2019-2021

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 25, 2019.

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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(518) 697-5288

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(Note: S = State mandated; F-x = federal mandated, where x = Form 990, Schedule H, Part V, Sec. B, Line 3 reference)

Volume Two --2019 Capital Region Community Health Needs Assessment

Available at: http://www.hcdiny.org/content/sites/hcdi/2019_CHNA/2019_HCDI-Community-Health-Needs-Assessment.pdf

2019-2021 Collaborative Community Health Needs Assessment, Implementation Strategy, Community Health Improvement Plan, and Community Services Plan for

Columbia and Greene Counties and their Hospital

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

A. New York State Required Cover Page

1. **Counties Covered:**

   Columbia and Greene

2. **Participating Local Health Departments:**

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

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

3. **Participating Hospital:**

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

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

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

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

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 2019 and ending in 2021. 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: Preventing Chronic Disease**
  Focus areas: (1) Healthy Eating and Food Security and (2) Physical Activity. The disparity to be addressed will be obesity in adults with disabilities.
- **Priority Area: Promoting Well-being and Preventing Mental/Substance Use Disorders**
  Focus areas: (1) Promote Well-being and (2) Prevent Mental and Substance Use Disorders

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 six-county Capital Region (see Volume Two), prepared and presented by the Healthy Capital District Initiative (HCDI). HCDI staff presented data on a total of 9 health issues related to four Prevention Agenda Priority Areas. Available data on prevalence, emergency department visits, hospitalizations, mortality, and trends were included for each health issue. Additionally, equity data for gender, age, race/ethnicity, and neighborhood groupings were presented whenever that data was available.

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 E, Part 1, page 35) that was convened on multiple occasions in the spring and summer of 2019 to review the Community Health Needs Assessment, identify the Prevention Agenda Priorities, and inform the selection of goals, objectives and interventions. 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 evidence-based 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 meetings. 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. Evidence-based interventions were selected directly from those offered in the Prevention Agenda. The Local Health Departments (LHDs) will utilize worksite nutrition and physical activity programs designed to improve health behaviors and results (Intervention 1.0.3). The LHDs will look to various county worksites, partners in other health and human services agencies, the private sector, and the local Chambers of Commerce to begin worksite program implementation. The LHDs will also implement and/or promote programs and places for physical activity **(**Intervention 2.3.1). Activities in this area will include engaging key partners from organizations serving disability groups to explore how the LHDs can support an increase in leisure-time physical activity among the people they serve. There is particular interest in engaging partners that serve individuals with disability by virtue of a mental illness, and particularly those groups that are peer-led.

For the second priority, *Promoting Well-being and Preventing Mental and Substance Use Disorders,* the LHDs will increase availability of and access to opioid overdose reversal medication (Naloxone) and provide trainings to prescribers, pharmacists and consumers (Intervention 2.2.2). The LHDs will also promote the integration of trauma-informed approaches in training staff and implementing program and policy (Intervention 2.2.6).

For its part in addressing the Prevent Chronic Disease Priority area, Columbia Memorial Hospital (CMH) is committed to the following: Administering an exercise program for patients in its Inpatient Psychiatric Unit; providing education on healthy food choices for patients in its Inpatient Psychiatric Unit; participating in the Columbia-Greene Breastfeeding Coalition; and, providing a variety of onsite employee wellness support tools and options. To address the Prevention Agenda Priority of Promoting Well-being and Preventing Mental Health and Substance Use Disorders, CMH will do the following: participate in the Columbia-Greene Addiction Coalition; convene the Controlled Substance Awareness Committee; and, offer Peer Support to individuals with addiction in its Emergency Department.

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 and identify improvements made as a result. Progress and improvement tracking for the activities of the Local Health Departments will make use of the following measures: the number of worksites that submit a response to the survey and how many

agree to create action plans; the number of employees reached through these efforts; the number of competitions and participants in the Chamber of Commerce administered "Challenges" focused on physical activity, nutrition, and stress management; the number of worksite-hosted wellness educational sessions and monitor continued engagement through Year Three of implementation; the number of Physical Activity Guides provided to the community; the number of community members reached; the number of websites with a link to the guide; the number of partners working with adults with disabilities that are engaged in the work; the number of outlets for guides; the number of naloxone trainings; the number of naloxone kits provided; and the number of Public Health detailing interactions with prescribers and pharmacists focusing on naloxone.

To evaluate its contribution to Preventing Chronic Disease (specifically, obesity-related illnesses), CMH will track the following: the number of patients participating in each session of the Inpatient Psychiatric Unit's exercise program; the number of patients participating in each session of the Inpatient Psychiatric Unit's Nutrition Education Program; the number of meetings of the Columbia-Greene Breastfeeding Coalition attended by at least one representative from CMH; the number of employee visits to HR Connection; the number of monthly newsletters distributed; the number of group challenges offered and the number of participants in each; the number of on-site fresh fruit and vegetable sales; the number of on-site produce deliveries; the number of employees enrolled in Employee Assistance Program; and, the number of employees enrolled in Flexible Spending Accounts.

To evaluate its contribution to Promoting Well-Being and Preventing Mental and Substance Use Disorders, CMH will track the following: the active participation in and contributions to the work of the Columbia-Greene Addiction Coalition from at least one member of the CMH staff; the maintenance of an active meeting schedule of the Controlled Substance Awareness Committee and the ongoing engagement of member; the number of individuals educated about the availability of peer support; the number of individuals referred to peer support; and, the number of individuals who meet with a peer.

C. Community Health Needs Assessment

1. Definition and Description of Communities Served

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 61,860) 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 (47.0 years). About 18.0% of Columbia County's population is 14 years of age or younger, while 15.7% are over 65 years old.

Just over half of Columbia County residents are male (50.2%), and 6.1% of the population report being born outside the United States.

Columbia County's poverty rate (12.7%) is the third lowest in the Capital Region and lower than New York State (15.5%). Approximately 10.5% of Columbia County's population is non-White, and 4.3% of the County's population is Hispanic. The Hudson neighborhood has the largest non-White population (20.4%) and also the highest neighborhood poverty rate (17.6%) in the county.

Of those in Columbia County over the age of 25, 89.4% hold a high school degree or higher; 30.1% hold a Bachelor's Degree or higher. Employment rate of change between 2015 and 2016 was 2.5% increase. 94.0% of Columbia County residents have health insurance.

Of all Columbia County residents with a disability (15.9%), 35.6% fell into the obese category in 2016, up from 30.9% in 2013-14. Many of those who are disabled in Columbia County are older people over the age of 75.

As illustrated in Figure 1 below, 15.9% of Columbia County residents live with a disability, which is above the state average of 11.4%. As illustrated in Figure 2, many of those in Columbia County who are disabled are over the age of 75 years old. Finally, of those with a disability in 2016, 35.6% were obese, up from 30.9% in 2013-2014.

Figure 1.

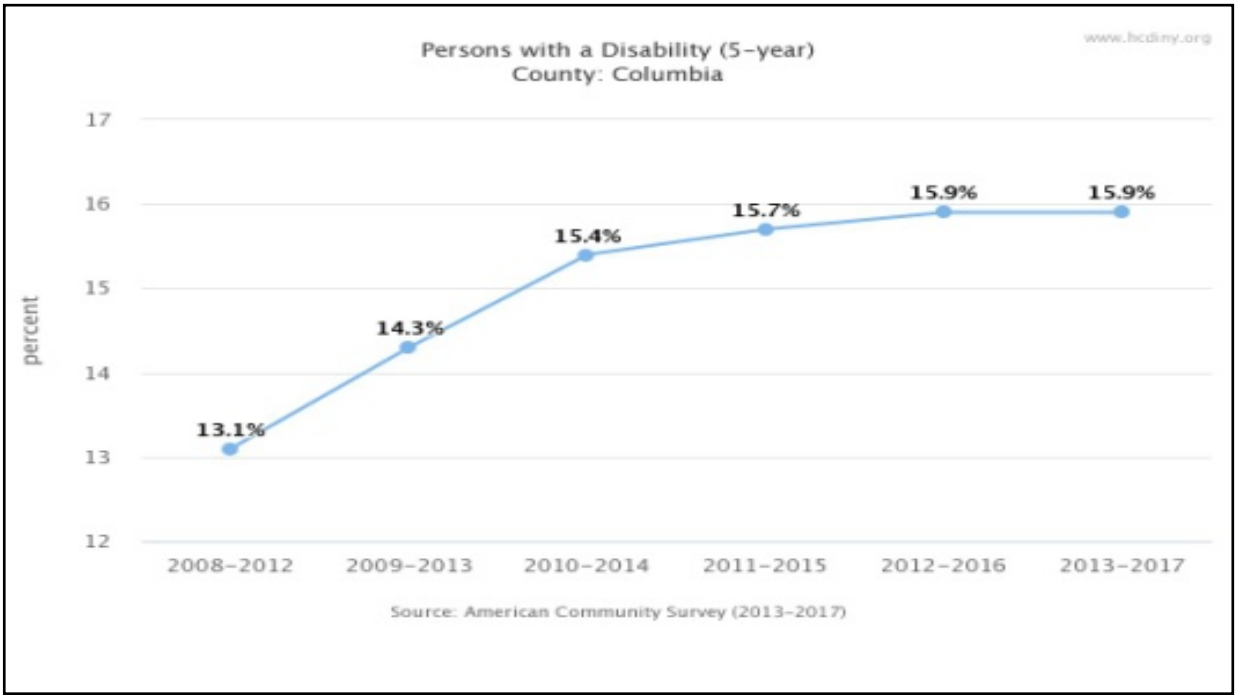
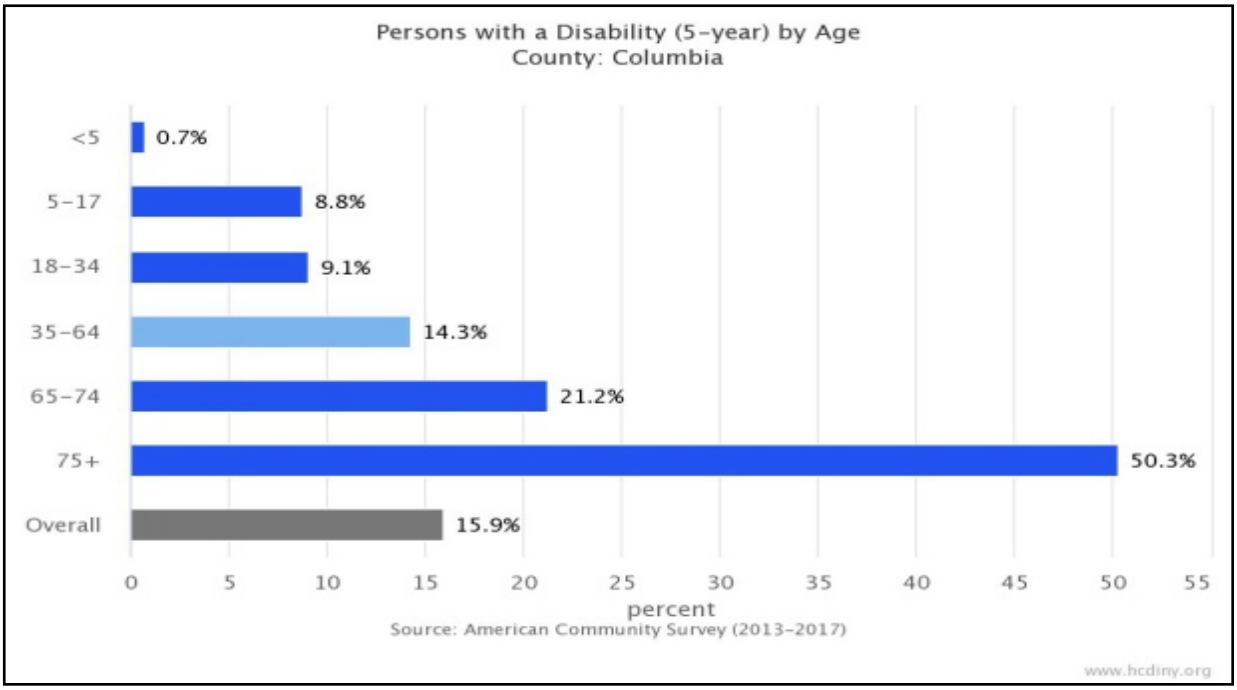


Figure 2.



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 48,069. 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 (45.4 years) in the Capital Region. Approximately 14% of the population is 14 years of age or younger, while about 20% of the population is 65 years of age or older. Greene County's population is 10.4% non-white and 5.4% is Hispanic. The non-white/Hispanic population in Greene County has increased since 2010. The Coxsackie/Athens neighborhood has the largest non-white population (14.6%), as well as the largest Hispanic population (8.7%).

Greene County's poverty rate was the highest in the Capital Region (13%), but lower than the rest of New York State (15.5%). The neighborhood of Catskill had the highest poverty rate (16.1%) in the County. Of those above the age of 25, 85.9% hold a High School Diploma, while 22% hold a Bachelor's Degree or greater. Approximately 94% of Greene County residents have health insurance.

As illustrated in Figure 3 below, sourced from the American Community Survey 2013-2017, 14.3% of Greene County residents live with a disability, which is above the state average of

11.4%. As illustrated in Figure 4, many of those in Greene County who are disabled are over the age of 75 years old. Finally, of those with a disability in 2013-2014, 40.7% were obese.

Figure 3.

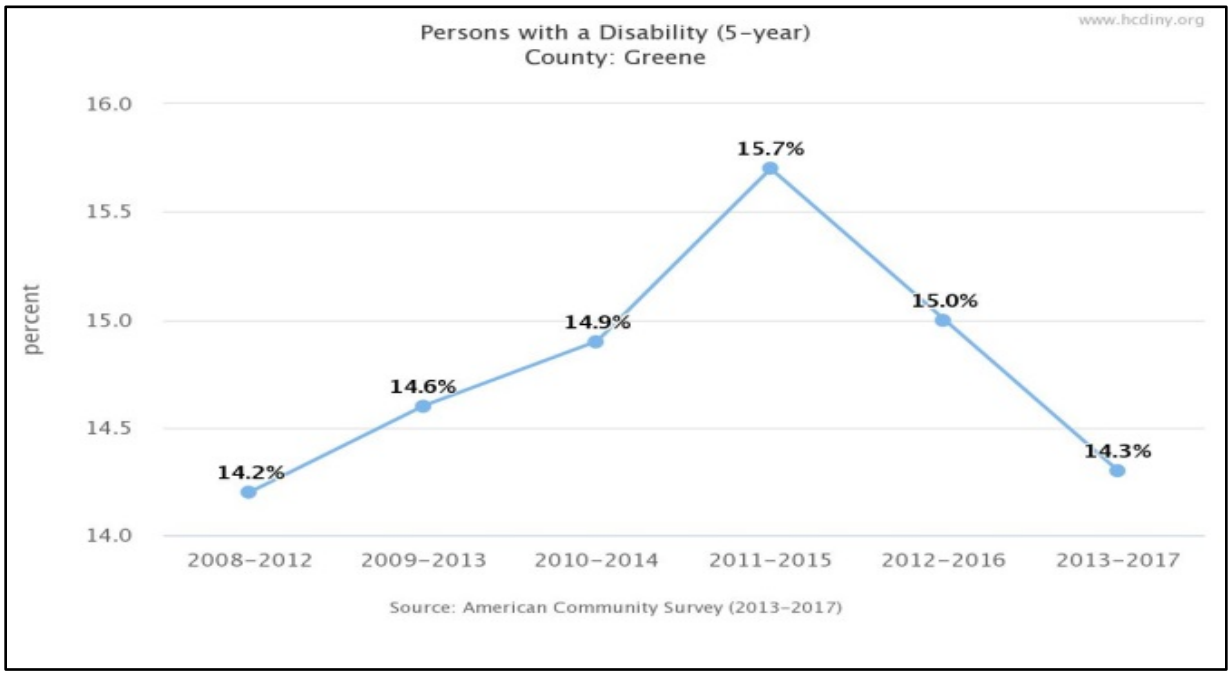
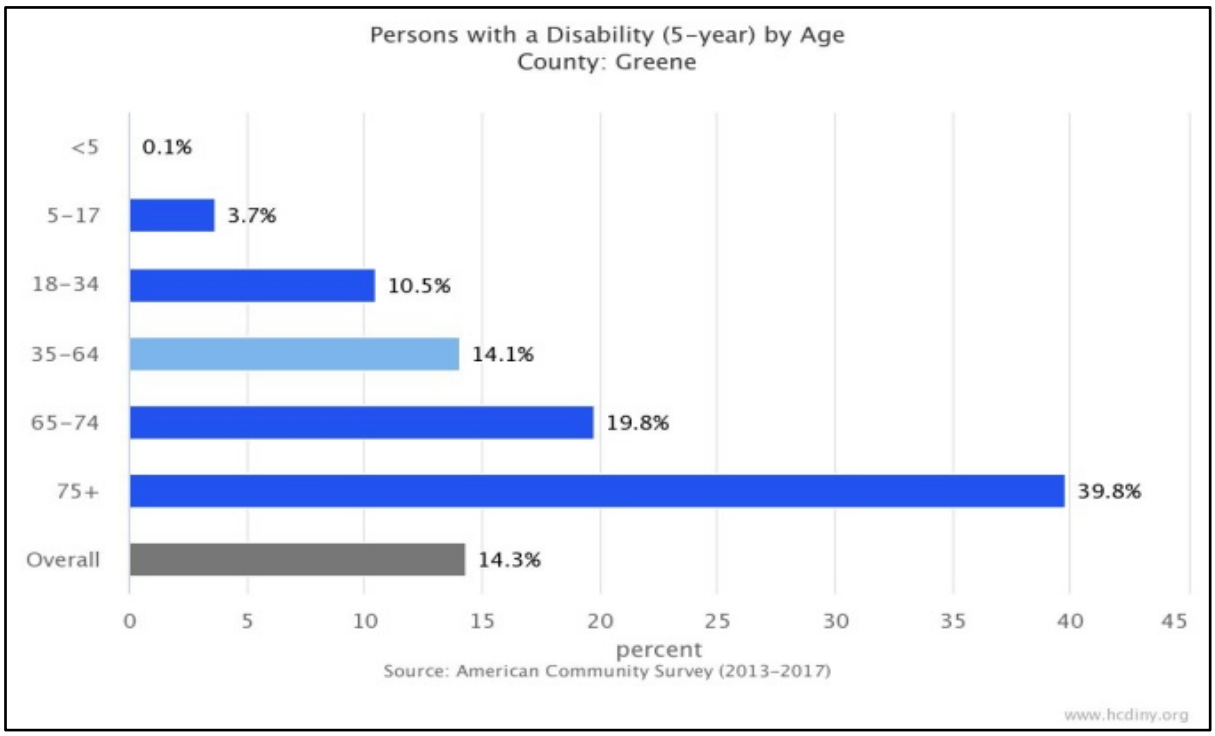


Figure 4.



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

According to the 2019 Roberts Woods Johnson County Health Rankings, Columbia County ranked 23rd 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 43rd in New York State in both categories, Overall Health Outcomes and Overall Health Factors. Columbia and Greene Counties share the same five leading causes of death. Columbia County's five leading causes of death in 2015 were as follows:

Cause of Death	Deaths per 100,000 Columbia	Deaths per 100,000 Greene
Heart Disease	195.9	204.2
Cancer	155.6	192.1
Chronic Lower Respiratory Disease	45.6	38.7
Stroke	27.7	26.0
Unintentional Injury	36.8	35.6

Information from the 2019 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 28% and 27.7%, respectively, are higher than the NYS rate of 27.4%
- Childhood obesity rates in Columbia and Greene Counties of 18.9% and 21.4%, respectively, are also higher than the NYS rate of 17.2%
- The obesity rate for WIC children in Columbia and Greene Counties of 18.6% and 17.8%, respectively, are higher than NYS rate of 15.2%;
- The percent of the Columbia County's and Greene County's low income population with low access to a supermarket of 5.19% and 6.22%, respectively, are higher than NYS excluding NYC (3.93%);
- Columbia County's and Greene County's opioid overdose mortality rates of 25.9/100,000 and 30.4/100,000, respectively, are considerably higher than NYS outside of NYC at 19.4/100,000 and showed a 175% increase from 2013 to 2017; and,
- Columbia County's and Greene County's suicide mortality rates of 17.2/100,000 and 15.3/100,000, respectively, are higher than NYS excluding NYC (9.6%).

A unique characteristic common to both counties is the high rate of Lyme Disease. Greene County's rate of 753.6/100,000 and Columbia County's rate of 711.6/100,000 are considerably higher than the rest of the state, averaging around 77.8/100,000. 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 130.1/100,000 and 121.4/100,000 were higher than the state wide rate of 116.5/100,000. The stroke mortality rates for the Columbia and Greene County were 30.6/100,000 and 23.2/100,000 compared to 28.1/ 100,000 for the rest of the state.

Lung cancer rates in Columbia and Greene Counties are 79.7/100,000 and 80.4/100,000, respectively, both higher than the NYS rate (excluding NYC) of 66.9/100,000. The Chronic Lower Respiratory Disease (CLRD) hospitalization rates are 28.9/100,000 in Columbia and 27.3/100,000 in Greene, both higher than the NYS (excluding NYC) rate of 23.4/100,000, and the CLRD mortality rates are 40.4/100,000 (Columbia) and 36.6/100,000 (Greene), both higher than the NYS (excluding NYC) rate of 34.4/100,000. Not surprisingly, in the 2019 CHNA, Columbia County's adult smoking rate of 20.3% is higher than the NYS (excluding NYC) rate and Columbia's incidence of asthma, 11.4%, was also higher than NYS (excluding NYC) rate of 10.4%. 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 dropped from 24.5% in 2013-2014 to 16.4% in 2016. While these rates did decrease, 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 Two).

COLUMBIA COUNTY

Chronic Disease

- Columbia's adult current asthma prevalence (11.4%), was higher than NYS excl. NYC (10.4%);
- Hudson neighborhood had 2.1 times the asthma ED visit rate and 2 times the asthma hospitalization rate as NYS excl. NYC;
- Columbia's adult smoking rate of 20.3% was higher than NYS excl. NYC (17.0%);
- The County's lung cancer incidence (79.7/100,000), CLRD hospitalization rate (28.9/10,000) and CLRD mortality (40.4/100,000) rates were higher than NYS excl. NYC (66.9, 23.4, and 34.4);
- Hudson had 2.1 times the CLRD ED visit rate and 1.6 times the CLRD hospitalization rate compared to NYS excl. NYC;
- Columbia's coronary heart disease mortality rate (130.1/100,000) was higher than NYS excl. NYC (116.5);
- Columbia's stroke mortality rate (30.6/100,000) was higher than NYS excl. NYC (28.1);
- While Columbia's colorectal screening rate of 72.5% was better than NYS excl. NYC (69.7%), the county's colorectal cancer incidence rate (40.6/100,000) and mortality rate (16.5/100,000) were both higher than NYS excl. NYC (38.9 and 12.9);
- While the County's mammography screening rate of 81.2% was better than NYS excl. NYC (79.2%), Columbia's female breast cancer late stage incidence rate of 51.0/100,000 was higher than NYS excl. NYC (43.0)
- The County's adult obesity rate of 28.0% (n=12,900), childhood obesity rate of 18.9% (n=1,700), and obesity rate for WIC children of 18.6% was higher than NYS excl. NYC (27.4%, 17.2%, 15.2%).

Healthy and Safe Environment

- Columbia's incidence rate of elevated blood lead levels (10+ug/dl) in children under 6 years of age of 13.2/1,000 was more than twice as high as NYS excl. NYC (6.0);
- The County's lead screening rates for children 9-17 months (53.2%) and 2 screens by 36 months (38.6%) were much lower NYS excl. NYC (71.1% and 55.9%);
- The percent of Columbia's low income population with low access to a supermarket of 5.19% was higher than NYS excl. NYC (3.93%);
- Columbia County's motor vehicle accident mortality rate of 14.3/100,000 and hospitalization rate of 8.1/10,000 was higher than NYS excl. NYC (6.8, 5.9);
- Columbia's elderly (65+ years) fall emergency department visit rate of 392.6/10,000 was slightly higher than NYS excl. NYC (381.2);
- Pine Plains neighborhood had 2.7 times the elderly fall ED visit rate, and 2.1 the hospitalization rate compared to NYS excl. NYC;
- Columbia's rate of occupational injury ED visits in 15-19 year olds of 53.4/100,000 was higher than the NYS excl. NYC rate of 29.4/100,000.

Healthy Women, Infants, and Children

- Hudson neighborhood's teen pregnancy (15-19 years) was the county's highest, and 1.1 times higher than NYS excl. NYC;
- Columbia's early prenatal care rate of 73.3% was lower than NYS excl. NYC (76.0%);
- Germantown neighborhood's rate of late or no prenatal care was 1.3 times higher than NYS excl. NYC.

Infectious Disease

- Columbia's early syphilis case rate for men of 13.1/100,000 was higher than NYS excl. NYC (9.1);
- Columbia's HIV case rate of 8.7/100,000 was higher than NYS excl. NYC (7.9);
- Columbia's Lyme disease case rate of 711.6/100,000 was markedly higher than Rest of State (77.8), and the 2nd highest rate of all NYS counties;
- Columbia's HPV vaccination rate for adolescent females of 41.1% was slightly lower than the rate for NYS excl. NYC (41.7%);
- The flu vaccination rate in Columbia's 65+ year population of 55.2% was lower than that for NYS excl. NYC (59.6%).

Mental Health and Substance Abuse

- Columbia's mental disease and disorder hospitalization rate (75.0/10,000), was higher than NYS excl. NYC (64.1), and showed a 13% increase from 2008 to 2014;
- Hudson had 1.5 times the mental disease and disorder ED visit rate and 1.6 times the hospitalization rate than NYS excl. NYC;
- Columbia's suicide mortality rate of 17.2/100,000 was higher than NYS excl. NYC (9.6), and showed a 27% increase from 2008-10 to 2014-16;
- The self- inflicted injury ED visit rate for Columbia residents 15+ years of age of 12.7/10,000, and hospitalization rate of 6.1 was higher than NYS excl. NYC (7.1, 5.3);
- Hudson neighborhood had 2.6 times the self-inflicted injury ED visit rate, while Canaan had 1.6 times the hospitalization rate than NYS excl. NYC;
- Columbia had an opioid overdose mortality rate of 25.9/100,000 that was higher than NYS excl. NYC (19.4), and showed a 175% increase from 2013 to 2017;
- Columbia's opioid overdose ED visit rate of 65.4/100,000 was lower than NYS excl. NYC (79.7), but increased 30% from 2013 to 2016;
- Columbia County's newborn withdrawal syndrome rate of 27.4/1,000 newborn discharges was higher than NYS excl. NYC (16.0)
- Germantown neighborhood had 1.9 times the opioid overdose ED visit rate and 1.5 times the opiate-related hospitalization rate than NYS excl. NYC;
- The opioid analgesics prescription rate for Columbia residents of 538.0/1,000 was higher than for NYS excl. NYC (453.1);
- Columbia's alcohol-related motor vehicle injury and death rate of 44.1/100,000 was higher than the NYS excl. NYC rate of 39.9/100,000;
- The County's cirrhosis mortality rate (9.3/100,000) were higher than NYS excl. NYC (8.1).

GREENE COUNTY

Chronic Disease

- The adult asthma prevalence rate of 12.0% was higher than NYS excl. NYC (10.4%);
- The County's lung cancer incidence (80.4/100,000), lung cancer mortality (48.6/100,000), CLRD hospitalization (27.3/10,000) and CLRD mortality (36.6/100,000) rates were higher than NYS excl. NYC (66.9, 40.4, 23.1 and 34.4);
- Catskill neighborhood had 1.7 times the CLRD hospitalization rate compared to NYS excl. NYC;
- Greene County's adult obesity rate of 27.7% (n=10,000), childhood obesity rate of 21.4% (n=1,260), and obesity rate for WIC children of 17.8% was higher than NYS excl. NYC (27.4%, 17.2%, 15.2%).
- The diabetes hospitalization rate of 15.8/10,000 was higher than NYS excl. NYC (13.8);
- The County's diabetes short term complication hospitalization rate of 5.8/10,000 was higher than NYS excl. NYC (4.1);
- The heart attack hospitalization rate (15.2/10,000) was higher than NYS excl. NYC (14.8), but showed a decreasing trend over the last decade;
- Catskill neighborhood had 1.1 times the heart attack hospitalization rate compared to NYS excl. NYC;
- The County's coronary heart disease mortality rate of 121.4/100,000 was higher than the NYS excl. NYC (116.5), but also showed a decreasing trend over the last decade;
- The colorectal screening rate of 69.0% was similar to NYS excl. NYC (69.7%), while the county's colorectal cancer incidence rate (42.0/100,000) and mortality rate (19.4/100,000) were both higher than NYS excl. NYC (38.9 and 12.9);
- While Greene County's mammography screening rate of 80.9% was higher than NYS excl. NYC (79.2%), the County's female breast cancer late stage incidence (43.6/10,000) and mortality (19.3/100,000) rates were slightly higher than NYS excl. NYC (43.0, and 18.9).

Healthy and Safe Environment

- Greene County's incidence rate of elevated blood lead levels (10+ug/dl) in children under 6 years of age of 7.0/1,000 was higher than NYS excl. NYC (6.0);
- The County's lead screening rates for children 9-17 months (70.3%) and 2 screens by 36 months (54.5%) were similar to NYS excl. NYC (71.7% and 55.9%);
- The percent of low income population with low access to a supermarket of 6.22% was higher than NYS excl. NYC (3.93%);
- Greene County's motor vehicle accident mortality rate of 12.7/100,000 and hospitalization rate of 11.5/10,000 was higher than NYS excl. NYC (6.8, 5.9);
- Greene's elderly (65+ years) fall hospitalization rate of 208.3/10,000 was higher than NYS excl. NYC (189.9);
- Catskill neighborhood had 1.2 times the elderly fall hospitalization rate compared to NYS excl. NYC;

- Greene County's assault ED visit rate (40.3/10,000) and hospitalization rate (4.0) was higher than NYS excl. NYC (35.0, 2.2);
- Catskill neighborhood had 1.3 times the assault ED visit rate, while Coxsackie/Athens had 1.7 times the hospitalization rate than NYS excl. NYC.

Healthy Women, Infants, and Children

- Coxsackie/Athens neighborhood's teen pregnancy (15-19 years) was 1.4 times higher than NYS excl. NYC;
- Greene County's early prenatal care rate of 75.2% was lower than NYS excl. NYC (78.4%);
- Windom/Ashland/Jewett neighborhood's rate of late or no prenatal care was 1.9 times higher than NYS excl. NYC ;
- The rate of premature births (< 37 weeks gest.) of 9.7% was higher than NYS excl. NYC (9.1%), but decreased 30% from 2010 to 2016;
- The County's rate of low birthweight (< 2.5 kg.) of 8.0% was higher than NYS excl. NYC (7.7%), but decreased 8% from 2010 to 2016;
- Cairo/Durham neighborhood had 1.6 times the low birthweight rate, and 1.2 times the prematurity rate than NYS excl. NYC;
- Greene County WIC mothers had a 6 month breast feeding rate of 18.4%, much lower than the NYS excl. NYC rate of 30.7%.

Infectious Disease

- Greene County's Lyme disease case rate of 753.6/100,000 was significantly higher than NYS excl. NYC (77.8), and was the highest rate of all NYS counties;
- Greene County's HPV vaccination rate for adolescent females of 40.5% was slightly lower than the rate for NYS excl. NYC (41.7%);
- The flu vaccination rate in Greene County's 65+ year population of 56.2% was lower than that for NYS excl. NYC (59.6%).
- Greene County's elderly population's rate of ever having a pneumonia vaccination of 64.4% was lower than that for NYS excl. NYC (76.2%);
- The County's pneumonia/influenza hospitalization rate of 98.6/10,000 was higher than NYS excl. NYC (93.7).

Mental Health and Substance Abuse

- About 15.8% of adult Greene residents indicated that they had 14+ poor mental health days in the past month, higher that NYS excl. NYC (11.2%);
- Greene's mental disease and disorder ED visit rate (165.2/10,000) was higher than NYS excl. NYC (147.8), and showed a 50% increase from 2009 to 2014;
- The County's mental disease and disorder hospitalization rate of 87.6/10,000 was higher than NYS excl. NYC (64.1), and showed a 35% increase from 2009 to 2014;
- Cairo/Durham had 1.3 times the mental disease and disorder hospitalization rate, while Catskill had 1.5 times the ED visit rate than NYS excl. NYC;

- The self- inflicted injury ED visit rate for Greene residents 15+ years of age of 9.6/10,000 and hospitalization rate of 6.0 was higher than NYS excl. NYC (7.1, 5.3);
- Cairo/Durham had 2.0 times the self-inflicted injury hospitalization rate, while Catskill had 1.5 times the ED visit rate than NYS excl. NYC;
- Greene County had an opioid overdose mortality rate of 30.4/100,000 that was higher than NYS excl. NYC (19.4), and showed a 125% increase from 2013 to 2017;
- Greene County's opioid overdose ED visit rate of 133.3/100,000 was higher than NYS excl. NYC (79.7), and increased 80% from 2013 to 2017;
- Greene County's newborn withdrawal syndrome rate of 21.3/1,000 newborn discharges was higher than NYS excl. NYC (16.0)
- Cairo/Durham neighborhood had 2.4 times the opioid overdose ED visit rate, while Greenville had 2.7 times the opiate-related hospitalization rate than NYS excl. NYC;
- The opioid analgesics prescription rate for Greene residents of 538.0/1,000 was higher than for NYS excl. NYC (453.1);
- Greene County's alcohol-related motor vehicle injury and death rate of 70.8/100,000 was higher than the NYS excl. NYC rate of 39.9/100,000, but showed a 37% reduction from 2008 to 2016.

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. Upon examination of these key resources, identification of additional indicators of importance with data available, and discussion with public health as well as health care professionals in the Capital Region, it was decided that building upon the recent 2013-2018 NYS Prevention Agenda, as well as the new 2019-2024 Prevention Agenda, would provide the most comprehensive analysis of available public health needs and behaviors for the Region. 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. While the 2019-2024 Prevention Agenda objectives and indicators have been developed, the present Prevention Agenda Dashboard still contains 2013-2018 indicators with corresponding data (as of May 2019). These measures, when complemented by the recent 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) and Vital Statistics Data Portals 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 2012-2016 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 was examined from a wide variety of sources:
• Prevention Agenda 2013-18 Dashboard of Tracking Indicators (2016)
• Community Health Indicator Reports Dashboard (2014-2016)

- County Health Indicators by Race/Ethnicity (2014-2016)
- County Perinatal Profiles (2012-2014; 2014-2016)
- Vital Statistics Annual Reports (2014, 2015, 2016)
- Behavioral Risk Factor Surveillance System (BRFSS) and Expanded BRFSS (2016)
- Cancer Registry, New York State (2011-2015)
- Prevention Quality Indicators (2014-2016)
- Communicable Disease Annual Reports (2013-2017)
- The Pediatric Nutrition Surveillance System (PedNSS) (2014-2016)
- Student Weight Status Category Reporting System (2014-2016)
- County Opioid Quarterly Reports (April 2017-October 2018)
- NYS Opioid Data Dashboard (2016-2017)
- NYS Child Health Lead Poisoning Prevention Program (2013 birth cohort; 2014-2016)
- NYS Kids' Well-being Indicator Clearinghouse (KWIC) (2012-14, 2017)
- County Health Rankings (2019)
- American Fact Finder (factfinder2.census.gov) (2017)
- Bureau of Census, American Community Survey (2012-2016)

These data sources were supplemented by a Siena College Research Institute Community Health Survey. The 2018 Community Health Survey was conducted in December 2018 by the Siena College Research Institute. The survey was a representative sample of adult (18+ years) residents of the Capital Region. The survey included 1,204 (MOE +/- 3.4%) total interviews made up of a phone sample, oversample of low income residents, and a small online sample. This consumer survey was conducted to learn about the health needs, barriers and concerns of residents in the Capital Region. The Appendix (2018 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 the 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 Initiative (HCDI), and John Lake, M.S, Public Health Data Analyst, HCDI. The 2019 Capital Region Community Health Needs Assessment Draft was sent to local subject matter experts for review in the health departments of Albany, Rensselaer, Schenectady, Saratoga, Columbia and Greene Counties and in St. Peter's Health Partners, Albany Medical Center, Ellis Hospital, Saratoga Hospital and Columbia Memorial, as well as being placed on the HCDI 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. Discussion of Risk Factors

i. Behavioral, Environmental and Socioeconomic Risk Factors

Behavioral risk factors identified by the Columbia-Greene Healthy People Partnership include sedentary life style, 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.

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. A challenge for many is the need for transportation to access the local recreation space. There are few indoor gyms in the Twin Counties and these require membership fees. Additionally, those in the population with disability have access to many state parks that are accessible but require transportation to get there.

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.

ii. Primary/Chronic Disease Needs of Uninsured/Low-income/Minority

Columbia and Greene Counties fortunately average lower rates of uninsured people, 6%, than the rest of NYS at 7%. This may be attributed to the many agencies in Columbia and Greene Counties which are able to assist the population in insurance navigation. However, Greene County and Columbia County, at 13% and 12.7%, have the two highest poverty rates of the Capital Region, averaging in at 11.1%. While the highest in the region, Columbia and Greene still fall below the rest of NYS at 15.5%. Minority populations, as defined by non-white and non-Hispanic, represent 14.8% of Columbia County and 15.8% of Greene County.

Rates determined by Healthy Capital District Initiative in the Health Disparity Report, Index of Disparity, show that populations living below the poverty line were 10.1 times more likely to have asthma related Emergency Department visits, 8.8 times more likely to be victims of assault, and 3.8 times more likely to be hospitalized for COPD/CLRD complications. Black Americans were 3.9 times more likely than white Americans to have an asthma related Emergency Department visit, and also 3.2 times more likely to be affected by diabetes.

b. Policy Environment

Tobacco-Free Action of Columbia and Greene Counties operates within 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.

Columbia and Greene County governments have given joint and individual support towards responding to the Opioid crisis. Columbia County has created its own Opioid Epidemic Response Plan that is available on their website (www.columbiacountyny.com). The two counties have passed local resolutions allocating funding towards a number of projects as well as funding a position for the Columbia-Greene Addiction Recovery Coordinator. This individual is responsible for coordinating the efforts between government agencies, community based organizations, and grassroots organizations in both counties.

c. 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 1,200:1. Columbia County has 2,030 residents per provider, and Greene County has 2,790 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, overdose death rates occurred at 12.3/100,000 individuals in the Capital Region. In 2016, the Greene County overdose death rate was 30.4/100,000, the Columbia County rate was 25.9/100,000. Each county reported twice the overdose death rate of the Capital Region. Opioid-related Emergency Department visits occurred at a rate of 61.5/100,000 in the Capital Region in 2016. Greene County had 115.8/100,000 visits, nearly twice the Capital Region rate. Columbia County had 60.7/100,000, slightly below 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 have also recently been included in a multistate study, funded by the National Institute of Drug Abuse (NIDA) and led by Columbia University that will commence in the fall of 2019.

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.

Preventing Chronic Diseases

Empire (health plan)	
Columbia and 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 and 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
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 Memorial Hospital	
Columbia and Greene	CMH has a Diabetes Educator. She is a full-time Registered Nurse working 100% of the time at Family Care Centers overseeing diabetes education, training of case managers to create larger teams of educators, and working with high risk patients and their providers. The Diabetes Educator is a key part of a team-based approach to diabetes management that includes provider, patient, case managers, etc.
Cornell Cooperative Extension of Columbia and Greene Counties	
Columbia and 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
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
	Coordinates Greene County Worksite Wellness Committee
Greene County Rural Health Network	
Greene	Provides seed money to local organizations in support of innovative obesity prevention programs
	Administers obesity prevention programs, including the Biggest Loser Contest, Greene Walking Trail Identification, Catskill District's Hall Walking Program, and the Greene Walks Program
	Promotes compliance with Health Screening Guidelines
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.
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.
St. Peter's Health Partners' Creating Healthy Schools and Communities Program	
Columbia	Works with Hudson Central School District through a NYS DOH grant to tailor their Wellness Policy to not only meet the NYS and Federal regulations but meet their district needs as well
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.
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.)

Promoting Well-Being and Prevent Mental and Substance Use Disorders

Alliance for Better Health	
Columbia and Greene	The Alliance's Syringe Exchange Program provides new, sterile syringes and other injection supplies, safe disposal of used syringes, and opioid overdose prevention. Services also include education and information on safer injection techniques, referrals to HIV/STI/Hepatitis testing, health care, and substance abuse programs.
American Foundation for Suicide Prevention-Capital Region Chapter	
Columbia and 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
Chatham Cares for You (CC4U)	
Columbia	In partnership with the Police Assisted Addiction Recovery Initiative, Chatham Cares 4 U encourages residents struggling with substance use to walk into the police station, turn over their drugs and ask for help. Instead of being charged, individuals will be placed into a drug treatment program regardless of financial means and/or insurance coverage. Participants will be assigned a volunteer to assist and guide them throughout the recovery process.
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, Michael Cole 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)
	Recovery Pod
	School Resource Officers
	Inmate Services Coordinator
	Vivitrol Program
Columbia Memorial Hospital (CMH)	
Columbia and Greene	Pain Management Program offers acute and chronic pain treatment and offers non-opioid treatment options Multiple Buprenorphine Prescribers practicing in various Family Care Centers Medication Assisted Treatment Services with one full-time addictionologist and one full-time Nurse Practitioner specializing in addiction treatment. Both are Buprenorphine Prescribers. Palliative Care Physician work with end-of-life patients, as well as chronic pain patients to reduce end-of-life suffering, maximize pain control, and reducing opioid use whenever possible/appropriate Partners with Greener Pathways to host peer recovery specialists in the ED and inpatient hospital ED physicians will induce Buprenorphine (3-day dose) in order to manage detoxification and “bridge” patients to appointments CMH conducts comprehensive depression screening in Primary Care settings, which includes identifying people with suicidal ideation. CMH has a Controlled Substance Committee that meets monthly. This is a multidisciplinary group that includes psychiatry, addiction, pain management, pharmacy, primary care, ER and hospitalists. The group convenes for case reviews that draw upon the expertise and collaboration of multiple specialties. It also provides oversight of the health system’s comprehensive programmatic response to controlled substance use, misuse and abuse. CMH has a 22-bed inpatient psychiatric unit and well as an outpatient clinic It has also integrated behavioral health into the primary care setting. Behaviorists (typically

	social workers or psychiatric nurses) are co-located in various family care centers in order to provide crisis intervention, short-term counseling and connection to long-term counseling. Behaviorists act as liaisons between primary care providers and psychiatrists to address difficult cases and present recommendations for changes in treatment, including prescription medications. The Behaviorists also on lifestyle interventions and identifying barriers to care for patients with chronic medical conditions.
Columbia-Greene Addiction Coalition (CGAC)	
Columbia and Greene	Developed Provider Resources around substance use including: Substance Use Contract Urine Drug test Protocol and Procedures Function-focused Pain Scale Substance Abuse Risk Measurement Tool Guidelines for comprehensive annual assessments of chronic pain patients
Columbia-Greene Suicide Prevention Coalition	
Columbia and 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 and 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 and 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: Two held per month (Chatham and Hudson)
	Family to Family (F2F): An educational program for families and caregivers of adults with mental illness
Greene	Family Support Groups: Three held per month
	Basics Class NAMI Basics is a free, 6-week education program for parents and family caregivers of children and teens whom are experiencing symptoms of a mental illness or whom have already been diagnosed.
	Family to Family (F2F): An educational program for families and caregivers of adults with mental illness
Northeast Career Planning	
Columbia and 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.
Our Wellness Collective (OWC)	
Columbia and Greene	Offers Recovery-Based Training, Wellness in the Workplace, Recovery Capital Building Resources, Consultation and Subject Matter Experts (SMEs).
	Services include: Certified Recovery Peer Advocate (CRPA) for NYS certification, Supervising Peers in Clinical Settings, Science of Addiction and Recovery, The Power of Peers, Our Stories Have Power

Project Safe Point (a program of Catholic Charities Care Coordination Services, Albany)	
Columbia and Greene	Naloxone training Risk Reduction Services Harm Reduction Case Management HIV/HCV Screening Syringe Exchange
Twin County Recovery Services (TCRS)	
Greene	Greener Pathways, a community-based outreach program offering the following support and services: • Off-Site Treatment and Mobile Services - Our community-based outreach program is committed to helping individuals and families who are struggling with substance use disorder. Our staff is on-hand to "just talk" or to help connect individuals to the many treatment options available. • Peer-to-peer support networks 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.
Columbia and Greene	TCRS offers a wide range of programs and services to meet the needs of those affected by substance use.
	Services include: Out-patient clinics, community residences, community prevention, Drinking Driver Program, School-Based Prevention (Greene).
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 and 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 Our 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). We also welcome all young allies in the community who have been impacted by SUD and who support recovery. Our vision is to empower young individuals in Columbia and Greene Counties to work collectively to achieve personal and shared goals related to recovering from addiction and to work towards overall life wellness. Through providing peer support, education, and prevention to youth and young adults, a foundation of life and recovery skills can be built, therefore improving young individual's overall life.
Youth Voices Matter	
Columbia and Greene	Youth Voices Matter helps and connects youth with needed addiction services. The organization partners with many programs such as the following, but not limited to: Friends of Recovery program partners with qualified trainers from throughout New York State and offers trainings to peer professionals, treatment providers, prevention specialists, and anyone interested in addiction and recovery Capital Region Recovery Center provides a safe and supportive space for people seeking recovery from addictions and offers 12 Step recovery meetings, recovery supports, and programs for self-improvement, and spiritual growth.

D. Actions Taken to Address Significant Health Needs Identified in 2013 and 2016 (with Selected Impact Metrics)

In 2013, Columbia County and Greene County along with Columbia Memorial Hospital developed individual, but coordinated, needs assessment/implementation plans. Columbia chose four health needs: 1) Chronic Disease Prevention (obesity focus; tobacco focus); Mental Health Promotion and Substance Abuse Prevention (prescription drug abuse focus); Arthropod-Borne Illness Prevention; Occupational Injury Prevention. During that same cycle, Greene County focused on Preventing Chronic Disease (obesity, tobacco, and physical activity), and Promoting Mental Health and Preventing Substance Abuse.

In 2016, both counties and the Hospital were more closely aligned and chose the same two focus areas: Chronic Disease Prevention (Obesity); and Mental Health Promotion and Substance Abuse Prevention.

Between 2013 and 2016 the Local Health Departments, Hospital, and numerous community partners worked collaboratively to address the identified needs. The following are some of the activities that were deployed for the response:

- Chronic Disease Prevention (Obesity):
  - The Greene County Public Health Department and the Greene County Rural Health Network collaborated on the Healthy Weight Initiative, as well as "Greene Walks"
  - Columbia County Department of Health and St. Peter's Health Partners Healthy Schools-provision of training, resources, and supplies to classroom teachers on implementing Physical Activity Bursts into their classrooms as brain breaks as well as curricula designed to promote physical activity throughout the school day; Implementation of 5210, evidence-based program for healthy policies for increased physical activity, decrease screen time, no sugary drinks, and increase fruit and vegetable consumption into the Bluehawk Nation Afterschool Elementary program (Hudson City School District) and sit on several school wellness committees promoting both student and faculty/staff wellness in the county school districts;
  - Columbia County Department of Health implements Healthy Monday program, promoting healthy community environments that promote healthy behaviors (physical activity, stress management, healthy eating) to many worksites in Columbia County, reaching thousands of adults living, and working in Columbia County;
  - Columbia Memorial Hospital, Columbia County Department of Health, and Greene County Public Health Department all participated in the Columbia-Greene Breastfeeding Coalition, resulting in an increase in the number of lactation consultants serving new moms in the Twin Counties and an increase in county and other agencies with policies ensuring access to lactation rooms.

- Mental Health Promotion and Substance Abuse Prevention:
  - Columbia and Greene Counties have diligently worked to coordinate their efforts. Collaboration begins with the Columbia-Greene Addiction Coalition (CGAC). Both counties have increased the number of medication drop boxes and sharps disposal kiosks. Columbia Memorial Hospital worked to reduce the number of opiates prescribed in their emergency department.
  - CGAC launched a new website and social media accounts to promote anti-stigma messages and information for services available to Twin County residents.
  - Both counties and the Hospital have worked to train the general public in naloxone overdose reversal. LHDs have partnered with academic institutions, local employers, county agencies, community based organizations, libraries and local town officials to reach as many community members with naloxone administration skills as possible. The CMH Emergency Department works with the local Center of Treatment Innovation (COTI) program to connect patients and their families with CRPAs. When those with overdose from opioids come into the ED, they are connected with CRPAs that help them navigate the available options for harm reduction, treatment and recovery.
  - Both counties are recipients of the New York State Department of Health's Opioid Crisis Funding Grant. The three year grant is focused on implementation of evidence-based programming for medication assisted treatment, naloxone training and dissemination to the public, and connecting with high-risk populations through partnerships with law

enforcement and the CMH Emergency Department. The previous grant cycle allowed for training of providers in buprenorphine prescribing and training for Certified Recovery Peer Advocates (CRPAs).

- The CMH Emergency Department works with the local Center of Treatment Innovation (COTI) program to connect patients and their families with CRPAs. When those with overdose from opioids come into the ED, they are connected with CRPAs that help them navigate the available options for harm reduction, treatment and recovery. CRPAs are individuals with lived experience in finding and maintaining recovery from substances. CRPAs are uniquely able to connect with people actively using drugs and help them navigate their path to recovery.
- Columbia and Greene Counties have implemented ODMaps overdose tracking software to identify spikes in overdoses and have policies in place to respond to areas of the county with education and local resources.
- Both Local Health Departments have provided targeted education for proper medication and sharps disposal.

E. Implementation Strategy/Community Service Plan/Community Health Improvement Plan

1. Identification of Two 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 two meetings for the purpose of identifying priorities and focus areas. These meetings took place on March 22, 2019 at the Greene County Public Health in Catskill (Greene County) and on April 2, 2019 at Columbia Memorial Hospital in Hudson (Columbia County). 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
- Columbia County Department of Health
- Columbia County Chamber of Commerce
- Columbia County Department of Human Services
- Columbia County Public Health Leadership Group
- Cornell Cooperative Extension
- Greene County Family Planning
- Greene County Mental Health
- Greene County Public Health
- Greene County Rural Health Network
- Greene County Department of Human Services
- Greene County Mobilizing for Action through Planning and Partnerships (MAPP)
- Healthcare Consortium
- Healthcare Consortium (Helpers for Health Project)
- Healthcare Consortium (Tobacco-Free Action Program)
- Healthy Capital District Initiative
- Hudson River Healthcare
- New York University Dentistry
- 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)

The meetings were led by staff at the Healthy Capital District Initiative (HCDI), the entity contracted to conduct the Community Health Needs Assessment for the region. At these meetings, HCDI presented data on a total of 9 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. The PowerPoint presentations used during these meetings were subsequently made available to the participants and the general public on the HCDI website (www.hcdiny.org).

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 Prioritization Tracking Tool to record their own comments and 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 three qualitative

dimensions: what the data and organizational experiences suggested; if there was community awareness and concern about the health issue; 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 mental health, 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 two Prevention Agenda Priorities for Columbia and Greene Counties, these were ***Prevent Chronic Diseases*** and ***Promote Well-Being and Prevent Mental and Substance Use Disorders.*** The following key considerations informed their selection:

- Both counties had higher rates of low income population with low food access when compared to the rest of upstate; Columbia was 33% higher and Greene was 58% higher than upstate. Food insecurity is trending upwards in the Twin Counties. Columbia County's low income population with low food access increased 12%, and Greene County increased 70% since the 2016 Community Health Needs Assessment.

- Obesity is ranked 18th in both Columbia and Greene Counties using the weighted methodology. Trends for adults are steady in Columbia County and in Greene County there has been a decrease in obese adults by 16% since the last CHNA cycle. Both counties saw large increases in obesity in WIC population 2-4 year olds. Obesity in the disabled population, however, is increasing. Columbia's disabled, obese population increased from 30.9% in 2013-14, to 35.6% in 2016. The percent of adults engaged in leisure time physical activity is trending upwards in both counties, increasing from 74.3% (2013-14) to 78.1 % (2016) in Columbia and 69.8% (2013-14) to 80.5% (2016) in Greene.

- It was also recognized that obesity is related to many illnesses, including those that are the leading causes of death in the Twin Counties. For this reason, the group was anxious to ensure that our collective efforts were focused "upstream."

- In Columbia County, drug use and mental health were ranked 8th and 13th respectively. In Greene County drug use is ranked 7th and mental health is ranked 4th. Over 9,000 people living in the Twin Counties reported 14+ poor mental health days in the past month. In Greene, their rate of poor mental health days was 41% higher than the rest of upstate. Mortality rate for Opioid use in Columbia and Greene Counties was 42% and 52% higher than the rest of upstate.

In the past, the collaboration between the partners would have ended after this prioritization process was complete. However, this year the Planning Partners were determined to continue working together, and committed to jointly hosting a series of stakeholder meetings, as follows:

- June 21, 2019 at Greene County Emergency Operations Center in Cairo (Greene County)

- July 15, 2019 at the Columbia County Department of Health in Hudson (Columbia County)
- August 19, 2019 at the Columbia County Department of Health in Hudson (Columbia County)
- October 21, 2019 at the Columbia County Department of Health in Hudson (Columbia County)

The purpose of these meetings was to gather input from a broad stakeholder group on the focus areas, goals, objectives, and interventions related to the selected Prevention Agenda Priorities. 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. Within the first Prevention Agenda Priority, *Prevent Chronic Disease*, and specifically, obesity-related disease, the group identified two focus areas, as follows: **(1) Healthy Eating and Food Security** and **(2) Physical Activity**. Within the second Prevention Agenda Priority, *Promote Well-being and Prevent Mental and Substance Use Disorders*, the group identified two focus areas, as follows: **(1) Promote Well-being** and **(2) Prevent Mental and Substance Use Disorders**.

After these Prevention Agenda 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 meetings. 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 summarized, by Priority Area, in the tables below:

Priority Area: Preventing Chronic Disease		
Focus Area 1		**Healthy Eating and Food Security**
Goal 1.2		**Increase skills and knowledge to support healthy food and beverage choices**
Local Health Department(s)	Objective 1.4	Objective 1.4 Decrease by 5% (from 24% to 22.8%) adults ages 18 years and older with obesity (among all adults) by December 31, 2021.
	Intervention 1.0.3	Worksite nutrition and physical activity programs designed to improve health behaviors and results
	Process Measures	Number of programs; number of active participants; number of worksites providing responses to inventory survey; number of employees reached; number of worksite hosts; number of competitions; number of competition participants; number of educational sessions
Hospital	Objective 1.6	Decrease the percentage of adults ages 18 years and older with obesity (among all adults living with a disability)
	Intervention 1.0.3	Worksite nutrition and physical activity programs designed to improve health behaviors and results
	Process Measures	Number of patients participating in each session of the nutrition education program; consistent participation in meetings of the Breastfeeding Coalition by at least one representative from CMH; number of employee visits to HR Connection; number of monthly newsletters distributed; number of group challenges offered and number of participants in each; number of on-site fresh fruit and vegetable sales; number of on-site produce deliveries; number of employees enrolled in Employee Assistance Program; number of employees enrolled in Flexible Spending Accounts

Priority Area: Preventing Chronic Disease		
Focus Area 2		**Physical Activity**
Goal 2.3		**Increase access for people of all ages and abilities, to indoor and/or outdoor places for physical activity**
Local Health Department(s)	Objective 1.0	Increase the percentage of adults age 18 years and older who participate in leisure-time physical activity (among adults with disabilities)
	Intervention 2.3.1	Implement and/or promote programs and places for physical activity
	Process Measures	Number of Physical Activity Guides provided to the community; Number of community members reached; Number of websites with a link to the guide; Number of partners working with adults with disabilities that are engaged in our work; Number of outlets for guide
Hospital	Objective 1.6	Decrease the percentage of adults ages 18 years and older with obesity (among all adults living with a disability)
	Intervention 2.3.1	Implement and/or promote programs and places for physical activity
	Process Measures	The number of patients participating in each session of the exercise program for patients in the Hospital's Inpatient Psychiatric Unit

Priority Area: Promoting Well-being and Preventing 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 Department(s)	Objective 2.2.2	Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists, and consumers
	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 Public Health detailing interactions with prescribers and pharmacists
Hospital	Objective 2.2.1	Reduce the age-adjusted overdose deaths involving any opioids
	Intervention 2.2.4	Build support systems to care for opioid users or others at risk of an overdose
	Process Measures	Active participation in the Columbia-Greene Addiction Coalition; facilitation of the Controlled Substance Awareness Committee; 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
Goal 2.3		**Prevent and address adverse childhood experiences**
Local Health Department(s)	Objective 2.2.6	Integrate trauma-informed approaches in training staff and implementing program and policy.
	Intervention 2.2.6	Integrate trauma informed approaches in training staff and implementing program and policy
	Process Measures	Number of trainings; Survey results

Greater detail about these goals, objectives, intervention strategies, and process measures are provided in the Work Plan Narrative (see section E3, below), the Work Plan Template, found as Appendix A, and in the Intervention Summary Sheets, found as Appendix B.

3. Work Plan Narrative

(see also Work Plan Template as Appendix A and Intervention Summary Sheets as Appendix B)

a. Local Health Department Actions and Impact

Prevention Agenda Priority Area 1: Preventing Chronic Disease

To address the Prevention Agenda Priority of ***Preventing Chronic Disease***, the Local Departments of Health in Columbia and Greene Counties will do the following:

Within the Prevention Agenda Priority Area, *Preventing Chronic Disease*, the group identified "Healthy Eating and Food Security" as a Focus Area. As the Planning Partners recalled the input of partners, it was persuaded to select Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices in order to achieve Objective 1.4: Decrease the percentage of adults ages 18 years and older with obesity (among all adults). In order to achieve this goal and objective, Intervention 1.0.3 will be pursued, which entails delivering worksite nutrition and physical activity programs designed to improve health behaviors and results.

The Local Health Departments (LHDs) will look to county worksites, our partners in other health and human services agencies, school districts, and partners in the private sector through our work with the local two chambers of commerce to support worksite program implementation. The focus of year one is on engaging these partners and beginning to create a survey tool to measure the status of any existing worksite programs, survey to be administered in year two. Upon collection of this information, the LHDs will make their staff available to help create worksite wellness action plans with participating worksites. In order to measure our success, we will be collecting information on the number of worksites that submit a response to our survey, and how many agree to continue work to create action plans. The LHDs will measure the number of employees reached through these efforts and the number of competitions and participants in the Chamber of Commerce administered "Challenges" focused on physical activity, nutrition, and stress management. They will also measure the number of worksite hosted wellness educational sessions and monitor continued engagement through year three of implementation.

Additionally, the group selected Physical Activity as a second Focus Area within this Prevention Agenda Priority Area and identified Goal 2.3: Increase access for people of all ages and abilities to indoor and/or outdoor places for physical activity in order to achieve Objective 1.0: Increase the percentage of adults age 18 years and older who participate in leisure-time physical activity (among adults with disabilities). In order to achieve this goal and objective, Intervention 2.3.1 will be pursued, which entails identifying and/or promoting programs and places for physical activity.

The LHDs will engage key partners from organizations serving disability groups to explore how an increase in leisure-time physical activity among the people they serve can be supported. The LHDs are particularly interested in engaging partners that serve individuals with mental illness, and particularly those groups that are peer-led.

The Local Health Departments, the Hospital, and the Healthy Capital District Initiative compiled a resource for residents of the Twin Counties that identified all of the opportunities for physical activity in Columbia and Greene Counties. During CHIP year two of implementation the Planning Partners along with key stakeholders will work to update the plan and add information specifically accessible to those with disabilities. The guide will be widely distributed and through year three of implementation. Our success will be measured by tracking the number of guides disseminated, number of community members reached, number of websites with a link to the guide, number of partners working with adults with disabilities that are engaged in our work and the number of outlets for guide.

Prevention Agenda Priority Area 2: Promoting Well-being and Preventing Mental and Substance Use Disorders

Within the Prevention Agenda Priority Area, *Promoting Well-being and Preventing Mental and Substance Use Disorders*, the group had identified Mental and Substance Use Disorders Prevention as its Focus Area. The Planning Partners further identified Goal 2.2: Prevent opioid and other substance misuse and deaths and Objective 2.2.2: Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists, and consumers, both of which it hopes to achieve through Intervention 2.2.2, which entails increasing the availability of and/or access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers. 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.

Also under the Mental and Substance Use Disorders Prevention Focus Area, the Planning Partners identified Goal 2.3: Prevent and address adverse childhood experiences and Objective 2.2.6: Integrate trauma informed approaches in training staff and implementing program and policy through Intervention 2.2.6, integrate trauma informed approaches in training staff and implementation of program and policy; Survey the extent of integration local health and human services staff are trained and provide trauma-informed care. Year one activities for LHD implementation will include the provision of assistance planning and participating in staff training/development on trauma-informed approaches to delivering programs and services for our multi-sector community partners. In year two community partners will be surveyed regarding the degree of integration of trauma-informed care. In year three the Planning Partners will continue providing accessible training and trauma-informed policy resources to local health and human

services agencies and law enforcement. Success will be measured by tracking the number of trainings and the results of the community partner survey.

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 Hospital (CMH) is to provide our communities 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.

Prevention Agenda Priority Area 1: Preventing Chronic Disease

To address the Prevention Agenda Priority of ***Preventing Chronic Disease***, CMH will do the following:

For its part, the Hospital will administer a nutrition education program and an exercise program for patients staying in its Inpatient Psychiatric Unit. Note these programs are ways in which the Hospital will address a disparity—overweight and obesity in people with a disability (mental illness)-- in the population it serves.

- ***Administer an Exercise program for patients in its Inpatient Psychiatric Unit***
  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. Note that this activity is one of the ways in which CMH will address a health disparity—overweight and obesity in people with a disability (mental illness)-- in the population it serves.

- ***Provide education on healthy food choices for patients in its Inpatient Psychiatric Unit***
  Dietitians from the food service company will work with the patients on supporting wellness through diet. Note that this activity is another way in which CMH will address the health disparity overweight and obesity in people with a disability (mental illness).

- ***Participate in the Columbia-Greene Breastfeeding Coalition***
  The Columbia-Greene Breastfeeding Coalition was initiated by CMH many years ago and has benefited from its participation. CMH commits to ongoing participation. Currently, two staff, Shannyn Dewey and Julia Hausman, both Certified Nurse Midwives for CMH, represent CMH in this Coalition and contribute to its work.

- ***Provide a variety of onsite employee wellness options***
  Since CMH is one of the largest employers in Columbia and Greene Counties, its on-site activities to promote employee wellness can have a significant impact. CMH commits to providing the following:
  - HR Connection, an online website that employees can access directly on the CMH intranet or at their home, in which facts, healthy recipes and monthly health awareness information is shared
  - Monthly “Live Well, Work Well” newsletters via email to all employees. This highlights healthy benefits, tips and includes a healthy recipe. They are also posted in the break areas throughout CMH and on HR Connection.
  - Group challenges that focus on eating healthy and physical activity such as “The Biggest Loser.”

- Onsite “Weight Watchers” program
- Healthy food options in the Cafeteria, including healthy snacks, vegetarian and vegan meal options
- A site for the sale of fresh produce during the spring and summer months
- A site for the drop off/pick up location for Field Goods, an organization that offers a weekly auto delivery of fresh produce from local farms, delivered to employees right at work.
- An Employee Assistance Program, provided to CMH employees at no cost, which offers CMH employees Life Style and Stress Management on a confidential 1-800 number.
- A benefits package that includes a Medical Flexible Spending Account. This is a plan that allows pre-tax dollars to be set aside to assist in covering medical and wellness items that are not covered by health insurance, such as Health Management Programs and Dietary Supplements.

Prevention Agenda Priority Area 2: Promoting Well-being and Preventing Mental and Substance Use Disorders

To address the Prevention Agenda Priority of ***Promoting Well-being and Preventing Mental Health and Substance Use Disorders*****,** CMH will do the following:

- ***Participate in the Columbia-Greene Addiction Coalition***
  Formerly called the Columbia-Greene Controlled Substance Awareness Group, the Columbia-Greene Addiction Coalition was initiated by CMH many years ago and has enjoyed the ongoing participation of several CMH staff members. CMH’s commitment to participating in the Coalition will continue, with representation from the Vice President of Medical Services and Care Centers, two providers of Medication Assisted Treatment, and one provider of Palliative Care.

- ***Convene the Controlled Substance Awareness Committee***
  The Vice President of Medical Services and Care Centers will convene, on a monthly basis, a diverse group of providers representing multiple disciplines including, but not limited to, primary care, pain management, addiction services, emergency services and psychiatric services. The purpose of this Committee is to create a forum in which to take a multidisciplinary and coordinated approach to managing patients at high risk of dependence and abuse of controlled substances, including opioids.

- ***Offer Peer Support to Individuals with Addiction in the Emergency Department***
  In partnership with Greener Pathways, a program of Twin County Recovery Services (Columbia and Greene Counties’ only OASAS-licensed treatment provider), CMH offers peer support to individuals who present with addiction in the hospital’s emergency department.

The actions of the LHDs and the Hospital are summarized the NYSDOH-required Work Plan Template, found in this document as Appendix A. Additionally, Intervention Summary Sheets have been created for each intervention; these can be found as Appendix B.

d. Hospital Resources to be Committed

CMH is committed to providing adequate resources to support the activities noted above. In order to support the physical activity and nutrition education activities in the Psychiatric Unit noted above, CMH will contract with providers of these services. In order to participate in the Columbia Greene Addiction Coalition and the Controlled Substance Awareness Committee, CMH will lend the time and effort of multiple members of its staff, including members of the Executive Team and providers from multiple disciplines. And, in order to offer peer support to individuals with addiction in the Emergency Department, it will offer staff time and effort to coordinate with its partner, Greener Pathways. We anticipate that periodic meetings and less formal, ongoing communication will be required to establish policies and procedures, evaluate performance, make mid-stream corrections as needed, and collect and report utilization data.

e. Roles and Resources of Others

Members of the Healthy People Partnership will disseminate materials supporting the identified goals and objectives. Healthy People Partners will engage and support local trainings provided by the Planning Partners.

The Columbia County Chamber of Commerce's Move Columbia initiative will assist with engagement of workplaces to promote worksite wellness initiatives to adults.

Twin County Recovery Services and the COTI program will continue to provide CRPA services to the CMH Emergency Department and provide support for referral to MAT as well as provide high risk naloxone trainings to individuals and families with Opioid use disorder.

f. How Activities Address a Disparity

A useful resource for our work in this area is the Physical Activity Guide for Columbia and Greene Counties. This document is an extensive list of all of the indoor and outdoor opportunities to engage in physical activity in the Twin Counties. The Planning Partners will use this guide with the intention to update and expand, to make it more accessible to our community members with disabilities. During year one of implementation the planning partners will engage community partners serving our target population, adults with disabilities. The Healthy People Partnership will work to determine which have existing physical activity programs and determine how our partners can strengthen their work. During year two the Planning Partners will work collaboratively to update the guide to include most recent information and create a designation for entries that are disability-accessible, including ramps and handicap-parking. During year three, the Planning Partners will continue to update the guide and promote widely. Process measures for this project will include tracking the number of print copies of the guide distributed to the public, the number of websites featuring an online version of the guide, and the number of partners working with adults with disabilities that are actively engaged in this project.

4. 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.

5. 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, along with substantial background material and copies of summary presentations, is available on the website of the Healthy Capital District Initiative (HCDI). This website provides detailed regional comparisons for each of the counties in the Capital Region: **http://www.hcdiny.org/**

APPENDIX A. WORK PLAN TEMPLATE

APPENDIX B. INTERVENTION SUMMARY SHEETS

Color Code:	
	Greene County Only
	Columbia County Only
	Both Columbia & Greene Counties

Agency	**Greene County Public Health Department**
Priority	**Prevent Chronic Diseases (Obesity)**
Focus Area	Focus Area 1: Healthy eating and food security
Goal	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices
Objectives	Objective 1.4 Decrease by 5% (from 24% to 22.8%) adults ages 18 years and older with obesity (among all adults) by December 31, 2021.
Disparities	N/A
Intervention	Intervention 1.0.3 Worksite nutrition and physical activity programs designed to improve health behaviors and results Local health departments, hospitals, health centers, businesses, CBOs and other stakeholders can implement wellness programs at their own worksite and work with local worksites to implement nutrition and physical activity interventions as part of a comprehensive worksite wellness program. Components to include: Education and information through classes, written & digital communication. Some programs will include incentives for participation/and or behavioral change.
Family of Measures	Input Measures: Number of programs Output Measures: Number of active participants
Projected/completed Year 1 (2019) Interventions	**Biggest Loser Contest**: 4 month weigh loss contest, with incentives provided for greatest number of pounds and greatest percentage lost. Contestants losing 5% or greater are eligible for a 3 month weight maintenance program. Weekly fitness, nutrition and wellness e-mails for all registered participants. **Vitality Greene**: A 10 activity week challenge available to all Greene County Employees; self-reported step/activity tracking contest with weekly prizes for employees logging the most minutes of activity (a different employee will be selected weekly), with a raffle entry for all employees completing the challenge login requirements. Weekly educational e-mails to all registered participants. **Biometric Screening Pilot Program**: Available to management confidential employees insured through Empire Insurance, including weight, blood pressure, glucose and cholesterol, followed up by a review of health report with nurse and guidance on healthy behavior changes; employees encouraged to follow-up with provider **Healthy Vending Machines**: Located in the Emergency Operations Building and the Mental Health Clinic in Cairo, NY; employees provided with healthier options in vending machines **Stair Signs**: Located in Main County Office Building in Catskill, NY; employees are encouraged to take the stairs with informational/motivational signs located near the

	door of each stair case and on the landings between floors **GreeneWalks**: Community activity program open to employees and their families. Participants who complete a paper tracking form are eligible for incentives. Participants making additional lifestyle changes are eligible for enhanced incentives.
Projected Year 2 (2020) Interventions	All 2019 programs will be continued annually for Greene County Employees In 2020, Health Incentive Rewards will be made available to all Greene County Employees; incentives will be provided to employees for completing annual physical/nutritional classes/etc.
Projected Year 3 (2021) Interventions	All 2020 programs will be continued annually for Greene County Employees
Implementation Partner	Community-based organizations
Partner Role(s) and Resources	**Greene County Public Health Department**: Worksite coordination of Biggest Loser Contest including coordination of contest for clients of the Mental Health Association of Columbia-Greene; participate in Go Greene for Wellness Committee; create and maintain Stair Signs

Agency	Columbia County Department of Health
Priority	**Prevent Chronic Diseases (Obesity)**
Focus Area	Focus Area 1: Healthy eating and food security
Goal	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices
Objectives	Objective 1.4 Decrease by 5% (from 24% to 22.8%) adults ages 18 years and older with obesity (among all adults) by December 31, 2021.
Disparities	N/A
Intervention	Intervention 1.0.3 Worksite and community based nutrition and physical activity programs designed to improve health behaviors and results Local health departments, hospitals, health centers, businesses, CBOs and other stakeholders can implement wellness programs at their own worksite and work with local worksites to implement nutrition and physical activity interventions as part of a comprehensive worksite wellness program. Educating and informing through classes, distributing written & digital communication.
Family of Measures	Output Measures: Number of worksites providing responses to inventory query; Number of employees reached; Number of worksites serving as hosts; Number of competitions; Number of competition participants; Number of educational sessions
Projected/Completed Year 1 (2019) Interventions	Engage partners
Projected Year 2 (2020) Interventions	Inventory of existing partnerships with employers and the worksite programs at their facility. Inventory current partners and those reached through the Chamber of Commerce. Promote physical activity in worksites through signage, policies, social support, and joint use agreements. Promote access to community resources, educational opportunities, and promote the Chamber of Commerce run wellness challenges. Work with employers to create agency wellness action plans for continued improvement.
Projected Year 3 (2021) Interventions	Continue Annual program evaluation, improvement efforts and action planning.
Implementation Partner	Local health department
Partner Role(s) and Resources	Empire Insurance Plan: Provide health and wellness programming, incentives, and employee aggregate data; participate in Go Greene for Wellness Committee

Agency	Columbia Memorial Hospital (CMH)
Priority	**Prevent Chronic Diseases (Obesity)**
Focus Area	Focus Area 1: Healthy eating and food security
Goal	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices
Objectives	Objective 1.4 Decrease by 5% (from 24% to 22.8%) adults ages 18 years and older with obesity (among all adults) by December 31, 2021.
Disparities	Overweight and obesity in individuals with disabilities (mental illness)
Intervention	Intervention 1.0.3 Worksite and community-based nutrition and physical activity programs designed to improve health behaviors and results CMH will provide a **nutrition education program** for patients in its Inpatient Psychiatric Unit. Note that this activity is one way in which the Hospital will address the health disparity of excess overweight and obesity in individuals with a disability (mental illness)
Family of Measures	**Output Measures:** • **T**he number of patients participating in each session of the **nutrition education program** for patients in the Hospital's Inpatient Psychiatric Unit
Projected/completed Year 1 (2019) Interventions	N/A
Projected Year 2 (2020) Interventions	Add Nutrition Education for patients in the Inpatient Psychiatric Unit and continue other interventions
Projected Year 3 (2021) Interventions	Continue intervention
Implementation Partner	Hospital
Partner Role(s) and Resources	Key partners in these endeavors include, but are not limited to: Psych Unit staff, and the nutrition education program vendor

Agency	Columbia Memorial Hospital (CMH)
Priority	**Prevent Chronic Diseases (Obesity)**
Focus Area	Focus Area 1: Healthy eating and food security
Goal	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices
Objectives	Objective 1.4 Decrease by 5% (from 24% to 22.8%) adults ages 18 years and older with obesity (among all adults) by December 31, 2021.
Disparities	N/A
Intervention	Intervention 1.0.3 Worksite and community-based nutrition and physical activity programs designed to improve health behaviors and results CMH will **participate in the Columbia-Greene Breastfeeding Coalition**
Family of Measures	**Output Measures:** Consistent participation in meetings of t**he Breastfeeding Coalition** by at least one representative from CMH
Projected/completed Year 1 (2019) Interventions	Breastfeeding Coalition
Projected Year 2 (2020) Interventions	Continue intervention
Projected Year 3 (2021) Interventions	Continue intervention
Implementation Partner	Hospital
Partner Role(s) and Resources	Key partners in these endeavors include, but are not limited to: Psych Unit staff, exercise program vendor; nutrition education program vendor; the members of the Breastfeeding Coalition; the Human Resources Department at CMH

Agency	Columbia Memorial Hospital (CMH)
Priority	**Prevent Chronic Diseases (Obesity)**
Focus Area	Focus Area 1: Healthy eating and food security
Goal	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices
Objectives	Objective 1.4 Decrease by 5% (from 24% to 22.8%) adults ages 18 years and older with obesity (among all adults) by December 31, 2021.
Disparities	Overweight and obesity in individuals
Interventions	Intervention 1.0.3 Worksite and community-based nutrition and physical activity programs designed to improve health behaviors and results CMH will provide a variety of **onsite employee wellness support tools and options**: – HR Connection, an online website that employees can access directly on the CMH intranet or at their home, in which facts, healthy recipes and monthly health awareness information is shared – Monthly "Live Well, Work Well" newsletters via email to all employees. This highlights healthy benefits, tips and includes a healthy recipe. They are also posted in the break areas throughout CMH and on HR Connection. – Group challenges that focus on eating healthy and physical activity such as "The Biggest Loser." – Onsite "Weight Watchers" program – A site for the sale of fresh produce during the spring and summer months – A site for the drop off/pick up location for Field Goods, an organization that offers a weekly auto delivery of fresh produce from local farms, delivered to employees right at work – An Employee Assistance Program, provided to CMH employees at no cost, which offers CMH employees Life Style and Stress Management on a confidential 1-800 number – A benefits package that includes a Medical Flexible Spending Account. This is a plan that allows pre-tax dollars to be set aside to assist in covering medical and wellness items that are not covered by health insurance, such as Health Management Programs and Dietary Supplements.
Family of Measures	**Input Measures:** • **Onsite-wellness support tools and options:** # of employee visits to HR Connection; # of monthly newsletters distributed; # of group challenges offered and # of participants in each; # of on-site fresh fruit and vegetable sales; # of on-site produce deliveries; # of employees enrolled in Employee Assistance Program; # of employees enrolled in Flexible Spending Accounts
Projected/completed Year 1 (2019) Interventions	Onsite-wellness support tools and options
Projected Year 2 (2020) Interventions	Continue intervention

Projected Year 3 (2021) Interventions	Continue intervention
Implementation Partner	Hospital
Partner Role(s) and Resources	A key partner in this endeavor is the Human Resources Department at CMH

Agency	Local Health Departments (LHDs)
Priority	Prevent Chronic Diseases (Obesity)
Focus Area	Focus Area 2: Physical Activity
Goal	Goal 2.3: Increase access, for people of all ages and abilities, to indoor and/or outdoor places for physical activity
Objectives	Objective 1.9 Increase by 6% (81% to 85.9%) adults age 18 years and older who participate in leisure-time physical activity (among adults with disability) by December 31, 2021.
Disparities	Overweight and obesity in individuals with disabilities (mental illness)
Interventions	Promote a combination of community walking, wheeling, or biking programs, Open Streets programs, joint use agreements with schools and community facilities, Safe Routes to School programs, increased park and recreation facility safety
Family of Measures	Output Measures: • Number of Physical Activity Guides provided to the community • Number of community members reached • Number of websites with a link to the guide • Number of partners working with adults with disabilities that are engaged in our work • Number of outlets for guide
Projected/completed Year 1 (2019) Interventions	Indoor/Outdoor Physical Activity Guide for Columbia and Greene Counties Currently details indoor/outdoor locations for physical activity in Columbia and Greene Counties; includes youth recreation programs, walking/hiking trails, walking/hiking/running clubs, cycling, skiing, swimming, fitness centers, school districts with open tracks, town parks, dog parks, and yearly activity-based events; available online or printed copies in Greene County libraries
Projected Year 2 (2020) Interventions	Indoor/Outdoor Physical Activity Guide - update Guide will be updated to include most recent information; guide will be updated to include disability-accessible locations, including ramps and handicap parking; online and print copies of this guide will be shared throughout community
Projected Year 3 (2021) Interventions	Indoor/Outdoor Physical Activity Guide - continue to update and disseminate guide as needed
Implementation Partner	Local Health Department; Community-Based Organizations
Partner Role(s) and Resources	Greene County Human Resources: Participate in Go Greene for Wellness Committee; marketing of programs; distribution of educational information and materials

Agency	Columbia Memorial Hospital (CMH)
Priority	**Prevent Chronic Diseases (Obesity)**
Focus Area	Focus Area 2: Physical activity
Goal	Goal 2.3 Increase access for people of all ages and abilities, to indoor and/or outdoors places for physical activity
Objectives	Objective 1.6 December 31, 2024, decrease the percentage of adults ages 18 years and older with obesity (among all adults living with a disability)
Disparities	Overweight and obesity in individuals with disabilities (mental illness)
Intervention	Intervention 2.3.1 Implement and/or promote programs and places for physical activity CMH will administer an **exercise program** for patients in its Inpatient Psychiatric Unit Note that this activity is a second way in which the Hospital will address the health disparity of excess overweight and obesity in individuals with a disability (mental illness)
Family of Measures	**Output Measures:** The number of patients participating in each session of the exercise program for patients in the Hospital's Inpatient Psychiatric Unit
Projected/completed Year 1 (2019) Interventions	Initiate exercise program for patients in the Hospital's Inpatient Psychiatric Unit
Projected Year 2 (2020) Interventions	Continue intervention
Projected Year 3 (2021) Interventions	Continue intervention
Implementation Partner	Hospital
Partner Role(s) and Resources	Key partners in these endeavors include, but are not limited to: Psych Unit staff and the exercise program vendor

Agency	**Local Health Departments (LHDs)**
Priority	**Promote Well-Being and Prevent Mental/Substance Use Disorders**
Focus Area	Focus Area 2: Prevent Mental and Substance User Disorders
Goal	Goal 2.2 Prevent opioid overdose deaths
Objectives	Objective 2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers. Expand access to Naloxone by increasing by 5% the number of Naloxone trainings held annually (38 trainings in 2018).
Disparities	N/A
Interventions	Intervention 2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers.
Family of Measures	Input Measures: - Number of trainings - Number of kits provided - Number of Public Health detailing interactions with prescribers and pharmacists
Projected/Completed Year 1 (2019) Interventions	**Greene County Family Planning** is a Registered New York State (NYS) Opioid Overdose ***Prevention Program (COOP)*** • Provided naloxone kits by NYS to distribute in community • Naloxone training and free kit provided by Greene County Family Planning Nurse Practitioners or Certified Peer Recovery Advocate (CRPA) **Columbia County Department of Health** is a Registered New York State (NYS) Opioid ***Overdose Prevention Program*** • Provided naloxone kits by NYS to distribute in community • Naloxone training and free kit provided to community members and workplaces hosting trainings
Projected Year 2 (2020) Interventions	• Continue Greene County Family Planning participation in NYS Opioid Overdose Prevention • Continue Columbia County Department of Health participation in NYS Opioid Overdose Prevention Program • Create and disseminate survey for local Pharmacists to determine local awareness of NYS Naloxone Co-Payment Assistance Program (N-CAP)
Projected Year 3 (2021) Interventions	Continue Greene County Family Planning participation in NYS Opioid Overdose Prevention Program Disseminate educational material regarding NYS N-CAP to pharmacists in Greene Co. Continue Columbia County Department of Health participation in NYS Opioid Overdose Prevention Program
Implementation Partner	Local health department

Partner Role(s) and Resources	**Greene County Public Health Department** - record and report on number of kits distributed in Greene County **Greene County Family Planning** - NYS Opioid Overdose Prevention Partner; provide Naloxone training and kit to consumers in community **Columbia County Department of Health** - NYS Opioid Overdose Prevention Partner; provide Naloxone training and kit to consumers in community **Healthy Capital District Initiative** **Local Pharmacies** **Twin County Recovery Services/Greener Pathways**

Agency	**Columbia Memorial Hospital (CMH)**
Priority	**Promote Well-Being and Prevent Mental/Substance Use Disorders**
Focus Area	Prevent Mental and Substance User Disorders
Goal	Goal 2.2: Prevent opioid and other substance misuse and deaths
Objectives	Objective 2.2.1 By December 31, 2024, reduce the age-adjusted overdose deaths involving any opioids by 7% to 14.0 per 100,000 population.
Disparities	N/A
Intervention	Intervention 2.2.4 Build support systems to care for opioid users or others at risk of an overdose To advance this goal, CMH **participate in the Columbia-Greene Addiction Coalition**, a multidisciplinary group focused on ensuring that there is adequate prevention, harm reduction, treatment and recovery supports
Family of Measures	**Input measures:** **Columbia-Greene Addiction Coalition:** Active participation in and contributions to the work of the Coalition from at least one member of the CMH staff
Projected/Completed Year 1 (2019) Interventions	This intervention is underway
Projected Year 2 (2020) Interventions	Continue the intervention
Projected Year 3 (2021) Interventions	Continue the intervention
Implementation Partner	Hospital
Partner Role(s) and Resources	Essential partners in this effort include the various members of the Addiction Coalition

Agency	**Columbia Memorial Hospital (CMH)**
Priority	**Promote Well-Being and Prevent Mental/Substance Use Disorders**
Focus Area	Focus Area 2: Prevent Mental and Substance User Disorders
Goal	Goal 2.2: Prevent opioid and other substance misuse and deaths
Objectives	Objective 2.2.1 By December 31, 2024, reduce the age-adjusted overdose deaths involving any opioids by 7% to 14.0 per 100,000 population.
Disparities	N/A
Intervention	Intervention 2.2.4 Build support systems to care for opioid users or at risk of an overdose To advance this goal, CMH will **convene the Controlled Substance Awareness Committee**
Family of Measures	**Input measures:** Maintain an active meeting schedule of the Controlled Substance Awareness Committee and foster the ongoing engagement of its members; the # of patient cases discussed
Projected/Completed Year 1 (2019) Interventions	This intervention is underway
Projected Year 2 (2020) Interventions	Continue the intervention
Projected Year 3 (2021) Interventions	Continue the intervention
Implementation Partner	Hospital
Partner Role(s) and Resources	Essential partners in this effort include the various CMH staff members who participate in the Committee

Agency	**Columbia Memorial Hospital (CMH)**
Priority	**Promote Well-Being and Prevent Mental/Substance Use Disorders**
Focus Area	Focus Area 2: Prevent Mental and Substance User Disorders
Goal	Goal 2.2: Prevent opioid and other substance misuse and deaths
Objectives	Objective 2.2.1 By December 31, 2024, reduce the age-adjusted overdose deaths involving any opioids by 7% to 14.0 per 100,000 population.
Disparities	N/A
Intervention	**Intervention 2.2.4 Build support systems to care for opioid users or at risk of an overdose** To advance this goal, CMH will offer **Peer Support to Individuals with Addiction in the Emergency Dept.**
Family of Measures	**Output Measures:** The # of individuals educated about the availability of peer support; Short-term outcome: the # of individuals referred to peer support; the # of individuals who meet with a peer
Projected/Completed Year 1 (2019) Interventions	This intervention is underway
Projected Year 2 (2020) Interventions	Continue the intervention
Projected Year 3 (2021) Interventions	Continue the intervention
Implementation Partner	Hospital
Partner Role(s) and Resources	Essential partners in this effort include the Emergency Department leadership and staff and Greener Pathways, a program of Twin County Recovery Services