2025 Community Health Assessment

2025-2030 Community Health Improvement Plan

and

2025-2027 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 Affairs Committee on October 27, 2025 and the Board of Governors of AMCH/GFH/CMH and the AMHS Board of Governors on December 3, 2025.

2025 Community Health Assessment,
2025-2030 Community Health Improvement Plan,
and 2025-2027 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. Cover Page

1. **Counties Covered:** Columbia and Greene

2. **A Joint Plan Prepared and Submitted by the following:**

   Participating Local Health Departments:

   Columbia County Department of Health
   325 Columbia Street, Suite 100
   Hudson, NY 12534
   (518) 828-3358
   CHA/CHIP Liaison: Victoria McGahan <victoria.mcgahan@columbiacountyny.gov>

   Greene County Public Health Department
   411 Main Street
   Catskill, NY
   (518) 719-3600
   CHA/CHIP Liaison: Laura Churchill <lchurchill@greenecountyny.gov>

   Participating Hospital:

   Columbia Memorial Hospital
   71 Prospect Avenue
   Hudson, NY 12534
   (518) 828-1400
   CSP Liaison: Claire Parde <cparde@columbiahealthnet.org>

3. **Coalition/entity completing Community Health Assessment and Plan:**

   Community Health Assessment:
   Healthy Capital District (HCD)
   175 Central Avenue, Albany, New York 12206

518-486-8400

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

Table of Contents

C. Executive Summary

This document provides a description of the collaborative community health assessment process for Columbia and Greene Counties that was initiated in 2024 and concluded in 2025; the result of that assessment process is variably called, "the Community Health Needs Assessment," "Community Health Assessment," or simply "CHA." It also describes the collaborative community health improvement planning process that occurred in 2025. The result of those assessment and planning processes are two plans: the 2025-2030 Community Health Improvement Plan, which is the responsibility of our local health departments, the Columbia County Department of Health and Greene County Public Health, and the 2025-2027 Community Service Plan, which is the responsibility of our local hospital, Columbia Memorial Hospital. As these entities have long committed to working closely together, their respective plans are aligned and submitted jointly. In this document, they will simply be referred to as "the Plan."

1. Prevention Agenda Priorities

The Plan identifies priorities for community health improvement that were selected from the 2025-2030 Prevention Agenda–New York State's "blueprint" for improving the health and well-being of New Yorkers. These Prevention Agenda priorities are as follows:

- Prevention Agenda Priority #1: Nutrition Security
- Prevention Agenda Priority #2: Tobacco/E-cigarette Use
- Prevention Agenda Priority #3: Suicide

Furthermore, the Plan reflects the goal of reducing health disparities and improving health equity. Residents of rural areas tend to be older, sicker and poorer than their urban and suburban counterparts; sadly, the residents of Columbia and Greene Counties offer no exception to those trends. Consequently, it could be argued that all the activities outlined in this Plan address the disparities in healthcare access and health outcomes that our residents experience simply as a function of their rurality. Still, there are other attributes, such as race/ethnicity and low income, which can further compound the challenges for rural residents. This Plan will focus on two special populations: residents experiencing economic insecurity, whose limited resources undermine their food security, and non-Hispanic Blacks, who have a higher rate of visits to the Emergency Department for self-harm than residents from other racial/ethnic groups. It is hoped that targeting interventions to particularly vulnerable members of our community will both address the greatest need, reduce health disparities, and contribute to health equity.

2. Data Review

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

3. Partners and Roles

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 processes and are committed to working jointly, both across agency 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 that was convened in May 2025 to review data from the Community Health Needs Assessment and inform the selection of community health priorities. This broad stakeholder group, referred to as the **Columbia-Greene Healthy People Partnership**, will continue to have a role throughout the implementation phase. The Partnership will be charged with reviewing reports, monitoring progress, and providing feedback.

4. Interventions and Strategies

The selection of priorities, interventions and activities was made by 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. Whenever possible, evidence-based interventions were selected directly from those offered in the Prevention Agenda.

With regard to **Priority Area #1: Nutrition Security**, the Planning Partners selected the following interventions:

- Conduct standardized screening of unmet Nutrition Security needs and provide referrals to state, local, and federal benefit programs and community-based, health-related social needs providers to address unmet needs
- Inventory and promote access points to get affordable, high quality, nutritious food, including expanding and promoting the availability of food vouchers and other opportunities for using entitlement dollars for food purchases
- Implement nutrition standards and food service guidelines for meals and snacks served in facilities, worksites and institutions
- Implement periodic community needs assessments to prioritize the development of nutrition programs in high-risk areas
- Convene and lead individuals and organizations that are working to address hunger and food insecurity in a collaborative learning and work effort

With regard to **Priority Area #2: Tobacco/E-cigarette Use**, the Planning Partners selected the following interventions:

- Provide access to tobacco cessation treatments, including individuals, group, telephone counseling, and food and drug admin approved cessation medications
- Implement screening for tobacco use and navigate to appropriate services in all health care practice settings.
- Advance community-wide support for restricting minors access to tobacco products
- Educate residents on the harms of tobacco and the benefits of tobacco-free treatment

With regard to **Priority Area #3: Suicide**, the Planning Partners selected the following interventions:

- Provide training for community members, organizations and other groups to identify and respond to people who may be at risk of suicide-on-suicide prevention
- Promote calling or texting 988 through social media, digital marketing campaigns, and other utilized marketing strategies
- Improve availability and access to culturally relevant information on suicide prevention and community resources, especially in underserved and historically marginalized communities
- Promote and conduct comprehensive suicide prevention training for staff

5. Progress and Evaluation

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

With regard to **Priority Area #1: Nutrition Security**, the Planning Partners selected the following measures:

- RE: the standardized screening of unmet Nutrition Security needs: # of patients screened; % of patients screened; # of screened patients referred; % of screened patients referred
- RE: the inventory of food access points and promotion of food vouchers: # of clicks to online inventory; # of FMNP and SFMNP coupons distributed
- RE: the implementation of nutrition standards and food service guidelines: # of patients selecting the “featured” health option or the # of cafe sales for certain “healthy option” items
- RE: the implementation of periodic community needs assessments: Track data collected and collection methods for needs assessments
- RE: the convening of organizations and individuals addressing hunger and food insecurity: # of stakeholders engaged; # of stakeholder meetings convened; # of action items identified; # of action items pursued

With regard to **Priority Area #2: Tobacco/E-cigarette Use**, the Planning Partners selected the following interventions:

- RE: providing access to tobacco cessation treatments: # of referrals made to cessation treatment; # of people served by cessation treatments
- RE: the implementation of screening for tobacco use in health care practice settings: Participation among organizations of focus; # of people screened; number of successful referrals made
- RE: advancing community-wide support for restricting minors access to tobacco products: Participation rates among CBOs, schools, retailers, and other organizations of focus; degree of accessibility of tobacco products (# of purchase locations; # of visible advertisements, especially near congregation sites for youth)
- RE: educating residents on the harms of tobacco and the benefits of tobacco-free treatment: # of outreach events and attendance, # of flyers distributed, # of QR code scans and website visits

With regard to **Priority Area #3: Suicide**, the Planning Partners selected the following interventions:

- RE: providing training for community members, organizations and other groups: # of trainings provided; # of people trained
- RE: the promotion of 988 through social media and marketing strategies: Data on reach of promotion strategy (e.g. # of views; # of website visits; source of website visits, etc.)
- RE: improving availability and access to culturally relevant information on suicide prevention: Participation among CBOs in promotion activities, manner of promotion activities and data on reach (# of outreach events, # of attendees, # of flyers distributed, # of website clicks, etc.)
- RE: promoting and conducting comprehensive suicide prevention training for staff: Participation among health care organizations; # of trainings delivered; # of staff trained; capacity of staff to implement skills gained from training

Greater detail about these intervention strategies, including related objectives and process measures, are provided in the Work Plan.

D. Community Health Assessment

The Community Health Assessment for Columbia and Greene Counties is part of the 2025 Capital Region Community Health Needs Assessment, available at the following link: https://www.healthycapitaldistrict.org/content/sites/hcdi/CHNA2025/CHNA_HCDI_2025.pdf.
The document includes a description of the communities being assessed – that is, Columbia and Greene Counties – and a description of the community's demographic profile, including socioeconomic, educational and environmental factors that affect health such as: age; race/ethnicity; education; languages spoken; poverty; unemployment; nutrition security; housing quality and affordability; social vulnerability; and, status as a disadvantaged community. Additionally, the Assessment includes a description of the community's health status, with explanations regarding the data sources, data collection methods, and relevant health indicators. While select findings from the Assessment are offered below, the reader is advised that the most comprehensive and complete information can be found at the link above.

1. Community Description

a. Service Area Defined

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 Med 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 developing 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 that require a similar set of activities in the next few years. The Planning Partners also chose this approach to reflect the history of collaboration between the Counties and their ongoing commitment to continue working closely together, across both agency and county lines.

b. Select Demographic Characteristics of the Community, by County

Columbia County

Columbia County (population 61,245) 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 (49.5 years). About 12.6% of Columbia County's population is 14 years of age or younger, while 25.4% are over 65 years old.

Of Columbia County residents, 10.3% are living in poverty. 7.8% of Columbia County's residents aged 65 years and older are living in poverty. Approximately 9.5% of Columbia County's population is non-White, and 6.0% of the County's population is Hispanic. Columbia County had the highest poverty rate among Asian (23.1%) and Black (33.1%) residents.

Of those in Columbia County aged 25 years or older, 78.3% hold a high school degree or higher; 19% hold a Bachelor's Degree. 3.5% of Columbia County residents are unemployed. 96.2% of Columbia County residents have health insurance.

Columbia County residents living with a disability (14.9%) exceeds the state average of 13.5%. Many of those who are disabled in Columbia County are older people over the age of 75. Sourced from the American Community Survey 2019-2023, the types of disabilities the residents of Columbia County live with are hearing difficulties (5.1%), vision difficulties (2.2%), cognitive difficulties (6.2%), ambulatory difficulties (7.1%), self-care difficulties (2.5%) and independent living difficulties (7.3%).

Greene County

Known as the Land of Rip Van Winkle, Greene County is the most rural county in the Capital Region, with a population of 47,930 residents. 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 (47.4 years) in the Capital Region. Approximately 13.5% of the population is 14 years of age or younger, while about 25.4% of the population is 65 years of age or older. Greene County's population is 11.1% non-white and 7.2% is Hispanic. The non-white/Hispanic population in Greene County has increased since 2010.

Greene County's poverty rate decreased from 14% to 10.4% in the past years. The neighborhood of Catskill had the highest poverty rate (19.4%) in the County. Of those above the age of 25, 88.8% hold a High School Diploma or higher, while 28.9% hold a Bachelor's Degree. The number of residents with a Bachelor's degree has doubled in 4 years. Approximately 95% of Greene County residents have health insurance.

Greene County residents living with a disability (14%) exceeds the state average of 12.0%. Many of those in Greene County who are disabled are over the age of 75 years old. Sourced from the American Community Survey 2015-2019, the types of disabilities the residents of Greene County live with are hearing difficulties (3.3%), vision difficulties (2.0%), cognitive difficulties (5.3%), ambulatory difficulties (7.9%), self-care difficulties (2.6%) and independent living difficulties (6.4%).

2. Assessing the Health Status of the Community

a. Data Sources and Collection Methods

The health indicators selected for this report were based on a review of available public health data and New York State priorities promulgated through the Prevention Agenda for a Healthier New York. The collection and management of these data has been supported by the state for an extended period and are very likely to continue to be supported. This provides reliable and comparable data over time and across the state. These measures, when complemented by the Expanded Behavioral Risk Factor Surveillance System and Prevention Quality Indicators, provide health indicators that can be potentially impacted in the short-term. The Common Ground Health provided SPARCS (hospitalizations and ED visits) data that were utilized to generate county and ZIP code level analyses of mortality, hospitalizations, and emergency room utilization, for all residents, by gender, race and ethnicity. The most recent SPARCS data available was from 2023, while the most recent Vital Statistics data available was from 2022. For some measures with small case counts, 3- or 5-year periods of aggregate data were used to establish more reliable rates, especially for less populous geographic areas or demographic groups.

Additional data were examined from several sources:

- New York State Prevention Agenda Tracking Dashboard
- New York State Community Health Indicator Reports Dashboard
- New York State Leading Causes of Death Dashboard (2022)
- New York State Cancer Registry Dashboard
- New York State County Health Indicators by Race/Ethnicity (2020-2022)
- New York State Annual Vital Statistics Tables (2022)
- New York State Behavioral Risk Factor Surveillance System (BRFSS) (2016, 2018, and 2021)
- New York State Statewide Planning and Research Cooperative System (SPARCS) (2019-2023) —Prevention Quality Indicators (2021-2023)
- New York State Opioid Data Dashboard
- New York State Opioid Annual Report (2024)
- State Unintentional Drug Overdose Reporting System (SUDORS) (2023)
- New York State Communicable Disease Annual Reports (2021-2023)

- New York State Division of Criminal Justice County Crime Rates (1990-2024)
- New York State Department of Health, Health Data NY (2025)
- New York State Education Department Report Card Database (2024)
- New York State Department of Environmental Conservation, Climate Justice Working Group (2023)
- U.S. Census, American Community Survey (2022 and 2019-2023)
- U.S. Department of Agriculture, Economic Research Service (2019)
- Centers for Disease Control and Prevention, Agency for Toxic Substances and Disease Registry, Geospatial Research, Analysis, and Services Program (2023)
- Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System (2024)
- University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation, County Health Rankings (2025)

These data sources were supplemented by the 2024 Capital Region Community Health Survey. The 2024 Capital Region Community Health Survey was conducted by Healthy Capital District in November and December of 2024, with the assistance of the Albany, Columbia, Greene, Rensselaer and Schenectady health departments, and Albany Med Health System, Columbia Memorial Hospital, Ellis Hospital, and St. Peter's Health Partners hospitals. The survey was a convenience sample of adult residents of the Capital Region (aged 18 years and older). The survey received 5,415 total responses from Capital Region residents. This survey was conducted to learn about the health needs, barriers and concerns of residents in the Capital Region.

Local data were compiled from these data sources and draft sections were prepared by health condition for inclusion in the Community Health Assessment. Drafts of this report were prepared by Spencer Keable, Data Analyst for Healthy Capital District. Drafts were reviewed for accuracy and thoroughness by Amanda Duff, Executive Director of Healthy Capital District. Drafts were then reviewed by the members of the Capital Region Prevention Agenda Work Group, local subject matter experts representing each of the participating health departments and hospitals in the Capital Region. Comments were addressed and changes were incorporated into the final report.

b. Community Engagement

The community health assessment process in Columbia and Greene Counties was undertaken in a highly collaborative and consultative way. 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 together throughout the Assessment. They were assisted in this work by Healthy Capital District (HCD), a private, not-for-profit organization that is contracted by all three entities to perform data analysis. Additionally, HCD convened and facilitated the Capital District Prevention Agenda Workgroup (PAWG), which, in addition to the involvement of the partners from Columbia and Greene, included representation from local health departments and hospitals from Albany, Schenectady, Rensselaer, and Saratoga Counties. The PAWG collectively developed a community survey which was administered in the Fall of 2024. Subsequently, the Columbia-Greene Planning Partners shared the results of that survey and other data with a large diverse stakeholder group referred to as the Columbia-

Greene Healthy People Partnership, which it convened across two meetings in May 2025. Members of the Healthy People Partnership reviewed and responded to the data that was presented and contributed their own insights. Subsequently, the Planning Partners hosted three separate focus groups with select stakeholders in August 2025 to further explore a smaller set of health issues, discuss the community assets, resources and activities related to those issues, and ultimately inform the selection of Prevention Agenda priorities.

c. Relevant Health Indicators

The 2025 Capital Region Community Health Needs Assessment, found at https://www.healthycapitaldistrict.org/content/sites/hcdi/CHNA2025/CHNA_HCDI_2025.pdf, contains the most comprehensive review of health indicators for Columbia and Greene Counties, and the reader is encouraged to explore those there. However, some of the most salient points have been extracted and listed below:

COLUMBIA COUNTY

Sociodemographic

- Columbia County had the oldest population in 2023, with more than 25% of the county's population aged 65 or older (U. S. Census)
- About one-third of rental units in Columbia County had a gross rent of at least 35% of household income in 2022 (U. S. Census)
- Columbia County had the highest Capital Region county rate of households with severe housing problems in 2017-2021, at 15.4%, which ranked 44th out of 62 NYS counties (U.S. Department of Housing and Urban Development)

General Health Status

- Columbia County had the highest Prevention Quality Indicator (PQI) rates in the Capital Region for the acute, circulatory, diabetes, and overall measures in 2021-2023 (NYS SPARCS)

Chronic Disease

- Columbia County had the highest age-adjusted prevalence in the Capital Region of adults with health care provider-diagnosed diabetes in 2021 (BRFSS)
- Columbia County had the worst age-adjusted percentage in NYS of adults having a test for high blood sugar in the past three years in 2021, at 38% (BRFSS)
- Columbia County's rate of Diabetes hospitalizations in 2020-2022 was 4.4 times higher among Black non-Hispanic residents than White non-Hispanic residents (NYS CHIRE)
- Columbia County had the lowest rate in the region for cervical cancer screening in 2018, and ranked in the bottom 10 NYS counties (NYS Cancer Registry)
- Columbia County ranked in the bottom 10 NYS counties for prostate cancer incidence in 2019-2021 (NYS Cancer Registry)

Healthy and Safe Environment

- Columbia County had the lowest 2025 County Health Ranking in the Capital Region for the access to exercise opportunities measure
- Columbia County had the lowest rate in the region of children born in 2019 with at least two lead screenings by age 3 (NYS Child Health Lead Poisoning Prevention Program)
- Columbia County also had the second lowest rate in NYS for children born in 2019 who received at least one lead screening by the age of 2, with less than 1 in 2 children being screened for lead (NYS Child Health Lead Poisoning Prevention Program)
- Columbia County had the highest incidence rate in the region in 2022 of elevated blood lead level among children under 6 years (NYS Child Health Lead Poisoning Prevention Program)
- Columbia County had the highest emergency department visit rate in the Capital Region due to falls among older adults aged 65+ in 2021-2023 (NYS SPARCS)
- Columbia County had the highest ratio in the Capital Region of work-related injury emergency department visit in 2022, when comparing rates for Black non-Hispanic residents and White non-Hispanic residents (NYS SPARCS)
- Less than half of cooling towers in Columbia County were in compliance with NY's "Protection Against Legionella" regulation in 2023 (NYS Cooling Tower Registry)
- Columbia County had 0% of residents receiving optimally fluoridated water in 2023 (Safe Drinking Water Information System)

Infant and Maternal Health

- Columbia County had the highest rate infant mortality rate in the Capital Region in 2020-2022 (NYS Vital Records)

Mental Health and Substance Use Disorder

- Columbia County had the second highest rate of mental health hospitalizations in the Capital Region, in 2023, where a mental health condition was the primary diagnosis (NYS SPARCS)
- Columbia County had the highest self-harm hospitalization rate in the Capital Region for Black non-Hispanic residents in 2021-2023 (NYS SPARCS)
- Columbia County female residents had a 35% higher self-harm ED visit rate than male residents in 20212023 (NYS SPARCS)
- Columbia County had the highest suicide mortality rate in the Capital Region 2020 to 2022 (Vital Statistics)
- Columbia County had the highest opioid overdose mortality rate in the Capital Region in 2022 (Vital Statistics)

Infectious Disease

- Columbia County had the lowest percentage in the Capital Region for 13-year-olds who were fully immunized for Human Papillomavirus (HPV) in 2022 (NYS Immunization Information System)
- Columbia County had the highest Anaplasmosis and Babesiosis incidence rates in New York State in 2023 (NYS Communicable Disease Reports)

GREENE COUNTY

Sociodemographic

- Greene County had the highest percentage of population with less than a high school education in 2023, at 11.5%, compared to 8.3% or less among the other Capital Region counties (U. S. Census)
- Greene County had the lowest 2025 County Health Ranking in the Capital Region for the "some college" measure

General Health Status

- Total mortality rates in the Capital Region were highest in Greene County in 2022 (NYS Vital Statistics)
- Greene had the lowest percentage in the Capital Region of adults with a routine health checkup in the past year in 2021 (BRFSS)

Chronic Disease

- Greene County had the second highest rates in the region for daily sugary beverage consumption in 2021 (BRFSS)
- Greene County had the second highest age-adjusted rate in NYS for adults with current asthma in 2021 (BRFSS)
- Greene County had the lowest breast cancer screening rate in the region in 2021; one of the lowest rates in NYS (BRFSS)
- Greene County had the second highest rate in the region for breast cancer late-stage incidence in 2019-2021, and ranked among the bottom 10 NYS counties (NYS Cancer Registry)
- Greene County had the 5th highest breast cancer mortality rate in 2019-2021 among NYS counties with available data (NYS Cancer Registry)
- Greene County had the highest rate in the Capital Region for both colorectal cancer incidence and mortality in 2019-2021 (NYS Cancer Registry)
- Greene counties had the 6th highest lung cancer incidence rate in New York State in 2019-2021 (NYS Cancer Registry)
- Greene County ranked in the bottom 10 New York State counties for lung cancer mortality in 2019-2021 (NYS Cancer Registry)

Healthy and Safe Environment

- Greene County had the lowest 2025 County Health Ranking (among Capital Region counties) on the “injuries deaths” measure
- Greene County had the highest motor vehicle injury mortality rate in the Capital Region in 2020-2022(NYS Vital Records)
- Greene County had the highest assault hospitalization rate in the Capital Region in 2023 (NYS SPARCS)
- Greene County had the third highest percentage in the Capital Region in 2021 of adults who had reported having experienced at least two adverse childhood experiences (ACEs) (BRFSS)
- Greene County had the highest rate in the Capital Region of reports indicating child abuse or maltreatment in 2022 (National Child Abuse and Neglect Data System)
- Greene County had the third highest rate of chronic absenteeism in the Capital Region among students in first to eighth grade in 2024 (NYS Education Department)
- More than one in three economically disadvantaged students in grades one through eight in Greene County was chronically absent in 2024 (NYS Education Department)
- Greene County had the lowest percentage in the Capital Region of high school students in the Class of 2023 who enrolled at a postsecondary institution within 16 months of their high school graduation (NYS Education Department)
- Greene County had less than 1 in 8 residents living in a certified Climate Smart Community in 2024 (NYS Department of Environmental Conservation)
- Greene County had less than 1 in 15 residents receiving optimally fluoridated water in 2023 (Safe Drinking Water Information System)

Infant and Maternal Health

- Greene County Greene County had the lowest percentage in the region for births with adequate prenatal care in 2022 (NYS Vital Records)
- Greene County had the lowest percentage in the region for births with early prenatal care in 2022 (NYS Vital Records)
- Greene County had the largest disparities in the Capital Region for percent of births with adequate prenatal care in 2020-2022, when comparing Hispanic and White non-Hispanic residents (NYS CHIRE)

Mental Health and Substance Use Disorder

- Greene County had a low 2025 County Health Ranking (among Capital Region counties) on the “poor mental health days” and “Mental Health Providers ratio” measures
- Greene County had the highest rate of frequent mental distress in the Capital Region in 2021; the 4th highest rate of frequent mental distress in New York State in 2021 (BRFSS)
- Greene County had the third highest rate of mental health hospitalizations in the Capital Region, in 2023, where a mental health condition was the primary diagnosis (NYS SPARCS)

- Greene County had the highest rate in New York State for alcohol-related motor vehicle injuries and deaths (combined) in 2020-2022 (NYS Department of Motor Vehicles)
- Greene County had the highest cirrhosis hospitalization rate in the Capital Region in 2020-2022 (NYS SPARCS)
- Greene County had the highest cirrhosis mortality rate in the Capital Region in 2020-2022 (NYS Vital Statistics)
- Greene County had the highest drug overdose mortality rate in the Capital Region in 2024, based on National Vital Statistics System data
- Greene County had the highest opioid analgesic prescribing rate in the Capital Region in 2022 (Prescription Monitoring Program Registry)

Infectious Disease

- Greene County had the lowest rate in the Capital Region of children aged 24-35 months who had received the full seven-vaccine immunization series (NYS Immunization Information System)
- Greene County had the highest rate of Lyme Disease incidence in the Capital Region in 2023 (NYS Communicable Disease Reports)
- Greene County had the second highest Babesiosis incidence rate in New York State in 2023 (NYS Communicable Disease Reports)

d. Health Challenges and Associated Risk Factors

Columbia and Greene Counties share the same five leading causes of death. Columbia and Greene Counties' five leading causes of death in 2022 were as follows:

Cause of Death	Deaths per 100,000 Columbia	Deaths per 100,000 Greene
Heart Disease	146.7	183.8
Cancer	143.1	175.0
COVID-19	35.0	52.7
Chronic Lower Respiratory Diseases	29.0	31.3
Unintentional Injury	45.1	75.6

In addition to these causes of death, the Assessment highlighted that there are a number of other pressing health concerns in the community including, but not limited to:

- Addiction to Drugs or Alcohol
- Asthma

- Stroke
- Hunger & Food Insecurity
- Mental Health and Suicide
- Obesity & Diabetes
- Sexually Transmitted Infections
- Tick-borne Disease
- Tobacco Use & Vaping

i. Contributing Causes of Health Challenges

There are a number of factors that contribute to the health challenges experienced in Columbia and Greene Counties, including behavioral, environmental, socioeconomic risk factors, as well as the policy environment and other considerations. Each is discussed briefly below.

Behavioral Risk Factors

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

Environmental Risk Factors

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

Socioeconomic risk factors

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

Policy Environment

There is only a modest amount of work in the Twin Counties that is explicitly focused on policy. One example is the Tobacco-Free Action Program of Columbia and Greene Counties,

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

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

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

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

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

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

ii. Health Disparities

The Community Health Assessment examined whether the health status and outcomes of residents were influenced by particular attributes such as race/ethnicity, gender or age. Whenever the analysis indicated the existence of a disparity, that was noted. While the analysis did not find that there was a pattern related to *who* was differentially affected, there was a pattern to *where* they lived. Whenever a zipcode-level analysis was possible (which is rare, in our sparsely populated rural counties), it was clear that residents of high-needs neighborhoods fared more poorly.

The Area Deprivation Index (ADI), through the Neighborhood Atlas, ranks neighborhoods by adverse social exposome in a region of interest (e.g., at the state or national level), taking into account factors related to income, education, employment, and housing quality. The ADI is a scientifically validated measure of the adverse social exposome (i.e., neighborhood disadvantage) that can be used to evaluate and improve factors that impact health across populations.
https://www.neighborhoodatlas.medicine.wisc.edu/mapping

According to the Neighborhood Atlas, several areas of Greene and Columbia County show the highest ranked scores on the Area Deprivation Index (ADI). These geographic areas span both rural and urban neighborhoods. For the purposes of the community health improvement plan, these disadvantaged communities will be included for interventions.

Another consideration of health disparities is the level of health professional shortages in a geographic area, known as HPSAs. These Health professional shortage areas are numbered with higher numbers indicating a greater shortage. Greene County has a HPAS score of 16 for primary care and mental health and 12 for access to dental care. Columbia County's score for dental is 16 and Primary care 15. Access to primary preventive care services and mental health are a key consideration for this CHIP application. These higher shortage scores highlight the need to coordinate efforts between the hospital systems and the associated primary care clinics and the health departments.

HPSA Find

3. Community Assets and Resources

The following charts summarize the numerous health care assets, facilities and resources available to the Columbia-Greene Healthy People Partnership. They are loosely organized in lists that relate to some of the community's most pressing health concerns.

Assets related to Hunger, Food Insecurity, Obesity and Diabetes

Ancramdale Neighbors Helping Neighbors Association Food Pantry	
Columbia	Monday 2-5pm
Alliance for Positive Health Food Pantry	
Columbia	Monday & Friday, 10am - 12pm
Athens Community Food	
Greene	Tuesday 2-3pm; Wednesday 2-3:30pm; Thursday 4:30-5:30pm
Bryant Nutrition	
Columbia & Greene	Certified Diabetes Lifestyles Coaches, Nutritionist and Personal Trainers
	Offers Diabetes Prevention Program
	Specializes in nutrition education
Cairo Food Pantry	
Greene	Provides assistance to residents of Cairo-Durham school district once a month Tuesday 5:30-6:30pm
Catskill Food Pantry	
Greene	Open Friday 1-4pm
Chatham Area Silent Pantry	
Columbia	Monday and Tuesday 10a-12pm; Thursday 4-6pm; Friday 10a-12pm
Coxsackie Community Food Pantry	
Greene	Open Saturday 10-11am; Tuesdays 1-2pm; Thursdays 7-8pm
Catholic Charities of Columbia and Greene Counties	
Columbia & Greene	Providers of WIC (Women, Infant, and Children) Supplemental Nutrition Education Program
	Assistance with enrolling or recertifying for Supplemental Nutrition Assistance Program (SNAP), also known as food stamps
	Care management services through Adult Health Homes
Catholic Charities Food Pantry	
Columbia & Greene	Columbia: Monday 9a-12pm; Wednesday 12-5pm Greene: Tuesday 9a-12pm
Charlie's Pantry-Immaculate Conception Church	
Columbia	Saturday 10:30a-1pm
Christ Episcopal Church Food Pantry	
Columbia	Emergency Food Pantry available 24/7 outside of church
Church of St. Joseph Food Pantry	
Columbia	Every other Friday of the month 1:30-3:30pm (excl. holidays)
Columbia County Department of Health	
Columbia	Provides health educators who present nutrition education at various locations
	Assists with planning and coordination of school and community wellness initiatives
	Facilitates action-oriented planning meetings with community partners
	Delivers instruction on Tai Chi

Columbia County Recovery Kitchen	
Columbia	Prepares and delivers nutrient-rich, balanced meals to vulnerable adults and children who have been referred by county social service organizations, public school social workers, and the Columbia County Sanctuary Movement.
Columbia Opportunities	
Columbia	Emergency Food Pantry Monday-Friday 9a-3:30pm
Columbia Memorial Hospital	
Columbia & Greene	Columbia Memorial Hospital (CMH) operates an extensive primary care network engaged in nutrition related education and services.
Columbia County Sanctuary Movement	
Columbia	Meal Delivery service
Cornell Cooperative Extension of Columbia and Greene Counties	
Columbia & Greene	Nutrition Education and SNAP education
Community Action of Greene County	
Greene	Emergency food pantry Monday, Tuesday, and Friday 1:30-3:30pm
Copake Falls Mobile Pantry & Blessing Box	
Columbia	Pantry: One Friday a month 1pm - 4pm; Blessing Box: 24/7
Elizaville Food Pantry	
Columbia	Serving residents of Clermont, Germantown School District and Tivoli. Wednesday, 9am - 11am, call for extra distribution dates
Germantown Community Cupboard	
Columbia	Serving residents of Germantown School District and Tivoli Wednesday 1-4pm
Ghent Food Pantry	
Columbia	Monday-Thursday 9a-12pm
Greene County Department of Human Services	
Greene	Provides nutritious meals for seniors 60 years of age and older.
	Provides funding to community organizations to implement evidence based health initiatives.
Greene County Public Health	
Greene	Provides resources and links for prevention and health promotion to schools and community groups
	Facilitates action-oriented planning meetings with community partners
	Participates in Greene County Worksite Wellness Committee
Greene County Rural Health Network	
Greene	Provides seed money to local organizations in support of health programs that improve the health of Greene County residents.
Hannaford Supermarket Eventbrite Classes	
Columbia & Greene	Hannaford offers free in-store and online Dietitian services, including classes that offer the latest nutrition trends and products or concerns about diabetes, heart health, food allergies or other nutrition needs. A team of registered and licensed dietitians can be found at hannaford.com/dietitians.
High Hill Food Pantry	
Greene	Wednesday 3-4:30pm; Friday 11a-12pm

Hillsdale Blessing Box	
Columbia	Open 24/7
Hudson Free Community Fridges	
Columbia	Outside Kitty's and Lil Deb's Oasis, open 24/7
Philmont/Mellenville Food Pantry	
Columbia	Tuesday 10:30-11:30am and 5:30-6:30pm
Matthew 25 Food Pantry	
Greene	Emergency 3 day food pantry Sunday 1-3pm; Wednesday 6-8pm
Philmont Library Purpose Pantry & Community Fridge	
Columbia	Pantry: open 24/7; Fridge open during library hours: Mon/Wed/Fri 1pm-7pm, Tues/Thurs/Sat 10am-2pm
Prabhuji Mission Food Pantry	
Greene	Food distribution Wednesday 10a-12pm
Rock Solid Church Food Pantry	
Columbia	Thursday 11:30a-1:30pm; visit www.rocksolidchurch.net for summer schedule
Roe Jan Food Pantry	
Columbia	Friday 10a-12pm
Rolling Grocer 19	
Columbia	Year round, full-service grocery store located on 2nd street in Hudson, NY, offering fresh produce, dairy, bread, grains, meat, seafood, non-perishables, toiletries and other miscellaneous products. Also, operate a grocery store on wheels serving the broader Columbia County. Made affordable through a fair pricing system, similar to sliding scale.
Salvation Army: Hudson Food Pantry & Friendly Kitchen	
Columbia	Pantry: Friday 7:30am - 10am; Kitchen: Monday-Friday 11:30am - 12:30pm
Seventh-day Adventist Church Food Pantry	
Columbia	Every three months, drive-through pantry (Feb, May, Aug, Nov)
Sprouts at Zinnia's Dinette	
Columbia	Wednesday - Monday 11:30am - 8:30pm
St. Mark's Lutheran Food Pantry	
Columbia	Tuesday and Saturday 9a-12pm
Valatie Ecumenical Food Pantry	
Columbia	Monday 12-2pm; 1st, 3rd & last Wednesday 6-8pm; 2nd & 4th Saturday 9-11am
Veterans' Food Pantry	
Columbia	Monday - Thursday 9:30am - 1:30pm; Friday 9am - 1pm
Zion Community Pantry	
Columbia	2nd & 4th Tuesday 5:30-6:30pm; 1st & 4th Friday 12-1pm
Windham Community Food Pantry at Restoration Christian Fellowship	
Greene	2nd and 3rd Saturday of the month 9a-12p and Thursday in-between 5-7pm

Assets related to Mental Health, Addiction (including to Tobacco), and Suicide

American Foundation for Suicide Prevention (AFSP)	
Columbia & Greene	Provides resources and local community events regarding suicide prevention
Columbia Memorial Health	
Columbia & Greene	In-patient and out-patient psychiatric treatment Provides tobacco/vaping screening and cessation tools Prescribing Nicotine Replacement Therapy
Columbia County Department of Health	
Columbia	Provides resources and connections regarding mental health/suicide prevention Provides tobacco/vaping related education to the general public ATUPA Enforcement
Columbia County Mental Health Center	
Columbia	Mental Health Counseling Provide tobacco/vaping screening and cessation tools Prescribes Nicotine Replacement Therapy
Columbia County Sheriff's Office	
Columbia	Local Policy and Procedure Enforcement ATUPA Enforcement
Columbia Greene Suicide Prevention Coalition	
Columbia & Greene	Stakeholders in Columbia and Greene Counties combining efforts and data to identify gaps in mental health care
Columbia Greene Addiction Coalition	
Columbia & Greene	Resources and education available on tobacco/vaping use
Greene County Public Health Department/Family Planning	
Columbia & Greene	Provides resources and connections regarding mental health/suicide prevention Provides tobacco/vaping related education to the general public Provides Nicotine Replacement Therapy
Greene County Mental Health	
Greene	Provides tobacco/vaping screening and cessation tools
Greene County Sheriff's Office	
Greene	Local Policy and Procedure Enforcement ATUPA Enforcement
Mental Health Associations of Columbia and Greene Counties (MHACG)	
Columbia & Greene	Mental Health Counseling Provides tobacco/vaping screening and cessation tools
Mobile Crisis Assessment Team (MCAT)	
Columbia & Greene	Assessment and resources for community members in mental health crisis
Tobacco Free Action Communities of Columbia and Greene Counties (TFAC)	
Columbia & Greene	Local Policy change and Advocacy Education and Prevention Anti-tobacco local events
Tobacco Free Health Systems (St. Peters Health Partners)	
Columbia & Greene	Provider education on tobacco/vaping cessation and Nicotine Replacement Therapy Train the Trainer on tobacco/vaping cessation
Twin County Recovery Services (TCRS)	
Columbia & Greene	In school tobacco/vaping prevention education and assistance with cessation and treatment/tools Prescribes Nicotine Replacement Therapy

Questar BOCES	
Columbia & Greene	Collaboration with CCDOH and GCPHD to provide tobacco/vaping related education to students, faculty/staff, and family members of students

E. Community Health Improvement Plan/Community Service Plan (CHIP/CSP)

1. Major Community Health Needs

The Community Health Needs Assessment compiled data related to no less than 25 separate health issues in order to identify the community's major health needs. Data that was collected for each health issue included prevalence, incidence, ED visits, hospitalization, and mortality and was used to "score" each issue along the following dimensions:

Count	The number of people impacted
Rate	Compared to the rest of NYS (excluding NYC)
Trend	Change over time
Seriousness	The impact from behavior through mortality
Disparity	Differential impact on certain subpopulations

For instance, the health issues with the highest counts in Columbia and Greene Counties were Obesity, Depressive Disorder, and Smoking, while tick-borne diseases had the highest rates ratios when compared to the rest of the State (excluding NYC). The most concerning trends were related to the incidence of gonorrhea and babesiosis, as well as the ED visits for Substance Use Disorder, while heart disease and stroke were the issues of greatest seriousness. Finally, disparities were most pronounced when considering asthma and ED visits for assault.

Following a close examination of these various factors, it was determined that the community's most pressing health issues are as follows:

- Addiction to Drugs or Alcohol
- Asthma
- Cancer
- Heart Disease & Stroke
- Hunger & Food Insecurity
- Mental Health and Suicide
- Obesity & Diabetes
- Sexually Transmitted Infections
- Tick-borne Disease
- Tobacco Use & Vaping
- Violence

It is this list of health issues that were then further examined and discussed in order to identify the priorities that would be incorporated into the Plan.

2. Prioritization Methods

a. Description of prioritization process and community engagement

The Columbia-Greene Healthy People Partnership was led by the Columbia County Department of Health, Greene County Public Health, Columbia Memorial Hospital—collectively known as the "Columbia-Greene Planning Partners"—with support from the Healthcare Consortium, a local public health organization that serves Columbia and Greene Counties. The rural communities of Columbia and Greene Counties share a single community hospital and have similar demographic characteristics and health metrics, so the Planning Partners elected, as they had in previous cycles, to align their assessment and planning efforts and submit a Joint Plan. Two initial planning meetings were held on April 21 and May 5, 2025, respectively, during which Healthy Capital District (HCD) provided an overview of the data, survey findings, and scores related to the fifteen initial public health issues and received input from the partners. The Planning Partners discussed the data and survey findings, and the health issues themselves, and selected a shortlist of eleven health issues to present at the public prioritization meetings.

The first public prioritization meeting took place at Columbia-Greene Community College on May 19, 2025. In the first half of the meeting, the Healthcare Consortium provided attendees with a detailed overview of the NYS Prevention Agenda and the health issue prioritization process. Then, HCD provided a data snapshot for each health issue, which covered the number of people affected, how the prevalence rates compared to NYS (excluding NYC), and how rates have trended in recent years. After each health issue's data snapshot was reviewed, the Healthcare Consortiums facilitated a brief discussion to encourage attendees to supplement the data findings with their own professional insights. The second public prioritization meeting, held on May 22, 2025, at the Greene County Department of Emergency Services, followed the same format. Both public prioritization meetings garnered rich discussion that informed the rest of the Planning Partners' prioritization process. The materials presented at the public health issue prioritization meetings are posted on the HCD website. Community attendees at the public prioritization meetings represented the following organizations:

- Addictions Care Center of Albany
- Alliance for Positive Health
- Alzheimer's Association
- BOCES
- Cancer Services Program, St. Peter's Health Partners
- Catholic Charities of Columbia and Greene Counties
- Columbia County Community Services Board
- Columbia County Department of Human Services
- Columbia County Mental Health Center
- Columbia County Office for the Aging
- Columbia Greene Workforce Development Board
- Columbia Kitchen
- Columbia Memorial Hospital
- Columbia-Greene Addiction Coalition
- Columbia-Greene Community College Health Services

- Cornell Cooperative Extension of Columbia-Greene Counties
- Gateway Hudson Valley
- Greene County Community Action
- Greene County Community Services Board
- Greene County Department of Human Services
- Greene County Department of Social Services
- Greene County Public Health
- Greene County Rural Health Network
- Greene County Sheriff's Office
- Mental Health Association of Columbia-Greene Counties
- NYS Department of Health
- St. Peter's Health Partners
- Sun River Health
- The Healthcare Consortium
- The Mountaintop Cares Coalition
- Tobacco-Free Action of Columbia-Greene
- Tobacco-Free Communities, St. Peter's Health Partners
- Town of Cairo
- Town of Canaan
- Town of Catskill
- Twin County Recovery Services
- University at Albany

Based on the results of the prioritization process, the Planning Partners then hosted three focused group discussions on related groups of health issues, colloquially termed the "Belly" (hunger and food insecurity, nutrition and physical activity, and obesity and diabetes), the "Brain" (mental health, suicide, and substance use), and the "Breath" (tobacco use and vaping), based on commonalities between the health issues and the potential for overlap in the interventions. Representatives from community partner organizations that work on these issues were invited to participate in the discussions to gather additional information that would help them better understand the community's existing activities, assets and resources related to those issues. The "Brain" and "Breath" focused group discussions occurred on August 5, 2025, while the "Belly" group discussion occurred on August 7, 2025. The group discussions were well attended and garnered rich discussion on the issues and potential collaborative efforts. The Planning Partners reconvened on September 2, 2025, to review the information gathered in the focused group discussions and select Prevention Agenda priority areas, and again on September 16th to select interventions, related measures, and potential partner organizations to work with on their community health intervention plans. Based on the results of the focus group meetings and the prioritization process, which included data, survey, community partner, and organizational scoring, the Columbia-Greene Planning Partners selected the following Prevention Agenda priorities:

Domain	Priority
Economic Stability	Nutrition Security

Social and Community Context	Tobacco/E-cigarette Use
	Suicide

b. Justification for Unaddressed Health Needs

It should be noted that with the selection of some health issues as a focus of the Plan, there are other, equally important health issues that were not selected. Of note for our community were Addiction to Drugs or Alcohol, and Obesity and Diabetes. There were a variety of reasons for deciding against including these health issues in the Plan, including but not limited to:

- **Practical considerations** such as agency/staff capacity/competencies and the availability of resources. For instance, this informed the selection of Tobacco/e-cigarette use as a priority since public health education is a core function of the LHDs and they will be deciding how best to expense JUUL settlement monies during the same project period
- **Alignment** with other efforts that are planned or already underway. For instance, this informed the selection of Suicide as a priority, since the Columbia-Greene Suicide Prevention Coalition was recently revived. Additionally, many interventions place an emphasis on screening and referrals in the health system, which is already engaging in this work through the 1115MRT waiver.
- The **need for attention** and the **opportunity to lead** in areas where there currently is none. For instance, the Partners did not select Addiction to Drugs and Alcohol, despite this continuing to be a pressing concern for our community, because there is already a significant amount of time and tender already devoted to this issue; indeed, while the Hospital and Local Health Departments were early leaders in bringing attention to and organizing the community around this issue, that work can and will continue without their leadership. Conversely, this same consideration informed the selection of Nutrition Security as a Priority, since the many entities that are currently engaged in this work appear to be doing so with little consultation or collaboration with each other.
- And the **interconnectedness** of health issues that allows us to work both "upstream" from and "adjacent to" other health issues. This informed the selection of Nutrition Security, which would presumably have a positive effect on obesity and obesity-related diseases and also of Tobacco/E-cigarette use, as this is related to other serious health concerns in our area, such as asthma, COPD and lung cancer.

3. Developing Objectives, Interventions and Action Plan

a. Alignment with Prevention Agenda

The Planning Partners aligned this Plan with the 2025-2030 Prevention Agenda by selecting three priorities, one of which (Nutrition Security) is a social determinant of health. For each selected priority, the Partners selected one or more objectives, with two such objectives being SMARTIE. Finally, the Partners selected evidence-based interventions for each priority, with an emphasis on promoting health equity.

b. Action Plan

i. Actions and Impact

Local Health Department Actions and Impact

As it pertains to the **Priority Area #1: Nutrition Security**, the local health departments will have two areas of focus: ***Strengthen Food Security*** and ***Increase Access to Nutritious Foods.***

The Local Health Departments (LHDs) will pursue strategies to improve food security among households with limited financial resources, particularly those earning less than $25,000 annually. Their efforts will be centered on increasing access to affordable, high-quality food by developing and promoting inventories of local food access points, as well as expanding the use of food voucher programs such as FMNP and SFMNP.

The LHDs will also lead several community-focused initiatives to further advance nutrition security. This includes conducting periodic community needs assessments to identify high-risk areas where new or expanded nutrition programs are most needed. LHDs will convene and coordinate stakeholders – ranging from community organizations to food access advocates – to develop collaborative solutions that address hunger and food insecurity. These coordinated efforts are to align priorities, amplify resources, and support meaningful action.

Within **Priority Area #2: Tobacco/E-cigarette Use,** the local health departments will have two areas of focus: ***Reducing Tobacco/E-cigarette Use*** and ***Preventing Nicotine Addiction among Youth.***

The LHDs will concentrate their efforts on reducing youth tobacco/e-cigarette use, with an aim to lower the percentage of high school students using tobacco/e-cigarette products. LHDs will strengthen community-wide support for restricting minors' access to tobacco/e-cigarette products by working with schools, community-based organizations, retailers, and other partners. These efforts will be supported by monitoring the accessibility of tobacco/e-cigarette products in the community, including the number of purchase locations and the visibility of advertisements near places where youth gather.

In addition, LHDs will implement education initiatives to raise public awareness about the harms of tobacco/e-cigarette use and the benefits of tobacco/e-cigarette cessation treatment. This work will include community outreach events, distribution of educational materials, and promotion of digital resources through QR codes and website content.

With regard to **Priority Area #3: Suicide,** the local health departments will have two areas of focus: ***Reducing Suicide Mortality*** and ***Strengthening Community-wide Prevention.*** These strategies focus on early identification, improved access to crisis support, culturally relevant outreach, and enhanced workforce training.

The LHDs will work to expand training opportunities for community members, organizations, and groups so they can recognize the warning signs of suicide and respond effectively to individuals at risk. These trainings aim to build a broader network of informed community members who can intervene early and connect individuals to support. Progress will be measured through the number of trainings delivered and the number of people who complete them.

LHDs will also promote awareness and utilization of the 988 Suicide & Crisis Lifeline. This will include coordinated campaigns using social media, digital marketing, and other outreach channels to increase community knowledge of 988 as an immediate source of help. Progress will be tracked through data on campaign reach, such as number of views and number of website visits.

To address youth mental health, the LHDs will expand access to culturally relevant suicide prevention information, especially in underserved and historically marginalized communities where disparities in emergency department visits for self-harm remain significant. Engagement will be monitored through participation among community-based organizations, the types of promotion activities implemented, and metrics such as the number of outreach events, attendance, flyer distribution, and online engagement.

Hospital Actions and Impact

To address the **Prevention Agenda Priority #1: Nutrition Security,** CMH will focus on ***screening and referral*** and ***improving food quality in institutional settings***

With regard to screening and referral, CMH will conduct standardized screening of unmet Nutrition Security needs and provide referrals to state, local and federal benefit programs and to community-based, health-related social needs providers to address patients' unmet needs.

With regard to improving food quality in institutional settings, CMH will implement nutrition standards and food service guidelines for the meals and snacks provided during patient stays and sold in its cafeteria.

Additionally, CMH will support its partners at the LHDs as they convene and lead individuals and organizations that are working to address hunger and food insecurity in a collaborative learning and work effort.

With regard to **Priority Area #2: Tobacco/e-cigarette use**, the Planning Partners aim to reduce the percentage of adults and high school students who use tobacco products. To advance this goal, CMH will focus on ***screening, referral, and treatment.***

With regard to screening and referral, CMH will implement screening for tobacco use and refer patients to appropriate services in all of its health care practice settings.

With regard to treatment, CMH will provide access to tobacco cessation treatments, including individual, group, and telephone counseling, and FDA approved cessation medications

With regard to **Priority Area #3: Suicide,** the Planning Partners will aim to both ***reduce suicide mortality*** and ***reduce adolescent suicide attempts***. To advance these goals, CMH will promote and conduct comprehensive suicide prevention training for staff. Additionally, it will partner with the LHDs to provide training for community members, organizations and other groups, and improve the availability and access to culturally relevant information on suicide prevention and community resources, particularly to underserved and historically marginalized groups.

ii. Geographic Focus

The geographic focus for all activities will be Columbia and Greene Counties. As both counties are considered rural, the Planning Partners will focus heavily on ensuring that the activities outlined in the Plan reach into every part of this geography, with an emphasis on improving access for those in the more remote and isolated areas.

iii. Resource Commitment

LHD Resources to be Committed

The Local Health Departments are committed to providing staff time, community partnerships, and evidence-based interventions to support all the activities noted above. The resources that will be dedicated to community engagement and outreach, include the development and promotion of food access inventories, tobacco/e-cigarette prevention education, and suicide prevention messaging. Staff will support public awareness campaigns, distribute educational materials, and collaborate with community-based organizations, schools, and other partners to expand reach and impact, particularly in underserved and economically vulnerable populations. The LHDs will allocate resources toward assessment, data collection, evaluation, and dissemination. This includes conducting meetings, periodic community needs assessments to identify high-risk areas for food insecurity, monitoring youth access to tobacco/e-cigarette products, tracking suicide prevention training participation and outreach effectiveness, and reporting to NYSDOH and other entities.

Hospital Resources to be Committed

CMH is committed to providing adequate resources to support all the activities noted above. All of these efforts will require some measure of stewardship, including periodic meetings and less formal, ongoing communication to establish policies and procedures, evaluate performance, make mid-stream corrections as needed, and collect and report utilization data. CMH will support that stewardship, both by deploying its own staff to the efforts, as well as contracting for services to manage its obligations under the Community Services Plan, including

ongoing collaboration with the Columbia-Greene Planning Partners and the Healthy People Partnership, the collection of data related to implementation and performance of these activities, and reporting to NYSDOH and other entities.

iv. Participant Roles

There are a number of entities that are key to the successful implementation of the interventions noted above. Chief among these are the Greene County Food Security Coalition, the JUUL Settlement Workgroup, and the Columbia-Greene Suicide Prevention Coalition.

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

v. Health Equity

Residents of rural areas tend to be older, sicker and poorer than their urban and suburban counterparts, and the residents of Columbia and Greene Counties are no exception to that sad rule. Consequently, it could be argued that ALL the activities outlined in this Plan address the disparities in healthcare access and health outcomes that our rural residents experience simply as a function of their rurality. Nevertheless, the Planning Partners have chosen to narrow the focus of the efforts to reduce disparities and achieve health equity to those experiencing economic insecurity and to non-Hispanic Blacks. With regard to Nutrition Security, efforts will focus on individuals experiencing economic insecurity because the Partners recognize that accessing affordable and nutritious foods is more challenging for those who are impoverished. With regard to Suicide, the Partners noted that there were differential rates for visits to the Emergency Department for self-harm among non-Hispanic Blacks and therefore decided to focus on directing at least one intervention to this historically underserved and marginalized community.

4. Partner Engagement

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 two years. This approach reflects an ongoing commitment to working jointly—both across agencies and county lines--throughout the entire CHIP cycle. 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.

For their part, the Planning Partners intend to convene on a monthly basis to track progress on the implementation of the Plan and determine the need for mid-course corrections, if any.

5. Sharing Findings with the Community

The Executive Summary of this Community Health Improvement Plan/Community Service Plan/ ("the Plan") and the full document, including the multi-county Community Health 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 Assessment, will be posted on the website of each of the Planning Partners, as follows:

Columbia County Department of Health:
https://columbiacountynyhealth.com/about-us/

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

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

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

Lastly, an electronic copy of the Community Health Needs Assessment is available at https://www.healthycapitaldistrict.org/content/sites/hcdi/CHNA2025/CHNA_HCDI_2025.pdf.

Appendix A: CHA/CHIP/CSP Self-Assessment Checklist

Local Health Department/Hospital Name: Columbia County Department of Health
Greene County Public Health
Columbia Memorial Hospital

Service County: Columbia and Greene Counties

Date of Submission: December 17, 2025

Required Components	Met √	Not Met X	Page #
Cover page that includes a list of participating organizations, service area, type of plan (joint vs. individual), and contact details	x		1
Table of Contents reflecting all sections and subsections	x		2
Executive Summary as outlined in the guidance	x		3
Community Health Assessment (CHA)			
Describe service area and reflect the demographic profile of population	x		7-9
Describe socioeconomic, educational, and environmental factors tha affect health	x		8-9
Provide an overview of the population's health and identify factors tha contribute to health status and health challenges	x		8-9
Assemble and analyze secondary data and whenever possible primar data to describe the health status of the community	x		9-10
Compile and analyze trend data to describe changes in community healt status and in factors affecting health	x		11-15
Use scientific methods for collecting and analyzing data	x		9
Compare selected local data with data from other jurisdictions (e.g., loca to state, local to local)	x		24-25
Provide evidence of community collaboration in planning and conducting the assessment	x		24-25
Identify leading community health problems	x		23
Identify population groups at risk for health problems	x		18
Identify existing and needed health assets and resources	x		19-23

Community Health Improvement Plan (CHIP)/ Community Service Plan (CSP)			
Workplan Template:			
Utilize CHA findings to identify priorities	**x**		**23**
Follow workplan template instructions to select priorities, objectives, interventions, and measures	**x**		**24-25**
Submit Workplan in Excel format	**x**		
CHIP/CSP Narrative:			
Describe the process and criteria used to identify priorities based on the findings of the community health assessment	**x**		**23**
Describe the community engagement process that was used to select the new priorities	**x**		**24-25**
Justify unaddressed health needs	**x**		**26**
Select at least three priorities from the Prevention Agenda list. At least one priority should include social determinants of health factors such as Poverty, Unemployment, Nutrition Security, Housing Stability and Affordability, etc.	**x**		**27-29**
Develop objectives, interventions, and an action plan	**x**		**27-29**
Describe the process for monitoring plan progress with community partners and making mid-course corrections	**x**		**29**

Submission: Send the documents to prevention@health.ny.gov on or before December 31, 2025.
Additional Comments:
OLHS USE ONLY: **Date received:** **Date of initial review: Reviewer(s):** **Date of emailing feedback:**

Appendix B: Plan Overview

PRIORITY AREA #1: Nutrition Security		
	Domain	**Economic Stability**
Hospital	Objective 3.0	Increase consistent household food security from 71.1% to 75.9%.
	Intervention	Conduct standardized screening of unmet Nutrition Security needs and provide referrals to state, local, and federal benefit programs and community-based, health-related social needs providers to address unmet needs.
	Disparities Addressed	None
	Process Measures	● Number of patients screened ● Percentage of patients screened ● Number of screened patients referred ● Percentage of screened patients referred
Local Health Dept(s)	Objective 3.1	Increase food security in households with an annual total income of less than $25,000 from 42.0% to 51.1%.
	Intervention	Inventory and promote access points to get affordable, high quality, nutritious food, including expanding and promoting the availability of food vouchers and other opportunities for using entitlement dollars for food purchases.
	Disparities Addressed	Economic Insecurity
	Process Measures	● Number of clicks to online inventory ● Number of FMNP and SFMNP coupons distributed
Hospital	Objective 3.0	Increase consistent household food security from 71.1% to 75.9%.
	Intervention	Implement nutrition standards and food service guidelines for meals and snacks served in facilities, worksites, and institutions
	Disparities Addressed	None
	Process Measures	● Number of patients selecting the “featured” health option or the number of cafe sales for certain “healthy option” items
Local Health Dept(s)	Objective 3.0	Increase consistent household food security from 71.1% to 75.9%.
	Intervention	Implement periodic community needs assessment to prioritize the development of nutrition programs in high-risk areas
	Disparities Addressed	None
	Process Measures	● Track data collected and collection methods for needs assessments
Local Health Dept(s)	Objective 3.0	Increase consistent household food security from 71.1% to 75.9%.
	Intervention	Convene and lead individuals and organizations that are working to address hunger and food insecurity in a collaborative learning and work effort
	Disparities Addressed	None
	Process Measures	● Number of stakeholders engaged ● Number of stakeholder meetings convened ● Number of action items identified ● Number of action items pursued

PRIORITY AREA #2: Tobacco/E-cigarette Use		
Domain		**Social and Community Context**
Hospital	Objective 14.0	Reduce the percentage of adults who use tobacco products from 9.3% to 7.9%.
	Intervention	Provide access to tobacco cessation treatments, including individual, group, and telephone counseling, and FDA-approved cessation medications
	Disparities Addressed	None
	Process Measures	● Number referrals made to cessation treatment ● Number of people served by cessation treatments
Hospital	Objective 14.0	Reduce the percentage of adults who use tobacco products from 9.3% to 7.9%.
	Intervention	Implement screening for tobacco use and navigate to appropriate services (i.e. ask, advise, assist) in all health care practice settings
	Disparities Addressed	None
	Process Measures	● Participation among organizations of focus ● Number of people screened ● Number of successful referrals made
Local Health Dept(s)	Objective 14.1	Reduce the percentage of high school students who use tobacco products from 17.0% to 14.5%.
	Intervention	Advance community-wide support for restricting minors' access to tobacco products.
	Disparities Addressed	None
	Process Measures	● Participation rates among CBOs, schools, retailers, and other organizations of focus ● Degree of accessibility of tobacco products (# of purchase locations; # of visible advertisements, especially near congregation sites for youth)
Local Health Dept(s)	Objective 14.1	Reduce the percentage of high school students who use tobacco products from 17.0% to 14.5%.
	Intervention	Educate residents on the harms of tobacco and the benefits of tobacco-free treatment.
	Disparities Addressed	None
	Process Measures	● Number of outreach events and attendance ● Number of flyers distributed ● Number of QR code scans and website visits

PRIORITY AREA #3: Suicide		
Domain		**Social and Community Context**
Local Health Dept(s)	Objective 6.0	Reduce the suicide mortality rate from 7.9% to 6.7%.
	Intervention	Provide training for community members, organizations and other groups to identify and respond to people who may be at risk of suicide-on-prevention
	Disparities Addressed	None
	Process Measures	● Number of trainings provided ● Number of people trained
Local Health Dept(s)	Objective 6.0	Reduce the suicide mortality rate from 7.9% to 6.7%.
	Intervention	Promote calling or texting 988 through social media, digital marketing campaigns, and other utilized marketing strategies
	Disparities Addressed	None
	Process Measures	● Data on reach of promotion strategy (e.g. # of views; # of website visits; source of website visits, etc.)
Local Health Dept(s)	Objective 6.2	Reduce adolescent suicide attempts from 9.4% to 8.5% (New York State outside New York City).
	Intervention	Improve availability and access to culturally relevant information on suicide prevention and community resources, especially in underserved and historically marginalized communities.
	Disparities Addressed	Differential rates of ED visits for self-harm among Black non-Hispanic residents
	Process Measures	● Participation among CBOs in promotion activities, manner of promotion activities and data on reach (# of outreach events, # of attendees, # of flyers distributed, # of website clicks, etc.)
Hospital	Objective 6.0	Reduce the suicide mortality rate from 7.9% to 6.7%.
	Intervention	Promote and conduct comprehensive suicide prevention training for staff
	Disparities Addressed	None
	Process Measures	● Participation among health care organizations ● Number of trainings delivered ● Number of staff trained ● Capacity of staff to implement skills gained from training