HEALTHALLIANCE HOSPITAL

COMMUNITY HEALTH NEEDS ASSESSMENT AND COMMUNITY SERVICE PLAN

2025 – 2027

HealthAlliance Hospital
105 Marys Ave, Kingston, NY 12401

HealthAlliance Hospital

2025 – 2027 Community Health Needs Assessment and Community Service Plan

County/Counties covered in CHNA and CSP: Ulster County, New York

Participating Local Health Department(s): Ulster County Department of Health

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I. Introduction

HealthAlliance Hospital is a 162-bed, acute care hospital located in Kingston, New York. The Level III Trauma Center also houses a new emergency care center, a critical care/intensive care unit, a family birthing center and an advanced imaging center. HealthAlliance Hospital's mission is to provide the highest quality health care services to all people in its community and continue being the destination of choice for regional health care services. Additionally, HealthAlliance Hospital emphasizes compassionate, coordinated, patient- and family-centered care, striving to excel in clinical outcomes and patient experience while respecting patient rights and privacy.

The Community Health Needs Assessment (CHNA) process is an integral part of HealthAlliance Hospital's and WMCHealth's population health and community engagement efforts. The purpose of the CHNA and subsequent Community Service Plan (CSP) is to promote the evidence-based and prioritized agenda of health needs that has been co-created with community residents in support of this mission.

It should be noted that the relationship between the CSP and WMCHealth's Strategic Plan are not mutually exclusive. The CSP reflects efforts to align with both longstanding community needs and the State's initiatives to improve the social determinants of health among certain populations, while the WMCHealth Strategic Plan aims to bolster the shifting governance structure and offer a roadmap toward the long-term sustainability of the system.

About WMCHealth
WMCHealth is an 1,800-bed health care system headquartered in Valhalla, New York, with nine hospitals on seven campuses spanning 6,200 square miles of the Hudson Valley. WMCHealth employs more than 13,000 people and has nearly 3,000 attending physicians. Today, WMCHealth is the pre-eminent provider of integrated health care in the Hudson Valley, with Level 1, Level 2 and Pediatric Trauma Centers, the region's only acute care children's hospital, an academic medical center, several community hospitals, dozens of specialized institutes and centers, skilled nursing, assisted living facilities, homecare services and one of the largest mental health systems in New York State.

II. Executive Summary

As required by the New York State Department of Health (NYSDOH), HealthAlliance Hospital reaffirms its commitment to improving population health in Ulster County, as presented in this 2025-2027 CHNA/CSP. Also included as part of the CHNA/CSP is HealthAlliance Hospital's adopted Implementation Plan, which outlines our action plans to address the identified health needs in Ulster County.

To identify the most pressing health needs in its service area, HealthAlliance Hospital collaborated with the Greater New York Hospital Association (GNYHA) and the Mid-Hudson Region Community Health Assessment collaborative. After defining the service area, HealthAlliance Hospital collected and analyzed both secondary and primary data to understand health challenges faced by residents in their service area.

At the conclusion of the CHNA process, HealthAlliance Hospital aligned its action plans with New York's State Health Improvement Plan, more commonly known as Prevention Agenda 2025-2030, by targeting three public health prevention priorities:

Domain	Priority	Goal
Social and Community Context	Depression	Increase screening and treatment for depression to decrease prevalence. • *With a focus on individuals in the postpartum period*
Health Care Access and Quality	Preventive Services for Chronic Disease Prevention and Control	Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases. • *With a focus on cancer*
Economic Stability	Nutrition Security	Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods. • *With a focus on low-income households*

III. Community Background

Service Area Geography

HealthAlliance Hospital serves Ulster County, New York. Its primary service area is defined by federal guidelines, encompassing the smallest set of contiguous ZIP codes that account for 75% of hospital discharges.

Secondary data for this assessment were primarily drawn from the Mid-Hudson Regional Community Health Assessment, along with publicly available sources such as the New York State Community Health Indicator Reports Dashboard and the New York Behavioral Risk Factor Surveillance System. Internal hospital records were also incorporated to provide additional context. These data sources include service utilization trends, quality and safety metrics, and other operational indicators that offer a more comprehensive understanding of Good Samaritan Hospital's community impact.

Demographics

The demographic composition of a community significantly influences the health status and needs of its service area, shaping the types of services required to effectively meet resident's needs.

HealthAlliance Hospital's service area is home to 182,000 residents, with a near 50-50 population between people with male and female sexes. Ulster County has an aging population, with the most residents reporting their ages as falling between 60-69 years old. The county has a steady distribution of residents aged in their 30s (12.2%), 40s (12.7%) and 50s (12.2%), indicating fairly stable proportions of working-aged people. About three in four residents in Ulster County (73.5%) identify as white, 5.7% identify as non-Hispanic Black, 5.7% non-Hispanic American Indians and Alaska Natives, 5.7% as two or more races (non-Hispanic), and 2% Asian. Overall, Ulster County's non-Hispanic population is 88.2% and Hispanic population is 11.8%, according to demographic data.

Social Determinants of Health

Social determinants of health (SDOH) are defined as the social and physical conditions in which people are born, live, learn, work, play, worship, and age. Considerable research has shown these conditions have a significant impact on health and quality-of-life outcomes. Healthy People 2030, led by the U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion define SDOH in five categories: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.[5] These categories align with the New York State's Prevention Agenda 2025-2030, which sets forth state and local priorities through 2030.

The following section presents key statistics for Ulster County by category.

Economic Stability

Ulster County faces economic challenges that directly influence health outcomes, as financial insecurity limits access to healthy food, stable housing, and preventive care.

- About 5.1% of the aged 16 and older population was unemployed in 2023, which is slightly below the state average of 6.2%.
- The county's poverty rate in 2023 was 14.3%, compared to 13.7% of New York State residents overall.
- Among those living in poverty, 24.4% identified as Hispanic, 14.1% as Non-Hispanic Black and 4.9% identified as white (non-Hispanic) between 2018-2022.

Education Access and Quality

Education plays a critical role in shaping healthy behaviors, developing health literacy and clinical outcomes. Education access among Ulster County residents varied in 2023:

- Among residents, 17.1% reported having attended college but not earning a degree.
- More than 20% of residents have a bachelor's degree.
- About 17% of residents identified that they attained a graduate or professional degree.

Health Care Access and Quality

The majority of residents in Ulster County had access to health insurance in 2023. Among children, 3% lacked coverage compared to 8% of adults. Both percentages are lower than the national average. About 5.3% of adults in 2021 reported that they didn't receive medical care due to costs, suggesting persistent issues in affordability and coverage.

Neighborhood and Built Environment

- The environment where people live shapes their experiences including their opportunities and challenges. In Ulster County, there were 130.9 violent crimes per 100,000 residents in 2021, which is below the national average.
- Ulster County residents experienced an average daily density of fine particulate matter of 8 micrograms per cubic meter in 2020, much lower than the national average of 35 micrograms per cubic meter.
- Eighteen percent of Ulster County residents had severe housing problems between 2017 and 2021, which means they experienced a lack of complete kitchen or plumbing facilities, overcrowding and/or severe cost burdens.
- About 6.1% of the population had limited access to healthy foods in 2019, meaning they are low income and do not live close to a grocery store.

Social and Community Context

Disconnected youth are teens and young adults ages 16 through 19 who are neither in school nor employed. They may face structural barriers like poverty, unstable housing, discrimination, chronic illness or caregiving responsibilities, and they tend to have higher rates of:

- Depression, anxiety, and psychological distress
- Substance use and substance use disorders
- Chronic disease later in life
- Exposure to violence or trauma

In Ulster County, 9% of the population between 2019 and 2023 were identified as being a disconnected youth.

Community Health Status

Data related to the health status of the community was analyzed to better understand the needs of the service area. The following section provides key data on the health status of the Ulster County community.

Physical Activity and Nutrition

Physical activity and nutrition are risk factors for many chronic conditions including type 2 diabetes, obesity, and hypertension. Within Ulster County:

- Adults reporting daily consumption of at least one sugary beverage account for 19.4% of the population.
- Adults reporting daily consumption of less than one fruit and one vegetable account for 30.4% of the population.
- Participation in physical activity is high with 82.6% of adults reporting participating in physical activity in the last 30 days; the New York State average is 74.6%.

Chronic Disease

Chronic disease refers to health conditions that last one year or more, require ongoing medical care, and typically limit daily activities in some way. In New York State, chronic disease is a leading cause of disability and death. [i]Within Ulster County:

- Among adults, 32.3% are obese and 11.4% have physician diagnosed diabetes.
- The percentage of adult residents with physician diagnosed with high blood pressure is 27.8%.

Cancer

Cancer remains one of the leading causes of death in the United States and is often associated with premature mortality. Within Ulster County:

- In 2019-2021, the lung and bronchus cancer incidence rate was 56.3 per 100,000, and the breast cancer incidence rate among females was 142 per 100,000.
- Colorectal cancer screening compliance among adults 50-64 years old was 68.8%, higher than the New York State value of 65.4%.
- The percentage of adolescents aged 13 years with a complete HPV vaccine series is 20.1% which is significantly lower than the New York State average of 37.2%.

Mental Health

Mental health plays a key role in quality of life, yet mental illness is widespread, impacting roughly 1 in 5 adults. [ii] Fortunately, many mental illnesses can be managed with proper treatment and care. Within Ulster County:

- Adults reporting poor mental health for 14 or more days in the last 30 days account for 15.7%; the New York State value is 13.4%.
- Adults who report having a depressive disorder account for 24.1%, which is higher than the New York State value of 17.4%.

Maternal and Infant Health

Maternal health has become a central focus for government and healthcare initiatives in recent years. Within Ulster County:

- Late or absent prenatal care occurred in 5.3% of births. This percentage is similar to the New York State value of 5.4%.
- The infant mortality rate is 4.8 per 1,000 live births which is higher than New York States rate of 4.2.

IV. Community-Identified Needs

Community input was collected from residents served by HealthAlliance Hospital to ensure their perspectives informed this assessment. These insights, drawn from the Ulster County Department of Health (DOH) Survey, GNYHA CHNA Survey, and key informant interviews build on the secondary data collected to create a complete view of community health needs.

Ulster County Survey

HealthAlliance Hospital participated in a DOH survey, which looked at demographic data, social determinants of health, health conditions, health maintenance and trusted health care experts. Surveys were distributed through QR codes and paper copies at community events, in collaboration with county agencies and local nonprofits. Based on 356 responses from Ulster County residents aged 18 years and older, key insights include:

- **Economic security.** The majority of survey respondents (64.3%) own their home, have their own car (77.2%) and are never worried about running out of food (68.6%).
- **Digital access.** The vast majority of survey respondents in Ulster County have access to a cell phone (95.5%) and the Internet (91.4%).
- **Chronic health conditions.** High blood pressure (22.5%), cancer (20.5%) and diabetes (18.4%) are the top three health conditions impacting Ulster County residents.
- **Health risks and access**. Respondents identified that lack of access to health care (26.8%) and smoking or vaping (25.6%) were the highest risk factors impacting their families. Still, more than a fifth of survey respondents (23.2%) reported regularly visiting a doctor's office was the way they stay healthy.
- **Trusted messengers**. One in five survey respondents (21.9%) reported that their health care provider is their most trusted messenger for keeping people healthy. The state's health agencies followed suit at 19.6%, with friends and family coming in third at 17.8%.
- **Health behaviors and barriers.** Exercise (21.8%) and healthy diet (20.5%) followed as the top ways respondents said they stay healthy, though about a third (31.8%) of residents reported that they wish they exercised more. Three in ten residents (29.8%) reported that motivation was the top barrier to maintaining health, followed by money (15.5%), time (13%) and physical ailments (7.1%).

GNYHA CHNA Survey

HealthAlliance Hospital participated in the GNYHA Survey Collaborative's CHNA survey which helps hospitals collect community input to better inform the health needs of their service area. HealthAlliance Hospital, a participating hospital, distributed a web-based survey tool and a paper-based tool to collect data between June and July 2025. After compiling and analyzing survey responses, GNYHA provided HealthAlliance Hospital with data specific to its defined service area. Based on 356 responses from residents of HealthAlliance Hospital's service area, key insights include:

- **Respondent Demographics**
    - *Majority English speakers*: Of respondents, 91% reported English as their primary language, and 92% identified as white or mixed race.

  - *Middle income*: Among 194 respondents,[1] 65% reported incomes under $100,000. The majority of respondents (65%) reported incomes between $35,000 and $149,999.
  - *Retiree and insured population*: More than half of respondents[2] (52%) reported that they are retired, with 78% of the county reporting their age was 55 or older. Eighty-three percent of respondents receive their health coverage through Medicare (43%) or employer- or union-sponsored health care (40%). Of respondents, 6% receive health insurance through Medicaid.
  - *Highly educated women*: The vast majority of respondents (85%) have attended or graduated from college and are predominantly women (68%).
- **Overall Health Status**
  - *Majority in fair to very good health*: In response to ranking the overall health of the people in their neighborhood, 21% answered "fair," with 54% answering "good" and 20% responding "very good."
  - *Stronger physical health versus mental health status*: When asked to provide an indication of their physical and mental health, 42% said their physical health was "good" whereas 37% said their mental health was "good." Of those surveyed, a higher percentage of respondents noted their mental health was "excellent" (15%) compared to their physical health (3%).
- **Social Determinants of Health**
  - *Approximately a quarter of residents experience food insecurity or receive food assistance*: When asked if they currently receive food stamps or SNAP benefits, 7% indicated that they do. To further assess food insecurity in the region, respondents were asked: "During the past 12 months, how often did the food that you bought not last, and you didn't have enough money to get more?" Among respondents in HealthAlliance Hospital's service area, 18% answered 'Always,' 'Usually,' or 'Sometimes.'
  - *Less than a fifth experience housing insecurity:* In response to the question: "During the last 12 months, was there a time when you were not able to pay your mortgage, rent, or utility bills?" Of respondents, 15% in HealthAlliance Hospital's service area replied 'Yes.'
  - Survey participants were also asked about housing insecurity. In response to the question: 'During the last 12 months, was there a time when you were not able to pay your mortgage, rent, or utility bills?' Of respondents, 15% in HealthAlliance Hospital's service area replied 'Yes.'

Finally, community members were presented a list of 21 health issues and asked to rank each by level of importance and satisfaction with current neighborhood services addressing that issue. Responses were scored on a 1-5 scale (1 = not at all, 2 = a little, 3 = somewhat, 4 = very, and 5 = extremely). For each health issue, an average Importance Score and Satisfaction Score were calculated ranked from highest to lowest. These scores were then compared to the overall averages and categorized as Above Average or Below Average. The health conditions were then grouped into three priority levels: Needs Attention, Maintain Efforts, and Relatively Lower Priority.

The Relatively Lower Priority category includes health issues with a below average Importance Score. The Maintain Efforts category covers issues with above average scores for both the Importance Score and Satisfaction Score. The Needs Attention category includes health issues with above average Importance Scores and below average Satisfaction Scores. Table 1 highlights the health issues identified as Needs Attention and Maintain Efforts based on responses from HealthAlliance Hospital community members. The Appendix provides the complete list of results for all three categories.

Table 1. Ranking of Health Issues Categorized as "Needs Attention" and "Maintain Efforts"

[1] Of 356 respondents, 162 respondents declined to share income information.
[2] Of 356 respondents, 136 respondents declined to share employment status.

Needs Attention	
Neighborhood and Built Environment	Violence (including gun violence)
Social and Community Context	Mental health disorders (such as depression)
Economic Stability	Affordable housing and homelessness prevention
Neighborhood and Built Environment	Stopping falls among elderly
Health Care Access and Quality	Arthritis/disease of the joints
Health Care Access and Quality	Obesity in children and adults
Economic Stability	Assistance with basic needs like food, shelter, and clothing
Maintain Efforts	
Health Care Access and Quality	Cancer
Health Care Access and Quality	Dental care
Economic Stability	Access to healthy/nutritious foods
Health Care Access and Quality	Heart disease
Health Care Access and Quality	Women's and maternal health care
Health Care Access and Quality	Infectious diseases (COVID-19, flu, hepatitis)
Health Care Access and Quality	High blood pressure
Education Access and Quality	School health and wellness programs
Health Care Access and Quality	Diabetes and high blood sugar

The ranked health needs outlined in Table 1 provide a snapshot of residents' health concerns and expectations. Seven issues stood out as requiring increased focus: violence (including gun violence), mental health disorders (such as depression), affordable housing and homelessness prevention, stopping falls among the elderly, arthritis/disease of the joints, obesity in children and adults, assistance with basic needs like food, shelter, and clothing.

Nine additional issues were identified as important to maintain momentum on, including cancer, dental care, access to health/nutritious foods, and heart disease, among others. These selections suggest that while progress may be underway in these areas, continued investment is needed to ensure long-term impact. Respondents reported "Neighborhood and Built Environment" as the most important Social Determinant of Health category, and the "Health Care Access and Quality" and "Neighborhood and Built Environment" categories tied for highest satisfaction.

Key Informant Interviews

Key informants were chosen for their expertise in public health, their knowledge of local community health needs, their ability to represent the broad interest of HealthAlliance's service area, and their insight into the needs of medically underserved or vulnerable populations.

Key themes from interviews conducted included:

Mental Health
Key informants emphasized the growing acuity and complexity of mental health needs in the community, particularly around postpartum depression, anxiety, and co-occurring substance use disorders. Participants also stressed the shortage of behavioral health resources and a need for enhanced screening and follow-up care across the WMCHealth.

Chronic Disease
Key informants underscored the prevalence of chronic conditions and associated risk factors throughout the community, including obesity, cancer, and elevated rates of smoking. Notably, persistent disparities exist in cancer screening, diagnosis, and outcomes across the region. These disparities are especially pronounced among immigrant and Orthodox communities, as well as individuals facing language and transportation barriers, which impact both screening and vaccination uptake.

Nutrition Security
Food insecurity is a high-priority concern across all regions served by WMCHealth, impacting chronic disease management, treatment compliance, and overall health outcomes. Despite these challenges, WMCHealth has worked to address nutrition insecurity by integrating screening and support into clinical workflows and by partnering with local community organizations to connect patients with essential resources.

V. Priority Community Health Needs

Community health needs were developed based on:

- High prevalence or incidence of health issues (e.g., rates exceeding regional averages)
- Community-identified priorities gathered through the GNYHA survey and key informant interviews
- HealthAlliance Hospital's service profile and the broader WMCHealth's service profile

Health needs that appear in both primary and secondary data will form the final list of Identified Community Health Needs.

The IRS mandates hospitals to list the needs generated from this assessment in priority order. The criteria below guided the prioritization of the Identified Community Health Needs:

- Alignment with state and local priorities
- Alignment with WMCHealth's strategic plan, services, and capabilities
- Community scores and ranking
- Ability to drive measurable change and population health impact at scale

Using these criteria, the HealthAlliance Hospital community confirmed the final prioritized list of community health needs presented below:

Domain	Priority	Goal
Social and Community Context	Depression	Increase screening and treatment for depression to decrease prevalence. • *With a focus on individuals in the postpartum period*
Health Care Access and Quality	Preventive Services for Chronic Disease Prevention and Control	Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases. • *With a focus on cancer*
Economic Stability	Nutrition Security	Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods. • *With a focus on low-income households*

VI. Community Assets

Ulster County, New York is a rural community rich in community assets that support health and well-being. The county benefits from a strong network of educational institutions, healthcare providers, and public service agencies that play a vital role in supporting residents. Organizations such as SUNY New Paltz, Ulster County Community College, HealthAlliance Hospital, and Ellenville Regional Hospital contribute to the county's capacity to address health needs and promote wellness. Building on these strengths, HealthAlliance Hospital partnered with the Ulster County Department of Health throughout the CHNA process to develop this report and establish goals aimed at improving the health of the community.

HealthAlliance has chosen specific Prevention Agenda goals based on our internal expertise, resources, and the desire and commitment to improve the health and well-being of our community members. As no one entity can address all needs, community partners are essential to help achieve the Prevention Agenda goals. The following community agencies and coalitions are uniquely positioned to serve as community resources to meet additional community needs:

- Healthy Schools and Communities
- Family of Woodstock
- YMCA of Kingston and Ulster County
- Midtown Neighborhood Center
- People's Place
- Center for Women's Health Equity
- Family Services
- Ulster County's Center for Well-Being Crisis Support Center
- HealthAlliance Breast Center
- Refuah Health
- Sun River Healthcare
- Cornerstone
- HealthAlliance Hospital Patient and Family Advisory Councils
- Regional Engagement Community Health (REACH) Council

Impact since Last CHNA
During its last CHNA cycle HealthAlliance Hospital identified the following as prioritized health needs:

Priority: Prevent Chronic Diseases

- **Goal:** Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes, and obesity
- **Impact:**
    - Through diabetes care and education specialists, HealthAlliance Hospital reduced the average HbA1c each year for about 220 Medicaid patients – helping reduce costs associated with poor diabetic management, like the need for medication or emergency room visits.
    - The hospital looked at key metrics like participants' weight and body mass index, HbA1c levels, and the number of tests conducted for lipids, eye dilation and center visits.
    - HealthAlliance Hospital also provided additional support for Medicaid members with Type 2 diabetes to improve glycemic control and reduce their risk factors for cardiovascular disease.
    - The hospital referred about 40% of its patients over a three-year period to the American Diabetes Association education program, which helps patients engage in self-care behaviors.

Priority: Promote Healthy Women, Infants, and Children

- **Goal:** Reduce maternal mortality and morbidity
- **Impact:**
    - HealthAlliance Hospital aimed to decrease the rate of low-risk C-sections to less than 25%. To do so, the hospital enrolled and trained its obstetrics staff in an interactive online training program that promotes vaginal birth and fetal heart rate monitoring. It also conducted more consultations and encouraged expectant mothers to enroll in prenatal care aimed at increasing the rate of vaginal births.
    - The hospital looked at key metrics like the total number of deliveries, whether a pregnant person received prenatal, late or no prenatal care, if they abstained from alcohol or smoking, and risk factors that could complicate pregnancy or delivery, such as diabetes and hypertension, among other factors.
    - The C-section rate over the three-year period was between 31%-33%, higher than the stated goal of under 25%.
    - HealthAlliance Hospital reported "failure to progress" as the dominant reason why C-sections were performed.

Looking Forward

WMCHealth's 2025 CHNA reaffirms the System's deep and enduring commitment to the people of the Hudson Valley. The insights shared by residents, community leaders, and partner organizations have been invaluable in shaping a responsive, data-driven understanding of the region's evolving health

needs. As WMCHealth advances this work, it remains steadfast in its dedication to delivering high-quality, culturally competent care that honors the diversity, lived experiences, and voices of the communities it serves. The ongoing review of health data, combined with continued engagement of stakeholders, will remain foundational to planning and decision-making, ensuring that strategies are aligned with local priorities and that progress can be measured transparently through clear, accountable indicators of success. Through this sustained partnership with the community, WMCHealth will continue to strengthen its role as a trusted regional anchor, working collaboratively to promote equity, improve outcomes, and support the long-term well-being of the Hudson Valley.

VII. Community Service Plan

WMCHealth's vital mission is to provide the highest-quality care for all residents of the Hudson Valley regardless of the ability to pay. WMCHealth will build on its long tradition of delivering the most advanced services in the region by providing a fiscally sound network that ensures access to a coordinated continuum of care for its community.

HealthAlliance's CSP serves as a strategic roadmap for advancing our mission, health equity, and population health across our service area, particularly for historically underserved populations. As outlined in this plan, HealthAlliance is committed to reducing disparities through targeted outreach to uninsured, underinsured, immigrant, and rural populations; translating materials and providing bilingual support; and addressing geographic barriers to care.

HealthAlliance is focused on advancing community health through its mission and capabilities; however, no one organization can comprehensively address all health needs in its community. Recognizing this, HealthAlliance prioritized 2025–2027 initiatives based on the most prevalent health issues, community feedback from surveys and interviews, and alignment with its own and WMCHealth's service capabilities. Reasons some health needs were not selected include:

- Resource constraints
- Other facilities or organizations in the community are addressing the need
- Relative lack of expertise or competencies to effectively address the need
- A relatively low priority assigned to the need by the community

Significant health needs in the HealthAlliance community that will not be addressed are:

- Affordable housing and homelessness
- Obesity
- Arthritis/disease of the joints
- Dental care
- Heart disease
- Violence
- Stopping falls among the elderly
- Infectious disease

Over the next three years, HealthAlliance will advance the NYS Prevention Agenda by implementing evidence-based strategies across our service area to address the three selected priorities as outlined below. These priorities were identified through the comprehensive CHNA process, consisting of a review of secondary data, Greater New York Hospital Association survey responses, and key informant interviews with WMCHealth leaders in mental health, chronic disease, and nutrition security.

Domain	Priority	Goal(s)
Social and Community Context	Depression	Increase early identification and treatment of postpartum depression (PPD) among birthing persons
		Reduce substance use, misuse, overdose and/or associated harms.
	Preventive Services for Chronic Disease	Improve equitable access to cancer screening and diagnostic services across all regions

Health Care Access and Quality	Prevention and Control	Increase HPV vaccination rates and preventive education
Economic Stability	Nutrition Security	Increase identification and support for patients experiencing food insecurity
		Increase household food security for low-income households

For each priority area identified through the comprehensive CHNA process, HealthAlliance will publicly share executive summaries and progress updates via hospital and community websites, local events, and partner organizations, in accordance with NYSDOH requirements.

Priority 1. Promote Mental Health and Well-Being

Focus Area: Increase Screening and Treatment for Depression to Decrease Prevalence

Goal 1: Increase early identification and treatment of postpartum depression (PPD) among birthing persons

Target Population: Postpartum birthing persons across primary and secondary service areas of the Westchester Medical Center Health Network (WMCHealth) and partner hospitals

Objective:
By December 2027, achieve 100% screening for postpartum depression among all birthing persons at participating hospitals and affiliated outpatient clinics.

Intervention: Screening

- Implement universal, standardized depression screening at three key points:
  - Early prenatal care
  - Late prenatal care
  - Postpartum (using validated tools such as the Edinburgh Postnatal Depression Scale)
- Ensure screening is documented in both inpatient and outpatient settings, with electronic tracking and dashboards for real-time monitoring.

Intervention: Care Team Training and Workflows
Expand care team capacity to deliver initial treatment and follow-up for patients screening positive for PPD:

- Train OBGYNs, mid-level providers, and maternal-fetal medicine (MFM) physicians in reproductive psychiatry (e.g., through certificate programs and Project TEACH).
- Engage social workers to provide immediate support, SDOH screening, and care coordination.
- Develop a referral protocol and criteria for high-acuity cases to behavioral health specialists.

Timeline:

- By December 2025: Launch universal screening and tracking at WMCHealth's main campus; begin provider training at all sites.
- By December 2026: Expand screening and training to Good Samaritan, St. Anthony, Bon Secours, HealthAlliance, and Margaretville.

- By December 2027: Evaluate and report screening and referral compliance network-wide and by site.

Data to be Collected:

- Number and percentage of birthing persons screened for depression (inpatient and outpatient)
- Number and percentage of positive screens, stratified by severity
- Number and percentage of positive screens receiving initial treatment or referral, stratified by severity
- Demographic data (race, ethnicity, age, insurance status, SDOH needs)
- Provider training completion rates by program
- Patient follow-up and engagement rates
- SDOH screening, referral, and closed-loop referral rates

Key Partnerships:

- Westchester Medical Center OBGYN and behavioral health providers who will support screening, treatment, and training
- Social workers who will provide SDOH screening and care coordination
- Center for Women's Health Equity who will provide the reporting capabilities to track screenings and referrals
- Project TEACH who will provide training and support for mental health in maternal care

Goal 2: Reduce substance use, misuse, overdose and/or associated harms.

Objective:
Increase the number of unique individuals enrolled in OASAS treatment programs, who reported any opioid as the primary substance by 4%.

Intervention: Outreach

- Continue providing treatment at Bridgeback Comprehensive Outpatient Program ("Bridgeback") to provide medication-assisted treatment to individuals with substance use disorder.
- Partner with local health departments, community-based organizations, and behavioral health providers to expand outreach, referral pathways, and wraparound support services for individuals with opioid use disorder.
- Conduct targeted outreach to high-risk populations, including uninsured, underinsured, and rural residents, to increase awareness and access to treatment at Bridgeback.
- Integrate social determinants of health screening and care coordination into intake and ongoing treatment to address barriers such as housing, transportation, and food insecurity.

Timeline:

- By March 2026: Train additional staff and providers and conduct initial outreach.
- By December 2027: Evaluate and report enrollment and outreach efforts.

Data to be Collected:

- Number of unique individuals enrolled in Bridgeback and other OASAS treatment programs
- Primary substance reported at enrollment

- Demographic data (age, race/ethnicity, insurance status, geography)
- Referral sources and pathways
- Retention and completion rates
- Screening and resolution of social determinants of health needs

Key Partnerships:

- Westchester Medical Center behavioral health providers who deliver medication-assisted treatment and support referrals to Bridgeback
- Ulster County Department of Health who will facilitate outreach to high-risk populations
- Community-based organizations who will provide wraparound support services

Priority 2. Preventive Services for Chronic Disease Prevention and Control

Focus Area: Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases, with a focus on cancer

Goal 1: Improve equitable access to cancer screening and diagnostic services across all regions

Objective:
Increase the percentage of adults aged 45 to 54 years who are up to date on their colorectal cancer screening based on the most recent guidelines by 10 percentage points.

Intervention: Screening

- Expand monthly cancer screening events at Good Samaritan Hospital, Saint Anthony and Bon Secours Community Hospital.
- Engage the Medical Group to increase participation in colorectal cancer screenings.

Intervention: Collaborations

- Partner with New York State Cancer Services Program to ensure uninsured and underinsured populations receive screenings when needed.
- Collaborate with federally qualified health centers (e.g., Refuah Health, Sun River Health), County Departments of Health, and other community organizations for outreach and education.
- Continue translating screening materials into multiple languages (English, Spanish, Creole, Yiddish) and utilize American Cancer Society resources for culturally and linguistically appropriate education.

Intervention: Care Coordination and Provider Awareness

- Strengthen integration between primary care and oncology, ensuring patients are connected to a PCP and referred for appropriate screenings.
- Educate primary care providers about available screening services and referral protocols.
- Address EMR gaps to improve documentation and tracking of screening rates.

Timeline:

- By December 2025: Launch expanded screening events and outreach, begin EMR improvements, establish baseline screening rates
- By December 2026: Increase provider education and community partnerships and continue expanded screening events
- By December 2027: Evaluate and report change in colorectal cancer screenings

Data to be Collected:
- Number and percentage of eligible adults screened for colorectal cancer (by site)
- Demographic data (race, ethnicity, language, insurance status, geography)
- Number of outreach events and materials distributed
- PCP connection rates and referral rates
- EMR documentation and tracking improvements

Key Partnerships:
- Westchester Medical Center oncology providers and Medical Groups who will support screening and treatment
- Regional FQHCs and local Department of Health to provide community outreach and education
- New York State Cancer Services Program who will ensure uninsured and underinsured populations receive screenings

Goal 2: Increase HPV vaccination rates and preventive education

Target Population: Adolescents

Objective:
By December 2027, increase the percentage of 13-year-old adolescents with a complete Human Papillomavirus (HPV) vaccine series by 10 percentage points, with targeted outreach to communities with low uptake

Intervention: Targeted Outreach
- Track and promote HPV vaccination through GYN services and pediatric care.
- Partner with schools, community organizations, and local health departments for education and outreach.
- Address cultural and religious barriers to vaccination through tailored messaging and community engagement.

Timeline:
- By December 2025: Establish baseline vaccination rates and launch outreach campaigns.
- By December 2026: Expand partnerships and education efforts.
- By December 2027: Evaluate and report change in vaccination rates.

Data to be Collected:
- HPV vaccination rates (by age, site, and demographic group)
- Number of outreach events and educational materials distributed
- Community feedback and engagement metrics

Key Partnerships:

- Westchester Medical Center GYN and pediatric providers who will support vaccination efforts

Priority 3. Nutrition Security

Focus Area: Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods

Goal 1: Increase identification and support for patients experiencing food insecurity

Objective:
By December 2027, achieve 100% screening for food insecurity among all patients admitted to participating hospitals and outpatient clinics, with robust tracking and referral systems.

Intervention 1: Workflows

- Implement universal food insecurity screening as part of the SDOH assessment during nursing triage and case management.
- Use EMR (e.g., Cerner) to track screening responses and referrals, with regular reporting and data review.

Intervention 2: Care Team Training and Awareness

- Educate staff on sensitive, effective ways to ask SDOH questions to improve patient comfort and accuracy of responses.
- Provide ongoing training for nursing, case management, and care coordination teams.
- Consider integrating new evidence-based care team roles (e.g., diabetes educators).
- Expand use of remote patient monitoring capabilities.

Timeline:

- December 2025: Expand screening to all sites and care teams, reinforced by regular staff education and EMR tracking.
- December 2026: Monitor progress, and address gaps.
- December 2027: Evaluate and report screening and referral tracking.

Data to be Collected:

- Number and percentage of patients screened for food insecurity
- Number and percentage of positive screens
- Number and percentage of positive screens receiving referrals
- Demographic data (race, ethnicity, insurance status, geography)
- Staff training completion rates

Key Partnerships

- Social work, discharge planning teams, and nursing staff who can screen patients for food insecurity needs
- WMC IT teams who can support EMR advancement

Goal 2: Increase household food security for low-income households

Target Population: Households with an annual total income of less than $25,000

Objective: Increase food security in households with an annual total income of less than $25,000 by 10 percentage points.

Intervention 3: Food Supply

- Formalize partnerships with local food banks, food pantries (e.g., People's Place, Catholic Charities), and community-based organizations for direct referrals and resource sharing
- Develop on-site food support (e.g., food bags, fridge space for pantry partners, regular food supply rotation).
- Train patients to use food delivery apps (e.g., Instacart, DoorDash), especially for those experiencing mobility or transportation barriers.

Intervention 4: State and County Resources

- Collaborate with county agencies (DSS, Office for the Aging, SNAP, WIC) to provide on-site benefits enrollment support for eligible patients.
- Explore partnerships with home care agencies to extend food insecurity support post-discharge.
- Explore Medicaid funding and reimbursement mechanisms to support nutrition services such as on-site nutritionists/dieticians, diabetes educators, food prescriptions, remote patient monitoring, etc.

Timeline:

- December 2025: Map existing and potential partnerships and referral pathways; pilot on-site food support.
- December 2026: Expand formal partnerships and on-site enrollment support.
- December 2027: Evaluate and report referral success rates.

Data to be Collected:

- Number of patients referred to food resources
- Number of patients successfully connected/enrolled in SNAP, WIC, etc.
- Number of food bags or pantry supplies distributed
- Number of home care agency collaborations
- Patient feedback and satisfaction

Key Partnerships

- Social work, discharge planning teams, and nursing staff who can identify patients with food needs
- Local food banks, food pantries, and community-based organizations for food access
- County agencies for support enrolling patients in programs such as SNAP and WIC for food access

Appendices

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

Local Health Department/Hospital Name: HealthAlliance Hospital
Service County: Ulster County
Date of Submission:

Required Components	Met	Not Met	Page #
Cover page that includes a list of participating organizations, service area, type of plan (joint vs. individual), and contact details	✓		1-2
Table of Contents reflecting all sections and subsections	✓		3
Executive Summary as outlined in the guidance	✓		4-5
Community Health Assessment (CHA)			
Describe service area and reflect the demographic profile of population	✓		5-6
Describe socioeconomic, educational, and environmental factors that affect health	✓		6-7
Provide an overview of the population's health and identity factors that contribute to health status and health challenges	✓		8
Assemble and analyze secondary data and whenever possible primary data to describe the health status of the community	✓		6-12
Compile and analyze trend data to describe changes in community health status and in factors affecting health	✓		6-8
Use scientific methods for collecting and analyzing data	✓		6-8
Compare selected local data with data from other jurisdictions (e.g., local to state, local to local)	✓		6-8
Provide evidence of community collaboration in planning and conducting the assessment	✓		9-12
Identify leading community health problems	✓		12-13
Identify population groups at risk for health problems	✓		12-13
Identify existing and needed health assets and resources			13
Community Health Improvement Plan (CHIP)/Community Service Plan (CSP)			
Workplan Template:			
Utilize CHA findings to identify priorities	✓		16-22
Follow workplan template instructions to select priorities, objectives, interventions, and measures	✓		16-22
Submit Workplan in Excel format	✓		N/A

CHIP/CSP Narrative:			
Describe the process and criteria used to identify priorities based on the findings of the community health assessment	✓		12
Describe the community engagement process that was used to select the new priorities	✓		9-12
Justify unaddressed health needs	✓		16
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.	✓		16-22
Develop objectives, interventions, and an action plan	✓		16-22
Describe the process for monitoring plan progress with community partners and making mid-course corrections	✓		16-22
Briefly describe plans for disseminating CHA/CHIP/CSP reports to the public	✓		17
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: 2025 GNYHA Community Health Needs Assessment Collaborative, Ulster County, Importance and Satisfaction Rankings

SDOH Domain	Health Condition	Importance Rank*	Importance Score^
Need Attention			
Neighborhood and Built Environment	Violence (including gun violence)	5	4.25
Social and Community Context	Mental health disorders (such as depression)	6	4.24
Economic Stability	Affordable housing and homelessness prevention	8	4.14
Neighborhood and Built Environment	Stopping falls among elderly	9	4.12

Health Care Access and Quality	Arthritis/disease of the joints	13	4.01
Health Care Access and Quality	Obesity in children and adults	14	3.96
Economic Stability	Assistance with basic needs like food, shelter, and clothing	15	3.96
Maintain Efforts			
Health Care Access and Quality	Cancer	1	4.51
Health Care Access and Quality	Dental care	2	4.39
Economic Stability	Access to healthy/nutritious foods	3	4.38
Health Care Access and Quality	Heart disease	4	4.27
Health Care Access and Quality	Women's and maternal health care	7	4.17
Health Care Access and Quality	Infectious diseases (COVID-19, flu, hepatitis)	10	4.07
Health Care Access and Quality	High blood pressure	11	4.07
Education Access and Quality	School health and wellness programs	12	4.04
Health Care Access and Quality	Diabetes and high blood sugar	16	3.92
Relatively Lower Priority			
Health Care Access and Quality	Adolescent and child health	17	3.89
Social and Community Context	Substance use disorder/addiction (including alcohol use disorder)	19	3.76
Education Access and Quality	Access to continuing education and job training programs	21	3.64
Economic Stability	Job placement and employment support	22	3.56
Social and Community Context	Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	23	3.41

Health Care Access and Quality	Hepatitis C/liver disease	24	3.28
Health Care Access and Quality	HIV/AIDS (Acquired Immune Deficiency Syndrome)	25	3.17
Health Care Access and Quality	Sexually Transmitted Infections (STIs)	26	3.09
Health Care Access and Quality	Asthma, breathing issues, and lung disease	18	3.86
Health Care Access and Quality	Infant health	20	3.75

*How important is this issue to you?
^Rated on a 5-point scale from 1='Not at all' to 5='Extremely'

[i] "Chronic Diseases and Conditions". New York State Department of Health. Available here.
[ii] "Mental Health By the Numbers". National Alliance on Mental Illness. Available here.