Area	Goal	Objectives through 2024	Disparities	Interventions	Family of Measures	By December 2023, we will have completed . . .	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	Objective 2.2.1: Reduce the age-adjusted overdose deaths involving any opioid from 18.7 (Columbia), 17.9 (Greene), to the Prevention Agenda Objective 2024: 14.3.	N/A	Intervention 2.2.2: Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers.	Number of trainings; Number of kits provided; Number of agencies able to provide overdose reversal trainings to their staff and community.	...the train-the-trainer narcan training of community partners to give them the ability to train their clients and consumers in the administration of narcan	Community-based organizations	Staff to become trainers, existing clients and consumers to be trained.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	Objective 2.2.1: Reduce the age-adjusted overdose deaths involving any opioid from 18.7 (Columbia), 17.9 (Greene), to the Prevention Agenda Objective 2024: 14.3.	N/A	Intervention 2.2.4: Build 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	The number of individuals educated about the availability of peer support; the number of individuals referred to peer support; the number of individuals who meet with a peer; the number of individuals who engage with peers, harm reduction strategies, and/or traditional treatment with 90 days	...an assessment of the first complete year of this partnership's implementation	Community-based organizations	Provision of CRPA trained staff to work in the Emergency Department and inpatient floors.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	Objective 2.2.1: Reduce the age-adjusted overdose deaths involving any opioid from 18.7 (Columbia), 17.9 (Greene), to the Prevention Agenda Objective 2024: 14.3.	N/A	Intervention 2.2.5: Establish additional permanent safe disposal sites for prescription drugs and organize take-back days	Number of new medication disposal sites; Number of take-back days	Locate, purchase, and install medication disposal kiosk	Law Enforcement	Establish an approptiate site for a medication disposal site.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	Objective 2.2.1: Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.3 per 100,000 population	N/A	Embed behaviorists in the outpatient setting to assist patients with goal-setting, MH/SUD screening and referrals, as well as coordinate consultation between Primary Care prescribers and psychiatry	Number of behaviorists working in outpatient setting Number of patients referred to behaviorists Number of patient contacts with behaviorists	...the hiring of behaviorists for the outpatient setting; the creation of protocols for referring patients to behaviorists; developing a method for tracking and reporting patient contacts with behaviorists	Providers	The Hospital will rely upon its network of primary care providers and nursing staff to develop protocols for making appropriate referrals to the behaviorists
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	Objective 2.2.1 Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.3 per 100,000 population	N/A	Expand mental health service capacity by contracting with a third-party virtual provider	Number of patient contacts with third party provider	...contracting with the third-party provider of telemental health services and established a mechansim for tracking and reporting the number of patient contacts	Apti Health	The Hospital will contract with AptiHealth, a telemental health service provider, to augment its own internal capacity for delivering outpatient mental health services
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	Objective 2.2.2: Increase the age-adjusted rate of patients who receive at least one Buprenorphine prescription for opioid use disorder by 20%	N/A	Intervention 2.2.1: Increase availability of/access and linkages to medication-assisted treatment (MAT) Including Buprenorphine	Number of discussions about system adequacy and increasing access across the provider network; Number of patients served (prescribed, inducted, maintained, titrated)	...discussions about system adequacy and increasing access across the provider network	Local health department	GCPH to provide MAT through Family Planning, which requires maintaining a Buprenorphine provider on staff

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Priority	Focus Area	Goal	Objectives through 2024	Disparities	Interventions	Family of Measures	By December 2023, we will have completed . . .	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Prevent Communicable Diseases	Focus Area 1: Vaccine Preventable Diseases	Goal 1.1: Improve vaccination rates	By December 31, 2024, increase the percentage of people with an up to date COVID-19 vaccination status, per CDC definition, by 10% from 58% to 63.8% (Columbia), 59% to 64.9% (Greene)	Rurality	Intervention 1.1.3: Implement and promote use of standing orders for vaccine administration.	Number of vaccinations provided; COVID-19 vaccination rates; Number of vaccination clinics provided; Rate of fully immunized (eligible ages) residents;	COVID-19 Vaccine available at 5 different locations throughout each County by appointment or walk-in registration.	Community-based organizations	Assist LHD and hospital in hosting and promoting community vaccine clinics to target populations.
Prevent Communicable Diseases	Focus Area 1: Vaccine Preventable Diseases	Goal 1.1: Improve vaccination rates	By December 31, 2024, increase the percentage of people with an up to date COVID-19 vaccination status, per CDC definition, by 10% from 58% to 63.8% (Columbia), 59% to 64.9% (Greene)	Rurality	Promote vaccination at CMH's clinical service sites	Number of posters and flyers developed for primary care and rapid care settings; # of 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	...the ongoing efforts to provide vaccination education and promote COVID-19 vaccination in the primary care, rapid care, and inpatient settings	Providers	The Hospital will rely on its staff in both inpatient and outpatient settings to continue monitoring the vaccination status of its patients and refer them to capitalreginvax.org for additional information; it will also rely on its partner at Albany Med, who created and continues to maintain the capitalregionvax.org website and updates the information therein
Prevent Communicable Diseases	Focus Area 1: Vaccine Preventable Diseases	Goal 1.2: Reduce Vaccination coverage disparities	By December 31, 2024 increase the percentage of county residents residing in rural areas completing their COVID-19 vaccination series by 10% from 70.2% to 77.2% (Columbia), 62.2% to 68.4% (Greene).	Rurality	Intervention 1.2.2: Offer 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.	Number of vaccine clinics in rural areas	Host 3 COVID-19 Vaccine clinics targeting rural areas.	Community-based organizations	Location of and promotion of COVID-19 Vaccine clinics in rural areas.
Prevent Communicable Diseases	Focus Area 1: Vaccine Preventable Diseases	Goal 5.1: Improve infection control in healthcare facilities	Reduce the spread of COVID-19 in clinical setting	N/A	Prevent and mitigate COVID-19 transmission among the CMH workforce and patients by providing COVID testing and the use of PPE / masking in public and clinical areas	Number of staff who are educated on infection prevention and control measures; COVID-19 infection rates among CMH staff	...education of staff on infection prevention and control measures related to COVID-19	Other (please describe partner and role(s) in column D)	The Hospital will rely on its staff who are invovled in staff education and infection control to educate staff about infection prevention and control measures