New York State Department of Health

Health Equity Impact Assessment Template

Refer to the Instructions for Health Equity Impact Assessment Template for detailed instructions on each section.

SECTION A. SUMMARY

1. Title of project	Critical Access Hospital Designation Application
2. Name of Applicant	Columbia Memorial Health
3. Name of Independent Entity, including lead contact and full names of individual(s) conducting the HEIA	Sachs Policy Group (SPG) – 212-827-0660 • Aisha King, MPH aking@sachspolicy.com • Anita Appel, LCSW - AnitaAppel@sachspolicy.com • Maxine Legall, MSW, MBA - mlegall@sachspolicy.com Qualifications: • Health equity – 6 years • Anti-racism – 6 years • Community engagement – 25+ years • Health care access and delivery – 10+ years
4. Description of the Independent Entity's qualifications	The Health Equity Impact Assessment (HEIA) Team at Sachs Policy Group (SPG) is a diverse and experienced group dedicated to addressing health disparities and promoting equitable access to care. The team comprises experts with extensive backgrounds in health policy, population health, data analysis, community engagement, and anti-racism. They are committed to understanding and improving how social, environmental, and policy factors impact health equity, particularly for historically marginalized communities. The team collaborates with a wide range of health care organizations, government agencies, and communities to provide strategic support with an overarching goal of advancing diversity, equity, and inclusion. Their work encompasses research and evaluation of health programs and initiatives, stakeholder engagement, policy analysis, and development of mitigation and monitoring strategies. In particular, the team has experience analyzing policy proposals that impact medically underserved groups, such as Medicaid programs serving low-income individuals and maternal health initiatives that aim to reduce pre- and post-partum health disparities. They are dedicated to supporting organizations that serve vulnerable populations, including safety net hospitals,

	community health centers, long-term care organizations, behavioral health providers, child welfare agencies, and providers that support individuals with intellectual and developmental disabilities. The HEIA team is deeply passionate about improving the health care delivery system, especially for underserved populations. The team is unwavering in its commitment to promoting equity through rigorous research, insightful consulting, and strategic advisory work.
5. Date the Health Equity Impact Assessment (HEIA) started	August 20, 2025
6. Date the HEIA concluded	November 25, 2025

7. Executive summary of project (250 words max)
Columbia Memorial Hospital (CMH; dba Columbia Memorial Health) is a multi-campus health care system and member of the Albany Med Health System (AMHS), the largest not-for profit health system in northeastern New York and western New England. CMH is certified as a 192-bed acute care hospital and 38 primary and specialty care centers.[1] CMH operates the only hospital in Columbia County and the closest hospital to Greene County. CMH is experiencing significant operating deficits, requiring cash flow relief of approximately $1 million/month from AMHS. CMH has a three-pronged approach to regain financial stability and remain operational: 1. Expand inpatient behavioral health services with separate licensure; 2. Develop a renovated and expanded ambulatory surgical center; and 3. Seek Critical Access Hospital (CAH) designation. The current HEIA addresses the third prong. CAH designation requires hospitals to have a maximum of 25 inpatient medical/surgical beds (excluding psychiatric beds) and an annual average length of stay of 4 days. Inpatient and emergency services will not be impacted. CMH's average daily census for medical/surgical beds is 30-50, or ~21% of capacity. Census reduction will be achieved through improved discharge and a shift to ambulatory same-day surgeries.

[1] Although CMH is certified for 192 beds, the hospital does not and has never operated the 192 beds. They have a current operational capacity of approximately 75 beds. CMH merged with Greene County Hospital in the 1990s and all certified beds were consolidated at the time, leaving CMH with 192 certified beds.

CAH designation will give CMH access to a new reimbursement model that will reimburse based on the cost of care provided, with the goal of regaining financial solvency and reinvesting across the care continuum.

8. Executive summary of HEIA findings (500 words max)

Background research for this HEIA utilized data provided by the Applicant, census data, information and data from the Columbia and Greene Counties Community Health Needs Assessment/Community Service Plan, county and state reports, academic literature, and grey literature. As part of our meaningful engagement, we conducted interviews and focus groups with 41 individuals, including leadership and staff from CMH and AMHS, local community-based organizations, government officials, and community leaders. A survey sent to over 10,000 CMH patients and employees received 308 responses. We also attended three in person town halls held for employees, physicians, and community members.

The HEIA found that CMH's hospital is viewed as a critical asset to the community. While not everyone who participated in meaningful engagement supported the transition to a critical access hospital (CAH) designation, everyone was united in wanting to retain the hospital and critical healthcare services in the community. All stakeholders wanted the hospital to remain in the community, and CAH designation is expected to achieve that goal. Given the scale of the project, all medically underserved groups are expected to be impacted by this project.

Majority of stakeholders, particularly those who were familiar with the project, viewed this project as a necessary change that would allow the hospital to stay open and financially viable, while enabling CMH to reinvest in the healthcare system across the care continuum. Stakeholders raised concerns about job security, reduced local healthcare access, strained EMS and regional hospital capacity, care quality and patient safety, family visitation burdens, increased patient costs, and widespread misinformation. We believe that these concerns highlight the need for transparent and proactive communication and that they can be addressed appropriately by the Applicant.

Our assessment recommends that the Applicant address transportation barriers that this project may cause for patients, families, and staff; develop and implement comprehensive communication plans for staff and the general public; establish contingency plans for ED holding and seasonal census increases; and implement workforce retention strategies.

The project would additionally benefit from the Applicant leveraging existing relationships to proactively communicate plans, changes, and updates to employees, local providers, community leaders, and community members, emphasizing the need for this project, the hospital's overall goals, and projected positive impacts of the project.

Lastly, the Applicant should use existing metrics and mechanisms to track how the project impacts local health disparities. By systematically monitoring patient demographics, outcomes, and service utilization trends, the Applicant can continue to tailor services to meet the needs of its patient population.

SECTION B: ASSESSMENT

For all questions in Section B, please include sources, data, and information referenced whenever possible. If the Independent Entity determines a question is not applicable to the project, write N/A and provide justification.

STEP 1 – SCOPING

1. **Demographics of service area: Complete the "Scoping Table Sheets 1 and 2" in the document "HEIA Data Tables". Refer to the Instructions for more guidance about what each Scoping Table Sheet requires.**

   Please see attached spreadsheet titled "heia_data_tables_CMH_CAH.xlsx"

   Columbia Memorial Health's (CMH's) primary service area includes Columbia and Greene Counties.

2. **Medically underserved groups in the service area: Please select the medically underserved groups in the service area that will be impacted by the project:**

Due to the scale of this project, all medically underserved groups may be impacted:

- Low-income people
- Racial and ethnic minorities
- Immigrants
- Women
- Lesbian, gay, bisexual, transgender, or other-than-cisgender people
- People with disabilities
- Older adults
- Persons living with a prevalent infectious disease or condition
- Persons living in rural areas
- People who are eligible for or receive public health benefits
- People who do not have third-party health coverage or have inadequate third-party health coverage
- Other people who are unable to obtain health care

3. **For each medically underserved group (identified above), what source of information was used to determine the group would be impacted? What information or data was difficult to access or compile for the completion of the Health Equity Impact Assessment?**

We utilized data provided by the Applicant, census data, information and data from the Columbia and Greene Counties Community Health Needs Assessment/Community Service Plan, county and state reports, academic literature, grey literature, and interviews and surveys with leadership, staff, clinical experts, community providers, community members, and community-based organizations.

4. How does the project impact the unique health needs or quality of life of each medically underserved group (identified above)?

This project involves transitioning CMH's 192-bed acute care hospital into a 25-bed Critical Access Hospital (CAH) with separately licensed inpatient psychiatric beds. Notably, although CMH is certified for 192 beds, only 70 beds are fully staffed and in use. The Emergency Department (ED) will remain as is and continue to provide 24/7 care.

Concurrently, the Applicant plans to open an outpatient surgery center at Greene Medical Arts in 2027, expand Cardiac Care services at Greene Medical Arts, and add new psychiatric inpatient beds for adult and geriatric patients within the hospital campus. These projects have been addressed in prior HEIAs.

We expect the Applicant's proposal to become a CAH to impact all individuals in the service area in the following ways:

- Access to local inpatient medical/surgical beds will be reduced.
- ED wait times may increase.
- Travel times to receive care external to CMH may increase.
- Families of patients transferred to AMC may have a more difficult time visiting their family members.

However, we expect the increased reimbursement rate of the CAH designation to allow the hospital to remain open, maintain access to core services, reinvest in the community, and increase availability of primary care and key outpatient services.

The following section describes the medically underserved groups in the Applicant's service area and how the project may impact those populations specifically.

Older Adults[2]

Age Group	New York State	Greene County	Columbia County
<18	20.7%	16.4% ↓	16.3% ↓
18-64	61.9%	60.2% ↓	58.3% ↓
65+	17.4%	23.4% ↑	25.4% ↑

Columbia and Greene Counties both have aging populations, with the 65+ age cohort forecasted to grow 10% over the next 5 years.[3] Older individuals typically require more

[2] U.S. Census Bureau. (2023). https://data.census.gov
[3] Data provided by the Applicant

inpatient services than younger individuals and may face barriers navigating transportation systems, telehealth and digital health platforms, and the geographic complexity of Albany Med Health System's (AMHS) multiple locations. These challenges may result in delayed care-seeking, difficulty attending follow-up appointments, and complications coordinating transfers between facilities - concerns that are particularly acute for older individuals living alone who lack transportation or caregiver support.

Low-income people, individuals who are eligible for or receive public health benefits, and individuals who are under- or uninsured[4]

	New York State	Greene County	Columbia County
Median household income	$84,578	$74,011 ↓	$83,619 ↓
Poverty rate	13.7%	11.6% ↓	11.4% ↓
% on public insurance	41.4%	46.5% ↑	46.3% ↑
% Uninsured	5.2%	3.5% ↓	3.8% ↓

Greene and Columbia Counties both have lower median household incomes than NYS, and higher proportions of the population receiving public health insurance. Although the poverty rates of both counties are lower than that of NYS as a whole, they are higher than that of NYS when excluding New York City (NYC); 11.1%[5]. Notably, the city of Hudson has the largest non-White population (21.2%) and also the highest neighborhood poverty rate (17.4%) in the county.[9] Multiple stakeholders noted that the region's demographic changes (i.e., gentrification and second-home purchases by individuals from NYC) have negatively impacted local families' ability to purchase homes, afford rent, and access healthcare. In Columbia County, the percentage of children aged 5-17 years living in poverty ranges from 8.3% in Chatham Central School District to 21.5% in Hudson City School District. In Greene County, the percentage of children aged 5-17 years living in poverty ranges from 10.5% in the Greenville Central School District to 19.8% in the Windham-Ashland-Jewett Central School District.[6]

Individuals with lower incomes often face difficulties accessing healthcare due to cost-related barriers such as high out-of-pocket expenses, lack of healthcare providers who accept public insurance, and transportation challenges. This project may impact individuals with lower incomes or those with public insurance if they fear seeking care due to perceived emergency medical transportation costs or beliefs that they will be transferred to Albany Medical Center (AMC). They may also be impacted by limited ability to access transportation services to receive care.

Racial and ethnic minorities and immigrant populations[7]

[4] U.S. Census Bureau. (2023). https://data.census.gov

[5] Columbia-Greene Planning Partners. (2022). *Community Health Needs Assessment Implementation Strategy Community Health Improvement Plan and Community Service Plan for Columbia and Greene Counties, NY and their Hospital 2022-2024.* https://www.columbiacountynyhealth.com/wp-content/uploads/2022/12/2022-2024-CHIP-CSP_Columbia-Greene.pdf

[6] U.S. Census Bureau. (2022). https://data.census.gov

[7] U.S. Census Bureau. (2023). https://data.census.gov

	New York	Greene County	Columbia County
White	55.2%	84.8% ↑	83.7% ↑
Black/African American	14.8%	5.0% ↓	4.2% ↓
Asian	9.6%	1.0% ↓	2.3% ↓
Hispanic/Latino	19.5%	6.5% ↓	5.8% ↓
Foreign born	23.1%	4.9% ↓	6.8% ↓
Speak English less than very well (2018-2022)	6.7%	1.0% ↓	1.2% ↓

While the Applicant's service area is majority White, racial and ethnic minorities face disproportionate socioeconomic challenges that may increase their need for specialized health services. In Columbia County, 32% of Black Americans live in poverty compared to 10.5% of White residents, highlighting significant racial disparities in financial security and access to resources.[8] The city of Hudson, which has both the largest non-White population (21.2%) and the highest neighborhood poverty rate (17.4%), exemplifies the intersection of racial and economic disparities in the region. Barriers related to transportation and costs may particularly impact racial and ethnic minority individuals.

Local stakeholders identified several key immigrant populations in the area, including predominantly Hispanic seasonal migrant farmworkers, Haitian communities, and Bengali communities. The transition to CAH designation may create additional challenges for immigrant populations and individuals with limited English proficiency. Increased reliance on transfers to Albany Medical Center for specialized services may compound existing barriers related to navigating unfamiliar healthcare systems, coordinating transportation across greater distances, and communicating with multiple provider teams. For immigrant communities, particularly undocumented individuals, concerns about immigration enforcement during transfers or at larger hospital systems may deter care-seeking behavior or cause delays in accepting necessary transfers.

People with disabilities and/or prevalent infectious disease or condition[9,10]

	New York State	Greene County	Columbia County
% Living with disability	13.0%	14.8% ↑	13.9% ↑
Percentage of deaths that are premature (< 75 years)	42.9%	44.0% ↑	42.5% ↓
Diabetes mortality per 100,000 population, age-adjusted	19.5	25.0 ↑	26.8 ↑
Diseases of the heart mortality per 100,000 population, age-adjusted	170.6	195.2 ↑	163.7 ↓
Lung cancer incidence per 100,000 population, age-adjusted (2019-2021)	51.1	78.3 ↑	65.6 ↑

[8] PolicyMap. (n.d.). *Community Health Report: Columbia County, NY.* PolicyMap. Retrieved April 9, 2025, from https://www.policymap.com/

[9] U.S. Census Bureau. (2023). https://data.census.gov

[10] New York State Department of Health. (2023). https://apps.health.ny.gov

The percentages of Columbia and Green County residents living with a disability both exceed the state average of 13.0%. Many of these individuals are also older people over the age of 75. The most common types of disabilities are hearing difficulties, cognitive difficulties, ambulatory difficulties, self-care difficulties, and independent living difficulties.[11]

People with disabilities can face significant barriers to accessing health care services due to physical accessibility issues, transportation limitations, communication challenges (such as for those with hearing or cognitive impairments), and a lack of providers trained in disability-sensitive care. Additionally, individuals with cognitive impairments or mobility limitations may experience greater difficulty in navigating complex healthcare systems, leading to delayed or inadequate treatment.

Populations with disabilities, infectious diseases, and chronic conditions are at increased risk for needing intensive healthcare services. Therefore, these individuals may be impacted by the conversion to CAH if they are unable to be cared for at CMH and require transfer to another hospital.

People living in rural areas

Access to health care is particularly challenging in rural areas due to provider shortages, far distances between healthcare facilities, and limited public transportation.[12] Both Greene and Columbia Counties are predominantly rural, with many residents living in areas where health services are scarce or difficult to access. In Columbia County, 82.8% of the population lives in a low population density area, and Greene County has the lowest overall population and population density in the Hudson Valley region.

Rural communities experience higher rates of social isolation and economic hardship, which can contribute to untreated or worsening health conditions if untreated.[13] As mentioned above, the older adults who make up a significant portion of the rural population in these counties may face compounding barriers related to living in a rural area, such as mobility limitations, lack of internet, limited skills to access telehealth services, and challenges navigating complexity of novel and larger healthcare systems.

Transportation was the most commonly mentioned impact of this project by local stakeholders. There is significant concern that individuals in rural areas will have increased transportation times both to CMH's ED and to external hospitals, particularly if EMS systems face increased burden. There are not currently any public transportation systems that individuals in the local community can utilize to get to Albany.

Women & Lesbian, gay, bisexual, transgender, or other-than-cisgender people [14,15]

[11] American Community Survey 2015-2019
[12] Edwards A, Hung R, Levin JB, Forthun L, Sajatovic M, McVoy M. Health Disparities among Rural Individuals with Mental Health Conditions: A Systematic Literature Review. Rural Ment Health. 2023 Jul;47(3):163-178. doi: 10.1037/rmh0000228. Epub 2023 May 11. PMID: 37638091; PMCID: PMC10449379.
[13] Warshaw, R. (2017). Health disparities affect millions in rural US communities. Association of American medical colleges, 31. Accessed on [April 2, 2025] from https://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities
[14] U.S. Census Bureau. (2023). https://data.census.gov
[15] The Williams Institute. (n.d.). *LGBT statistics: Social services in ZIP code 36101 — economic*. University of California, Los Angeles. Retrieved August 24, 2025, from https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=SS&area=36101#economic

	New York State	Greene County	Columbia County
Cisgender women as % of total population	51.0%	48.0% ↓	49.0% ↓
Fertility (%) (*women who gave birth past year)*	4.9%	2.8% ↓	4.6% ↓
Marital status (%): Married	44.6%	47.6% ↑	53.0% ↑
Same-sex couples per 1,000 households	16.7	7.6 ↓	13.6 ↓

The transition to CAH designation may disproportionately impact women with cardiac and stroke emergencies, who face lower survival rates from out-of-hospital events compared to men. While emergency services will remain available, potential challenges with timely transfers to higher-level care facilities or diversions that increase time to specialized treatment could compound existing gender disparities in outcomes and recovery.[16] However, the planned development of an enhanced cardiac care center could help mitigate these concerns and improve prevention options and outcomes for women (and all patients) with cardiac care needs. Additionally, women are more likely to be primary caregivers and may face barriers accessing care due to caregiving responsibilities, transportation limitations, and financial constraints. The need to travel to more distant facilities for specialized care may create additional logistical and financial burdens for this population.

For lesbian, gay, bisexual, transgender, queer, or other-than-cisgender people (LGBTQ+), the transition could impact quality of care if there is inconsistent staff cultural competency across hospitals or reductions in on-site specialty services that LGBTQ+ patients disproportionately rely on.

All groups

Importantly, all medically-underserved groups will be positively impacted by the hospital remaining open and providing vital acute care services. The CAH model has proven viable for many hospitals across the state.

In response to the Department of Health's request for additional information, the Applicant has provided the information provided below:

Over the past few decades, rural hospitals in the U.S. have faced severe financial and systemic challenges, driven by low patient volumes, high proportions of Medicare/Medicaid patients, and changing policy environments. Nearly half of all rural hospitals are currently operating at a financial loss, resulting in widespread closures and critical service reductions.

The most prominent trends affecting rural hospitals include:

[16] Mody, P., Pandey, A., Slutsky, A. S., Segar, M. W., Kiss, A., Dorian, P., Parsons, J., … Morrison, L. (2021). Gender-based differences in outcomes among resuscitated patients with out-of-hospital cardiac arrest. *Circulation, 143*(7), 641-649. https://doi.org/10.1161/CIRCULATIONAHA.120.050427

- **Accelerating Closures and Conversions:** Since 2005, over 200 rural hospitals have either partially or completely closed, with rates far outpacing urban hospital closures. To avoid full closure, many facilities are converted to outpatient-only centers or Rural Emergency Hospitals (REHs), which do not offer inpatient beds.
- **Loss of Essential Service Lines:** To stay financially viable, hospitals have been forced to drop unprofitable, resource-intensive services. Between 2010 and 2023, nearly 300 rural hospitals discontinued obstetric (labor and delivery) units, and over 400 ceased offering chemotherapy services.
- **Shifting Payer Mix and Low Reimbursements:** Rural populations are older, face more chronic health conditions, and rely heavily on Medicare and Medicaid. However, these government payers typically reimburse hospitals less than the actual cost of care. Additionally, the rise of Medicare Advantage plans has introduced significant administrative burdens, delayed payments, and frequent care (payment) denials for rural providers.
- **Severe Workforce Shortages:** Geographic isolation, a shrinking local tax base, and difficulties in recruiting primary care physicians, surgeons, and nurses make staffing a persistent struggle.
- **Impact of Evolving Healthcare Policies:** Federal rule changes—including shifts in the Affordable Care Act (ACA) subsidies, and broader healthcare legislation—have added significant financial strain and mandatory staffing burdens to rural health systems.

In 2023, post pandemic, Columbia Memorial Health continued to realize substantial losses, and the health care system remained in flux while transitioning from the pandemic response to preparing for the future and grappling with our significant financial challenges. At that time CMH recommended to its legacy board that the way to move forward was to review and explore potential new hospital designations, models of care and population management opportunities. At the same time, we continued to see an increase in our mental health population. CMH began the process of recruiting consultants to evaluate the current state of our healthcare system and the market. This included an assessment of existing services, market demographics, current and future market demand for services and the competitive landscape to develop a list of key gaps and preliminary opportunities.

In 2025, we unveiled the guiding core principle of continuing the mission-based obligation of maintaining health care services in Columbia and Greene counties, which was fully supported by the Albany Med Health System Governing Board. Recognizing that no other Health Systems were serving Columbia and Greene counties and the high proportion of Medicare and Medicaid recipients that reside there, the consultants recommended that CMH implement a structurally redesign of its financial reimbursement model. This was recommended as the best way to facilitate sustainable transformational change and preserve care for these residents. The consultants

recommended a clear strategic vision for a new hospital designation, expansion of mental health beds, and creation of an ambulatory surgical center in Greene County. This three-pronged approach was explained as the single most effective way for CMH to improve its financial results.

The current hospital facility was built in a bygone era, and the distribution of clinical assets is mismatched to the current care needs of the Columbia and Greene populations. Today, eighty percent of the services provided at CMH are ambulatory services. There is little available capital to maintain the hospital's physical plant, and there is a huge need to modernize; none of which CMH can do with a lack of cash-on-hand and minimal capital funding.

Aging Facility Infrastructure – 1950s Mechanical, Electrical, HVAC, and Plumbing requires replacements (some of these systems have already been addressed) and the 1997 building needs mid cycle renovations in near future.

Clinical Obsolescence - Many existing inpatient, perioperative, and diagnostic spaces are undersized, functionally obsolete and/or have suboptimal layout, negatively impacting operations, quality, demand management, as well as the patient and provider experiences.

As a result, CMH is evaluating and prioritizing facility investments; assessing and prioritizing capital acquisition options that align with our market strategies and that optimize the current facility footprint. The Albany Med Health System is supporting this effort with three million dollars annually to manage immediate needs.

The hospital's structural financial deficits are due to a myriad of shortcomings: low Medicare and Medicaid payments; high levels of uncompensated care, patient bad debt and charity care; the lack of government payment programs in rural settings; the rising costs of labor, supplies, and drugs; insurance denials and delays, and high fixed costs that do not change with the number of patients that are in the hospital. The chart below shows CMH's annual net income loss, year over year, from 2013 through 2023 when we began our strategic planning process. As the table clearly shows, continuing losses year over year demonstrate a structural financial deficit. Additionally, market headwinds related to the local patient demographic changes (aged and stagnant), negative growth rates, an increasingly competitive environment, the poor condition of CMH facilities, and ongoing provider and non-provider staffing challenges, CMH's financial position and operations are fragile and keeping the status quo at CMH is simply unsustainable.

CMH Annual Net Income (Loss)

	Pre-Pandemic							Post-Pandemic			August
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Net Income	149,590	901,139	3,022,484	(2,805,554)	1,438,701	2,154,884	591,500	11,129,495	7,453,216	(16,072,330)	(10,486,129)
Non-Operating Activity											
Investment Income	2,794,293	801,416	164,176	1,518,146	2,055,767	(123,361)	(286,837)	811,730	2,375,796	(3,109,035)	2,855,673
Kaaterskill Care	(550,492)	(949,488)	4,002,665	(36,163)	-	-	-	-	-	-	-
Addis Donation	-	1,480,121	-	-	-	-	-	-	-	-	-
MLMIC	-	-	-	-	-	3,381,222	6,106,058	-	-	-	-
DSRIP	-	-	-	-	-	-	-	6,692,623	5,867,757	-	-
COVID-related funding	-	-	-	-	-	-	-	16,396,000	2,677,317	4,834,734	-
Operating Loss	(2,094,211)	(430,910)	(1,144,357)	(4,287,537)	(617,066)	(1,102,977)	(5,227,721)	(12,770,858)	(3,467,654)	(17,798,029)	(13,341,802)
Non-Core Mission Activity in Operating Results											
340B			2,724,240	3,792,578	6,472,490	8,606,300	7,849,872	5,894,194	4,996,504	1,829,305	1,356,386
Meaningful Use	1,955,274	1,130,229	648,125	250,493	154,493	327,536	85,000	-	-	-	-
DSRIP			-	1,303,329	1,177,740	1,882,101	1,311,430	961,343	430,895	-	-
Net Healthcare Operation	(4,049,485)	(1,561,139)	(4,516,722)	(9,633,937)	(8,421,789)	(11,918,914)	(14,474,023)	(19,626,395)	(8,895,053)	(19,627,334)	(14,698,188)

Transformative change is necessary, but it will require incremental investment, creativity, and time; there are no quick wins that will fundamentally alter CMH's financial outlook. Maintaining local emergency, general acute/inpatient, and psychiatric care is critical for the 111,000 residents of Columbia and Greene counties. CMH is indispensable to the community, and the goal should be to keep care local whenever clinically appropriate and financially feasible. Pursuing a special federal designation may provide financial support and influence target average daily census and inpatient programming. While CMH may not be able to achieve breakeven operations as a standalone entity, transforming its operating model and rebasing its cost structure are essential to avoiding crippling losses in the near future, absent major reimbursement reform. CMH should pursue all available state, federal, and philanthropic funding opportunities, as funding availability will shape what can be achieved. CMH has applied for multiple grants and received awards, including VAP funding, a Statewide Transformation III award providing $5 million to support Greene County expansion, and $5 million to support mental health expansion; additional rural grants have also been pursued. Immediate action was taken to stabilize and then optimize CMH's current operations, demonstrating responsible stewardship of grant and philanthropic funding as the organization transforms services for the community.

CMH also reviewed outpatient assessments for improved reimbursements.

- An RHC is a clinic located in a rural, medically underserved area that has a separate reimbursement structure from a standard medical office
    - RHCs can be public, nonprofit, or for-profit healthcare facilities; however, they must be located in a non-urbanized area, as defined by the U.S. Census Bureau, and located in a federally designated shortage area (MUA, HPSA, or HPSP)

- RHCs must be “primarily engaged,” that is, at least 51 percent of the services provided, in non-behavioral/mental health services
- RHCs must employ an Advanced Practice Provider (APP), which includes a physician assistant (PA), certified nurse midwife (CNM), and/or nurse practitioner (NP), for at least 50% of the time that the practice is open to see patients
- Starting on April 1, 2021, all new RHCs established after December 31, 2020, shall be reimbursed by Medicare based on reasonable cost with an upper payment limit (UPL)
    - In 2025, at $152 per visit; in 2026, at $165 per visit; in 2027, at $178 per visit; in 2028, at $190 per visit;
        - In subsequent years, the rate will increase based on the Medicare Economic Index (MEI) for primary care services
- NY Medicaid pays RHCs a capped all-inclusive rate, with a capital cost add-on, to RHCs owned and operated by a hospital
    - In 2023, the capped rate was $235.57 in the Columbia service area plus a capital cost add-on
- CMH selected the following practices based on those currently operated by Columbia that could benefit from a Rural Health Clinic (RHC) designation:
    - Rapid Care Catskill (Catskill), a free-standing health clinic (FSHC) located 10 Grandview Ave., Catskill, NY 12414
    - Lafayette Family Care (Lafayette), a FSHC located at 24 Lafayette Ave., Coxsackie, NY 12051
    - Main Street Family Care (Main), a FSHC located at 130 Main St., Cairo, NY 12413
    - Tannersville Family Care (Tannersville), a FSHC located at 6225 NY-23A, Tannersville, NY 12485
- The following presents the net financial impact on the system if it converted the practices to RHCs under Columbia
    - Since these practices are all FSHC, they would be newly eligible for participation in the 340B program as RHCs and the 340B benefit is included in the final impact
    -

Summary	FSHCs			RHCs		
Payor Data	Payment / Visit	Visits	Revenue	Payment / Visit	Visits	Revenue
Practice Impact						
Medicare	$ 126.69	10,389	1,316,191	$ 119.57	10,389	$ 1,242,198
Medicaid	105.16	8,889	934,755	248.07	8,889	2,205,094
Average	$ 116.76	19,278	$ 2,250,945	$ 178.82	19,278	$ 3,447,292
Hospital Impact						
CAH Impact			$ -			
340B Program			-			424,260
Total Hospital Impact:			$ -			$ 424,260
Total Revenue:	$		2,250,945	$		3,871,552
Variance With Current State				**$**		**1,620,607**

CMH has applied to Columbia County and has been surveyed at the centers listed and awaiting final approval letters from Medicaid and has approval from Medicare.

- Chatham Ghent Family Care 31 Dardess Drive Chatham, NY 12037

- Valatie Family Care, 2827Route 9 Valatie, NY 12184
- Kinderhook Medical Care 2827 Route 9 Valatie, NY 12184
- Valatie Pediatrics 2827 Route 9 Valatie, NY 12184
- CMH Rapid Care 2827 Route 9 Valatie, NY 12184
- Callan Family Care283 Mountain View Road Copake NY 12516

Today Columbia Memorial Health's Current Medicare designation is "Rural Referral Center"

CMH has received the Alternative Medicare Designation as a Rural Referral Center since 2002. Although there is no additional Medicare reimbursement benefit, as there is with CAH and SCH designations, the RRC designation offers certain flexibility with other Medicare programs.

- Eligibility for the 340B program with a DSH percentage greater than 8%. (Acute Care Hospitals without special designation must be at least 11.75%)
- Waiver of certain wage requirements when applying for a Medicare Wage Index reclassification. This has been leveraged in recent years to reclassify when otherwise not eligible. With the increase in the Rural Floor in New York State, it is financially advantageous to remain as a Rural NY Hospital with no Wage Index reclassification. There may be a point in the future where the RRC status would be helpful in leveraging Wage Index reclassifications should the Rural floor decrease.

CMH previously qualified as an RRC under the alternative criteria for eligibility but would be challenged to requalify if the RRC status was cancelled as the status applies to hospitals with 275 or more beds.

CMH has reviewed all possible and appropriate federal designations prior to submitting its application to the NYSECON for a Critical Access Hospital. The decision was based on the following findings.

<u>Potential Designation:</u> Sole Community Hospital (SCH)

Requirements:

- Be located more than 35 miles from other like hospitals, or, if closer than 35 miles, meet alternative criteria regarding accessibility to other like hospitals: severe weather, topography, or travel time of 45 minutes or more.
- No more than 25% of residents from primary service area who become inpatients are admitted to other hospitals located within a 35-mile radius
- No maximum number of beds or ALOS requirements

Process:

- Wellpoint Federal would review our application and supporting data and send the application to CMS with a recommendation for their consideration.

Reimbursement:

- SCH's receive reimbursement based on hospital cost structure vs. traditional Medicare PPS payment, receiving the most advantageous payment amount in the comparison of the two.
    - Currently, CMH's traditional Medicare PPS payment exceeds the Hospital Specific Payment as a SCH, yielding no financial benefit.
    - Due to wage index increases, the Inpatient Federal Specific Payment remains higher than the Hospital Specific Payment
    - Separately, If downward volume trends exceed 5% in any given year, CMH is eligible for a low-volume adjustment payment
- Sole Community Hospital's 340B eligibility is consistent with CMH's current Medicare Designation (>8%), so 340B eligibility would not be different under this program.
- However, the 340B orphan drug discount requires a DSH percentage of 11.75%. CMH's DSH percentage in 2025 was 12.37%, a decrease from 2024's percentage of 13.52%.
- Outpatient APC reimbursement would increase 7%, or approximately $1.8m - $2m annually based on 2025 Medicare FFS and Medicare Managed Care.
- The Federal DSH award is capped at 12%. CMH's DSH percentage was 12.37%, resulting in a $12k reduction annually based on 2025 data.

Conclusion:

- CMH continues to focus efforts on Outpatient growth and serves a high percentage of Medicare-eligible patients. The 7% increase in Outpatient OPPS payments would be financially beneficial, up to $2m annually at current volumes. The concern is we see a decrease in volume year by year and the ambulatory space is growing.
- The DSH eligibility threshold of 8% will ensure CMH is able to retain 340B program savings.
- The financial analysis does not suggest an immediate financial benefit on the Inpatient side; there is the possibility of a future opportunity with CMH's cost increasing, however, it is not enough to offset the current financial losses.

<u>Potential Designation:</u> Medicare Dependent Hospital (MDH)

Requirements:

- Located in a Rural area as defined by Medicare.
- It has fewer than 100 beds.
- At least 60% of Hospital discharges are Medicare patients, including inpatient behavioral health.
- Must qualify 2 out of 3 years on a rolling basis and continue qualifying to retain status.

Process:

- Request change of status to MDH through Wellpoint Federal.

- Rolling qualification requirements based on annual cost report filings.

Reimbursement:

- MDH's receive reimbursement based on hospital cost structure vs. traditional Medicare PPS payment, receiving the most advantageous payment amount in comparison of the two.
    - Currently, CMH's traditional Medicare PPS payment exceeds the Hospital Specific Payment as an MDH, yielding no financial benefit.
    - Increasing industry costs and trend factors could show a financial benefit in future years, as the gap between Federal Specific Payments and CMH costs
    - Separately, if downward volume trends exceed 5% in any given year, CMH is eligible for a low-volume adjustment payment.
- CMH's 340B eligibility would be in jeopardy as an MDH, due to the increased DSH requirement of 11.75% for 340B eligibility. CMH's DSH percentage was 12.37% in 2025.

Conclusion:

- It is recommended that *this re-designation* ***not be*** *pursued due to* the negative financial consequences of potentially losing 340B eligibility.
- CMH has fluctuated with some recent cost report years showing Medicare payor mix less than the required 60%, which would put CMH at risk of not being able to requalify for this status.
- CMS has considered eliminating/modernizing the MDH designation since 2018.
- There is no financial benefit as the current Medicare payment exceeds the Hospital-specific payment.

<u>Potential Designation:</u> Critical Access Hospital Designation

- A Critical Access Hospital (CAH) is a federal designation under the Rural Hospital Flexibility Program (FLEX) that provides cost-based reimbursement for eligible Medicare services, and in NY, provides cost-based reimbursement for eligible inpatient acute Medicaid services. The purpose of the CAH designation is to ensure that people enrolled in Medicare and Medicaid have access to healthcare services in rural areas, particularly hospital care
- Each CAH must comply with the following conditions of participation (COPs):
    - Must be located in a rural area,
    - Must offer Emergency Services:
        - Offer 24-hour emergency department, laboratory, and diagnostic x-ray services
    - Inpatient Bed Limit:
        - Operate with 25 or fewer inpatient beds
    - Average Length of Stay: Maintain an average length of stay of less than 96 hours for inpatient acute care services
    - Distance Criteria:

- Meet federal distance requirement that a CAH must be at least a 35-mile drive on primary roads or 15 miles on secondary roads to the nearest hospital or CAH

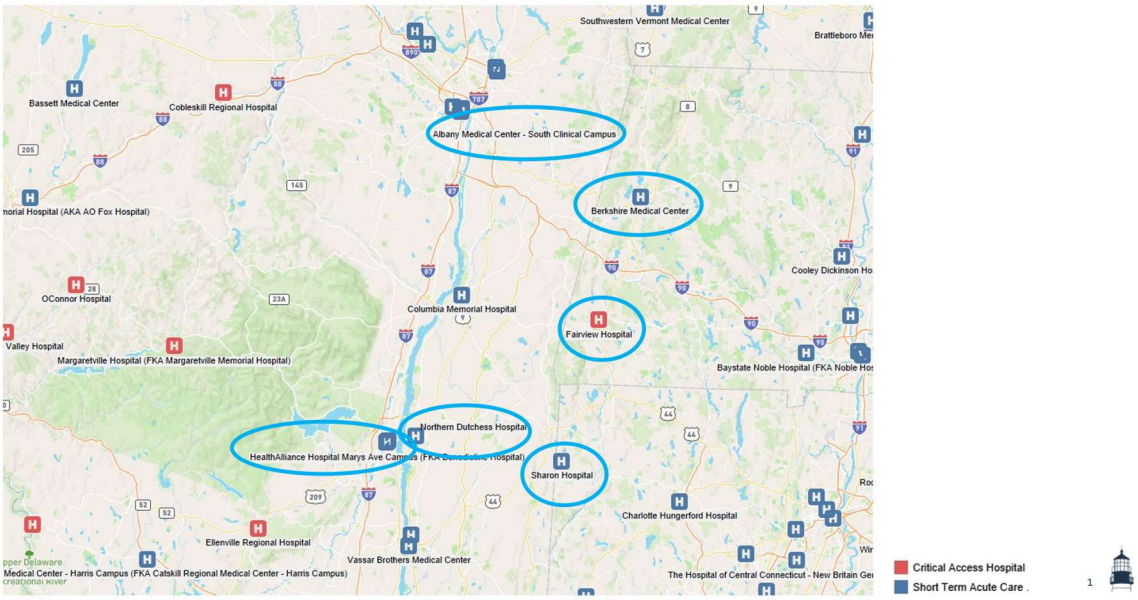
Process:

- CMH would need to be certified by the NYS Department of Health against the Conditions of Participation for a CAH and be designated by the State as a CAH (different than a general acute care hospital).
- CMS subsequently recognizes the CAH designation and provides funding in accordance with the CAH reimbursement methodology.

Evaluation of Distance Criteria:

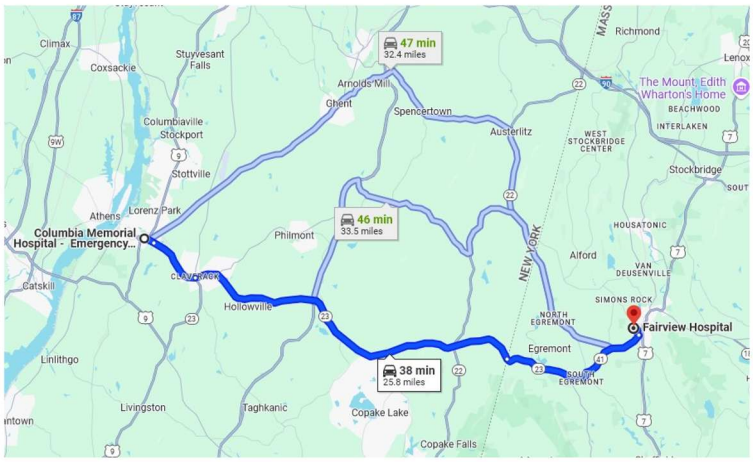
Consultants reviewed distance: please see maps below.

CRITICAL ACCESS HOSPITAL FEASIBILITY



CRITICAL ACCESS HOSPITAL FEASIBILITY

Columbia Memorial Hospital to Fairview Hospital (MA) (NY-23/MA-23) MEETS

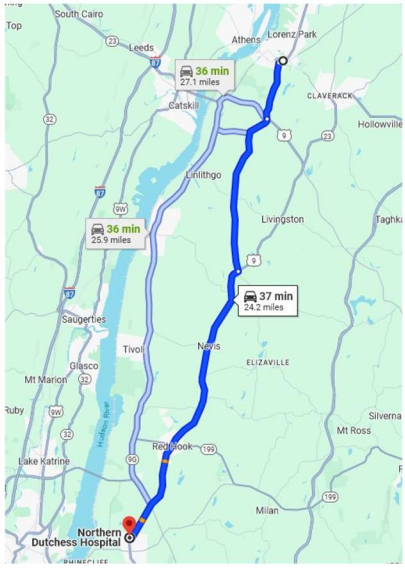


- Columbia Memorial Hospital is under then 35-mile limit for standard CAH conversion with a total of 25.8 miles between the hospital and Fairview Hospital via NY-23 and MA-23.
- However, it **does** qualify for reduced distance with the new designation of primary and secondary roads, with all 25.8 miles on secondary roads with this route.

Source: Google Maps

CRITICAL ACCESS HOSPITAL FEASIBILITY

Columbia Memorial Hospital to Northern Dutchess Hospital (US-9) MEETS

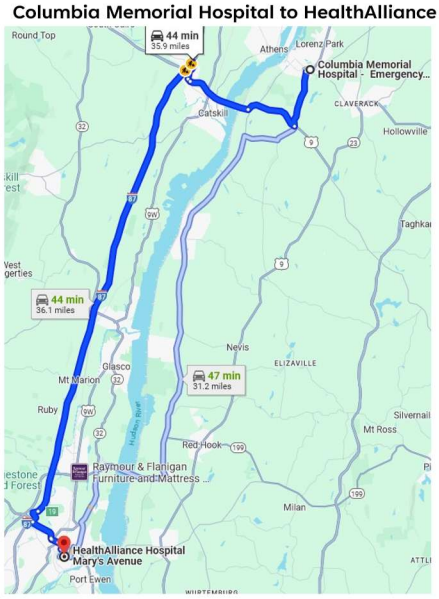


- Columbia Memorial Hospital is under then 35-mile limit for standard CAH conversion with a total of 24.2 miles between the hospital and Northern Dutchess Hospital via US-9
- However, it **does** qualify for reduced distance with the new designation of primary and secondary roads, with all 24.2 miles on secondary roads
- Even though US-9 is a major highway, this section is only 2 lanes so all the miles count toward the distance criteria

Source: Google Maps

CRITICAL ACCESS HOSPITAL FEASIBILITY

Columbia Memorial Hospital to HealthAlliance Hospital Mary's Ave (I-87) MEETS

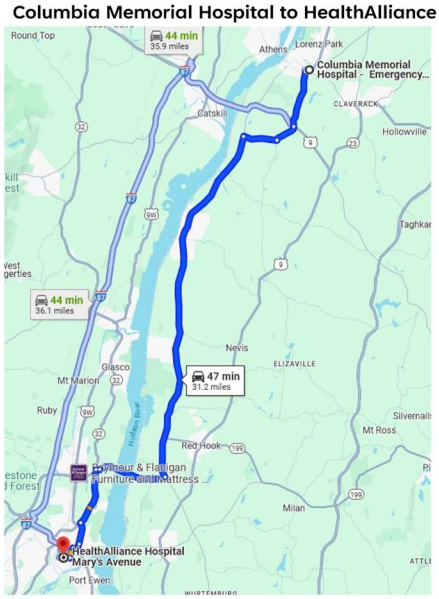


- Columbia Memorial Hospital is over then 35-mile limit for standard CAH conversion with a total of 35.9 miles between the hospital and HealthAlliance Hospital Mary's Avenue via I-87

Source: Google Maps

CRITICAL ACCESS HOSPITAL FEASIBILITY

Columbia Memorial Hospital to HealthAlliance Hospital Mary's Ave (NY-9G) MEETS

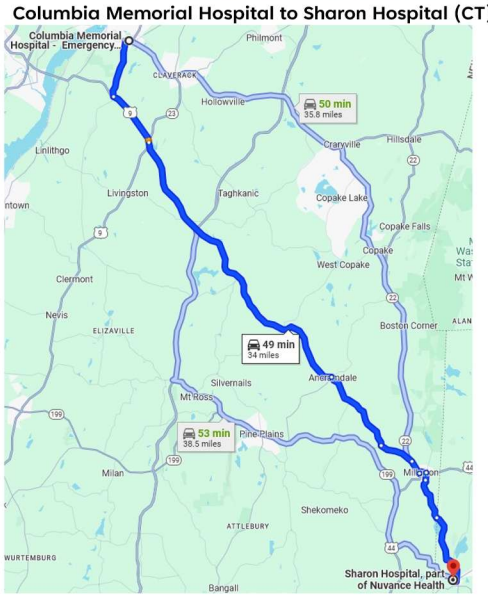


- Columbia Memorial Hospital is under then 35-mile limit for standard CAH conversion with a total of 31.2 miles between the hospital and HealthAlliance Hospital Mary's Avenue via NY-9G
- However, it **does** qualify for reduced distance with the new designation of primary and secondary roads, with 28.9 miles on secondary roads and 2.3 on primary roads.
- Once you cross the Hudson River heading south, sections of NY-32 are 4 lane primary road, and the combined sections (2.3 miles) can't be used in the total distance

Source: Google Maps

CRITICAL ACCESS HOSPITAL FEASIBILITY

Columbia Memorial Hospital to Sharon Hospital (CT) (NY-82) MEETS

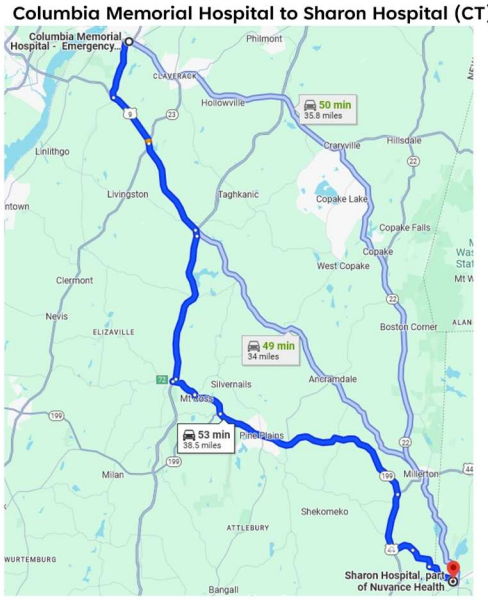


- Columbia Memorial Hospital is under then 35-mile limit for standard CAH conversion with a total of 34 miles between the hospital and Sharon Hospital via NY-82.
- However, it **does** qualify for reduced distance with the new designation of primary and secondary roads, with all 34 miles on secondary roads

Source: Google Maps

CRITICAL ACCESS HOSPITAL FEASIBILITY

Columbia Memorial Hospital to Sharon Hospital (CT) (NY-199) MEETS



- Columbia Memorial Hospital is over then 35-mile limit for standard CAH conversion on this route with 38.5 total miles.

Source: Google Maps

CRITICAL ACCESS HOSPITAL FEASIBILITY

Mileage between Columbia Memorial Hospital and other Hospitals

Type	Location	Columbia Memorial Hospital
CAH	Fairview Hospital (MA) (NY-23/MA-23)	25.8
CAH	Fairview Hospital (MA) (NY-66)	32.4
CAH	Fairview Hospital (MA) (Taconic State Parkway)	33.5
STAC	Northern Dutchess Hospital (US-9)	24.2
STAC	Northern Dutchess Hospital (NY-9G)	25.9
STAC	HealthAlliance Hospital Mary's Avenue (NY-9G)	31.2
STAC	HealthAlliance Hospital Mary's Avenue (I-87)	35.9
STAC	Sharon Hospital (CT) (NY-82)	34
STAC	Sharon Hospital (CT) (NY-23/NY-22)	35.8
STAC	Sharon Hospital (CT) (NY-199)	38.5
STAC	Berkshire Medical Center (MA) (NY-66/NY-295)	36.3
STAC	Albany Medical South Clinical Campus (NY-9H/I-90)	37.8
STAC	Albany Medical South Clinical Campus (I-87)	39.1

Mileages in blue meet the requirement by being over 15 miles between facilities with only secondary roads available.
Mileages in gray meet the requirement by being over 35 miles between facilities
Source: Google Maps

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Reimbursement:

- Inpatient and Outpatient Hospital services are paid at 101% of reasonable costs.
    - Both inpatient and qualifying outpatient services (ED, Observation, Imaging, Lab) would be included in the cost-based reimbursement methodology.
- Physicians' services remain at the current reimbursement rates under the Medicare Physician fee schedule.
- The inpatient behavioral unit would become exempted and paid at an enhanced rate for these patients, reflecting their typically longer length of stay. It is estimated that conversion to CAH status would result in an overall increase in Medicare, Medicaid, and Medicare Advantage net patient reimbursement totaling $19.7M for FY23
    - FY23's cost report was used as the basis for analysis since FY24's cost report was not yet filed at the time of analysis—this data is currently being refreshed.

Strategic rationale: Given CMH's current financial challenges and ongoing operating gaps, Critical Access Hospital designation offers the strongest opportunity to stabilize reimbursement and support long-term access to care. CMH should continue working with New York State to develop an operating model that meets the required Conditions of Participation while preserving essential healthcare services for the communities it serves and reducing ongoing solvency risk.

Service Area	2023
Medicare	
Acute Care IP	$ 1,539,883
OP	6,645,940
OP FFS	834,267
Total Medicare	$ 9,020,090
Medicaid	
Acute Care IP	$ 1,660,376
OP	-
Total Medicaid	$ 1,660,376
Medicare Advantage	
Acute Care IP	$ 2,346,887
OP	6,678,644
Total Medicare Advantage	$ 9,025,531
Total	**$ 19,705,997**

Conclusions:

Although CAH designation would provide a more stable, cost-based reimbursement methodology, the transition would require significant inpatient case management, particularly for an average of 10 complex-care patients with lengths of stay ranging from 20 to 367 days. CMH has a well-developed transportation network to help meet community inpatient needs while also satisfying Medicare length-of-stay requirements

In late 2024 and 2025, CMH held several meetings with NYSDOH to review historical and current financial outcomes, discuss federal designation options, and present strategies to improve operational efficiency. CMH articulated its daily patient census, the need to pursue an **Article 31** designation for the existing 22-bed OMH-certified inpatient unit, and the potential for a co-located model like Claxton-Hepburn. Under this approach, CMH could operate as both a CAH and an Article 31 provider, enabling the organization to continue serving the community, benefit from CAH reimbursement, and use the $5 million grant award to develop a geriatric psychiatry unit.

CMH recognizes both the complexity of the application process and the operational challenges associated with its current medical-surgical inpatient volume. With the buildout of Greene Medical Arts, several surgical patients are expected no longer to require overnight stays, reducing the acute daily census by approximately six cases per day. In parallel, CMH is working with AMHS to strengthen case management for complex-care patients and better align inpatient utilization with CAH requirements. The outlier to this application and approach remains the clear focus on remaining financially solvent and providing quality safe care. As requested below is the ADC over the last 3 years. It outlines what CMH has been describing.

Columbia Memorial Health
Patient Average Daily Census by Patient Type
June YTD

	FY2024	*FY2025*	*FY2026*
Acute ADC	46.6	46.2	45.6
Critical Care ADC	4.9	4.2	3.9
ALC ADC	2.7	-	-
Psych ADC	18.0	14.5	19.5
OBS ADC	5.5	5.2	7.6
	77.7	70.0	76.6

Acute ADC	46.6	46.2	45.6
Critical Care ADC	4.9	4.2	3.9
	51.5	50.4	49.5

Removing Psychiatry as described previously to be counted separately to apply for Article 31 and removing observation we are at the 50 inpatient beds as we outlined in our town halls and described the work with management of the complex case patients with AMHS. CMH bed status has not changed over the last 5 years however; the financial outcomes continue to demonstrate unsustainable outcomes.

Today, CMH continues to work with AMHS to advance operational goals and improve efficiency; however, these efforts have not changed CMH's underlying financial position. Discharges have declined, and inpatient revenue per admission has fallen significantly from FY 2025 to YTD April 2026, decreasing by more than 7.9%, or $1,089 per admission. Net revenue per adjusted patient declined 2.2% over the 12-month period and fell 5.0% year to date, representing a $64 per day revenue loss. This deterioration shows that the hospital is generating less revenue for each day of patient care, despite higher utilization. CMH's case mix index also declined from 1.51 to 1.41 year to date, a 6.8% decrease, reflecting a shift toward lower-acuity, less complex patients. Compared with the FY 2026 budget, CMH was projected to incur an approximately $9.3 million loss; based on annualized year-to-date performance, the projected loss has increased to approximately $15.5 million.

AMHS has provided significant financial support to CMH for the past 18 months, including support for payroll and accounts payable. Without CAH designation, the health system would need to reassess the scope of services the hospital currently provides and its operating structure, up to and including an evaluation of a Rural Emergency Hospital designation. Other sources of fiscal support would also need to be identified for the hospital to achieve long-term sustainability.

Therefore, we believe that the most viable option for CMH, without any additional State or Federal financial subsidy would be the Critical Access designation.

CMH has always considered that the State certification process may provide flexibility through waivers to certain CAH eligibility requirements; knowing that this current structural model is unsustainable. CMH has reviewed alternative models. There is no realistic financial alternative then the critical access program—access to this federal program has prevented hospitals from discontinuation of healthcare services.

If CMH does not receive CAH designation, it could attempt to seek a Sole Community Hospital (SCH) designation. ***It is important to note, however, that any reimbursement increases stemming from CMH moving to the SCH designation would not be sufficient to cover the $10-20 million-dollar structural losses gap.***

5. **To what extent do the medically underserved groups (identified above) currently use the service(s) or care impacted by or as a result of the project? To what extent are the medically underserved groups (identified above) expected to use the service(s) or care impacted by or as a result of the project?**

The tables below outline utilization across all CMH services among key medically underserved groups between November 1, 2023 and October 31, 2024.[17] The total number of individuals accessing inpatient med/surg services is expected to decrease with transition to CAH designation; however, the proportion of individuals across medically underserved groups who access services is not expected to change, as the location and all other components of the service (e.g., accepted insurance) are expected to remain the same.

Race/Ethnicity

Race	% of Patients
Black	4.1%
White	77.7%
Other	17.3%
Asian	0.8%
American Indian/Alaska Native	0.1%
Native Hawaiian/Pacific Islander	0.0%

Ethnicity	% of Patients
Hispanic or Latino (any race)	10.0%
Not Hispanic or Latino	81.1%
Declined to Answer	8.9%

Payor Mix

Payor	% of Patients

[17] Data provided by Applicant

Medicaid	25.1%
Medicare	25.3%
Dual Eligible (Medicaid & Medicare)	12.2%
Commercial	32.7%
Uninsured	3.3%
Other (NF/Comp)	1.5%

Patient Average Daily Census by Patient Type

Columbia Memorial Health
Patient Average Daily Census by Patient Type
June YTD

	FY2024	*FY2025*	*FY2026*
Acute ADC	46.6	46.2	45.6
Critical Care ADC	4.9	4.2	3.9
ALC ADC	2.7	-	-
Psych ADC	18.0	14.5	19.5
OBS ADC	5.5	5.2	7.6
	77.7	70.0	76.6
Acute ADC	46.6	46.2	45.6
Critical Care ADC	4.9	4.2	3.9
	51.5	50.4	49.5

6. What is the availability of similar services or care at other facilities in or near the Applicant's service area?

CMH is the only hospital in Columbia and Greene Counties. According to NYS DOH, there are 29 hospitals including CMH in the Capital District. The table below shows these hospitals and their distance to the Applicant.

Additionally, some hospitals in the Southern regions, including HealthAlliance Hospital and Northern Dutchess Hospital, are located 20 to 40 miles from the Applicant.

Name	Region/County	Distance from CMH
Columbia Memorial Hospital	Columbia	-
Samaritan Hospital - Albany Memorial Campus	Albany	34.7 miles
Albany Medical Center Hospital	Albany	36.1 miles
Albany Medical Center - South Clinical Campus	Albany	39.1 miles
Samaritan Hospital	Rensselaer	40.3 miles
St. Peter's Hospital	Albany	40.5 miles
St. Peter's Addiction Recovery Center	Albany	43.8 miles
Sunnyview Hospital and Rehabilitation Center	Schenectady	50.2 miles

St. Peter's Hospital - SPARC	Rensselaer	51.1 miles
Ellis Hospital - Bellevue Woman's Care Center Division	Schenectady	54.4 miles
Ellis Hospital	Schenectady	54.9 miles
Cobleskill Regional Hospital	Schoharie	57.2 miles
Margaretville Hospital	Delaware	59.5 miles
Saratoga Hospital	Saratoga	69.5 miles
St. Mary's Healthcare - Amsterdam Memorial Campus	Montgomery	72.4 miles
St. Mary's Healthcare	Montgomery	72.7 miles
O'Connor Hospital	Delaware	77.1 miles
A.O. Fox Memorial Hospital	Otsego	81.9 miles
Mary Imogene Bassett Hospital	Otsego	82.6 miles
Glens Falls Hospital	Warren	83.6 miles
Nathan Littauer Hospital	Fulton	85.9 miles
Delaware Valley Hospital Inc	Delaware	98.3 miles
A.O. Fox Memorial Hospital - Tri-Town Campus	Delaware	116 miles
The University of Vermont Health Network - Elizabethtown Community Hospital Moses Ludington	Essex	135 miles
The University of Vermont Health Network - Elizabethtown Community Hospital	Essex	153 miles
Adirondack Medical Center-Lake Placid Site	Essex	170 miles
Adirondack Medical Center-Saranac Lake Site	Franklin	181 miles
The University of Vermont Health Network - Champlain Valley Physicians Hospital	Clinton	191 miles
The University of Vermont Health Network - Alice Hyde Medical Center	Franklin	238 miles

7. What are the historical and projected market shares of providers offering similar services or care in the Applicant's service area?

The Applicant is the only hospital in Columbia and Greene Counties.

8. Summarize the performance of the Applicant in meeting its obligations, if any, under Public Health Law § 2807-k (General Hospital Indigent Care Pool) and federal regulations requiring the provision of uncompensated care, community services, and/or access by minorities and people with disabilities to programs receiving federal financial assistance. Will these obligations be affected by implementation of the project? If yes, please describe.

The Applicant is committed to providing comprehensive care and support to individuals who are uninsured or underinsured, in accordance with current financial assistance policies and federal/state regulations. This commitment is not expected to be impacted by the proposed project. The Applicant's current policy states that the hospital will not discriminate based on race, color, religion, creed, sex, national origin, marital status,

sexual orientation, transgender status, gender identity, veteran status, or any other characteristic as protected by applicable law.

The Applicant participates in efforts to support the Prevention Agenda, New York State's Health Improvement Plan, which serves as a blueprint for state and local action to improve the health and wellbeing of all New Yorkers and promote health equity across any population that is experiencing a health disparity. The Applicant also implements community service activities and conducts a Community Health Assessment (CHA) every three years.[9]

The Columbia Memorial Hospital Health Affairs Committee, which replaced the Board of Trustees when the Applicant joined AMHS, is representative of the community, and all members either live, work, or have family ties to Columbia and Greene Counties.[18]

CMH is compliant with New York State's Public Health Law 2807-k, which requires hospitals to establish financial aid policies and procedures for reducing charges to low-income individuals without health insurance or who have exhausted their health insurance benefits and demonstrate an inability to pay full charges. As part of AMHS, CMH has a financial assistance policy that provides medically necessary care at no charge or reduced charge for patients who meet eligibility requirements.[19] Patients are provided with a financial counselor who provides assistance in the patient's language or via qualified telephonic interpreters through each phase of the application process.

9. Are there any physician and professional staffing issues related to the project or any anticipated staffing issues that might result from implementation of project? If yes, please describe.

The Applicant has stated that there will be limited, if any, impact on current staff. They note that agency staff and Per Diem employees are currently needed to fill vacancies throughout the organization, and that this would no longer be necessary if CMH is approved for CAH designation. Remaining employees would either 1) not be impacted or 2) have the opportunity to work elsewhere in the organization.

Stakeholders identified staffing concerns including potential workforce attrition, logistical barriers, and pipeline disruption. Despite assurances to the contrary, anxiety regarding potential layoffs may prompt employees to seek alternative employment, exacerbating existing staffing challenges. If staff are relocated or assigned to work at sites outside of the main Hudson campus, transportation barriers and/or retraining/credentialing requirements present significant retention risks, particularly for employees without personal vehicles or those facing increased commuting costs. Lastly, reduced acute care volume may jeopardize clinical placement partnerships with local nursing programs and limit internship and training opportunities, compromising the long-term staffing pipeline.

[18] Data provided by the Applicant

[19] Albany Med Health System. (n.d.). *Financial Assistance Programs*. Retrieved [April 2, 2025], from https://www.albanymed.org/patients-visitors/billing-insurance/financial-assistance-programs/

The Applicant is deliberate when hiring, retaining, and developing diverse talent. Specific steps taken to ensure diversity among staff are as follows:

- Diverse and inclusive job advertisements
- Inclusive language in their job postings
- A culture that welcomes all candidates
- Recruiting from a wide variety of sources; high schools, universities and a variety of job posting websites
- Partnering with local minority groups to help promote job opportunities.

CMH staff currently self-identify as the following:[20]

- American/Alaska Indian: 2
- Asian: 68
- Black/African American: 105
- Hispanic/Latino: 45
- White: 1,012
- Two or more races: 63

10. Are there any civil rights access complaints against the Applicant? If yes, please describe.

There are no civil rights access complaints against the Applicant.[21] Over the past 10 years, two cases have been filed under the jurisdiction of the Employment Opportunity Commission and one case under the Division of Human Rights, all three by employees.

11. Has the Applicant undertaken similar projects/work in the last five years? If yes, describe the outcomes and how medically underserved group(s) were impacted as a result of the project. Explain why the applicant requires another investment in a similar project after recent investments in the past.

The Applicant has not undertaken similar work in the las five years. However, this project is related to the organization's broader efforts to regain financial viability and maintain and expand access to vital services in the region. As mentioned in the executive summary, CMH's three-pronged strategy to return to financial stability includes: (1) the conversion of the hospital to Medicare's Critical Access Hospital designation, which will provide additional reimbursement for acute care services; (2) the expansion of inpatient behavioral health services and transition of licensure for these services; and (3) the development of an ambulatory surgery center to provide renewed surgical facilities and increase capacity in the region.

STEP 2 – POTENTIAL IMPACTS

[20] Data provided by the Applicant
[21] Data provided by the Applicant

1. **For each medically underserved group identified in Step 1 Question 2, describe how the project will:**
    a. **Improve access to services and health care**
    b. **Improve health equity**
    c. **Reduce health disparities**

The transition of CMH to a CAH will enhance access to services, advance health equity, and reduce health disparities in the following ways:

1. Preserving acute inpatient care in the community. Without CAH designation and the associated reimbursement rates, the hospital would continue to run a significant deficit and be unable to continue services. The CAH designation will enable the hospital to achieve financial viability while continuing to provide vital emergency and acute care services to the community. All medically underserved groups will benefit from retaining these services locally; both Columbia and Greene Counties are designated by HRSA as Medically Underserved Areas. In particular, older individuals, individuals with public health insurance, and individuals in rural areas - the Applicant's primary patient population - will benefit from having a nearby hospital with a fully functional ED, 25 inpatient med/surg beds, and separately licensed inpatient psychiatric beds. These services prevent the need for longer-distance travel to access emergency and acute care, which disproportionately burdens elderly patients, those without reliable transportation, and individuals with mobility limitations. Additionally, increased visibility surrounding this transition could enhance community awareness of CMH's outpatient and ambulatory services and improve access to wraparound health services such as primary care, chronic disease management, and support programs.

2. Enabling strategic reinvestment in hospital infrastructure and outpatient services. Financial stability will allow CMH to focus resources on services with demonstrated community need (emergency care, medical-surgical services, behavioral health, cardiac care). Increasing the kinds and quality of services available locally will benefit all medically underserved groups. Planned developments include the 2027 opening of Greene Medical Arts, a state-of-the-art ambulatory surgical center that will expand access to outpatient procedures closer to home, and a specialty cardiac care center designed to address cardiovascular health needs - a leading cause of morbidity and mortality in the region. Modern equipment and technologies will improve diagnostic capabilities and treatment quality, particularly benefiting patients with complex chronic conditions who require ongoing specialized care. Enhanced outpatient services will also reduce reliance on emergency department visits for non-emergent conditions, improving care coordination and health outcomes for vulnerable populations including those with diabetes, hypertension, and behavioral health needs.

3. Focusing resources on services that best meet community needs. By concentrating on services where CMH has demonstrated community demand, the CMH can reduce health disparities through improved quality and outcomes. CMH will be able to provide higher-quality care in specialty areas rather than spreading resources thinly

across services that may be better delivered at tertiary care centers. For example, establishing formal transfer protocols and partnerships with specialty facilities ensures patients requiring complex interventions receive timely access to care at appropriate levels, while CMH maintains excellence in services most relevant to daily community health needs. This approach benefits rural residents, older individuals, and those with limited mobility who gain access to high-quality local care for most of their health needs, with clear pathways to specialized care when necessary.

2. **For each medically underserved group identified in Step 1 Question 2, describe any unintended positive and/or negative impacts to health equity that might occur as a result of the project.**

Potential unintended negative impacts of the project are as follows:

Community perception and utilization:

- **Public misconception about hospital closure:** The transition has generated confusion in the community, with misinformation circulating on social media platforms and in the news suggesting that the hospital is closing entirely. The misconception could lead to decreased utilization of available services (e.g., currently thriving orthopedic surgery practices), worsening the hospital's financial position.
- **Political opposition:** Public criticism from local political figures may amplify negative perceptions and contribute to community mistrust of the hospital, potentially deterring patients from seeking care at CMH.
- **Population outmigration concerns:** Community fear that the hospital is diminishing could accelerate population loss, particularly among young people and healthcare workers, straining the local economy and tax base.

Workforce impacts:

- **Staff attrition:** Healthcare workers may leave due to concerns about job security, reduced clinical variety, relocation requirements, or feelings of being misled by hospital administration. Staff without reliable transportation or unwillingness to commute longer distances may be disproportionately affected. Loss of experienced staff would directly impact care quality for all patients.
- **Clinical skill degradation:** Reduction in acute care volume, particularly ICU beds, may lead to fewer opportunities for staff to maintain and develop critical care skills.
- **Reduced training opportunities:** Local nursing programs and healthcare training institutions may lose clinical placement sites for students needing acute and critical care experience. This could make local educational programs less competitive and reduce healthcare workforce pipeline development.

Access and care coordination challenges:

- **Emergency department strain:** Increased transfers could lead to ED overcrowding and increased ambulance wall times (i.e., when ambulances

cannot unload patients due to lack of ED capacity), potentially delaying emergency response times for the broader community.

- **Burden on regional systems:** Increased patient transfers may overwhelm receiving facilities like AMC and Kingston Hospital and strain regional EMS systems transporting patients longer distances.
- **Family visitation barriers:** Patients transferred to Albany face significant visitation challenges for family members lacking transportation, financial resources, or ability to travel due to work or caregiving responsibilities. This particularly affects elderly patients, those with serious illnesses requiring family support, and immigrant communities with limited mobility.
- **Care fragmentation:** Patients transferred to Albany for surgical procedures may not return for post-operative follow-up due to transportation barriers or confusion about care coordination, leading to gaps in care and potentially avoidable complications.

Service reduction impacts:

- **Strain on community services:** Social service organizations, transportation providers, and community health programs may face increased demand as patients need more assistance navigating transfers and accessing care at farther locations.

Potential unintended positive impacts of the project are as follows:

Enhanced community awareness and engagement:

- **Improved awareness of available services:** With appropriate communication strategies, the increase in public attention caused by the proposal could serve as an opportunity to educate the community about the full range of services CMH provides beyond inpatient care, including primary care, behavioral health, and planned ambulatory services. Improved awareness could increase opportunity for health education and utilization of preventive and outpatient services, leading to reduced need for inpatient care. This may particularly impact underserved populations unaware of available resources.
- **Enhanced reputation:** Visible investments in hospital infrastructure and service quality could improve CMH's reputation, increasing community confidence and willingness to utilize available services. In addition, facilitating access to specialty services and clinicians through improved collaborative systems with AMHS could improve CMH’s reputation as people access the care they need with increased ease.

Improved partnerships and regional systems:

- **Increased collaboration with community organizations:** With proper planning and communication, the transition could help CMH develop stronger partnerships with local social service providers, public health organizations, and community-based organizations. These collaborations could improve care transitions,

discharge planning, and wraparound services for vulnerable populations, improving continuity of care.

- **Formalized transfer protocols:** Development of clear pathways between CMH and specialty facilities could improve care coordination and reduce delays for patients requiring higher levels of care, benefiting all patients and particularly those with complex needs or who experience difficulties navigating healthcare systems.

3. **How will the amount of indigent care, both free and below cost, change (if at all) if the project is implemented? Include the current amount of indigent care, both free and below cost, provided by the Applicant.**

   The current amount of indigent care is $9,916,126, which includes both bad debt and charity care activity only. Several services are reimbursed "below cost" (most Medicaid services and certain Medicare services) which are not included in this number.[22] Designation as a CAH will not change the Applicant's requirements to provide indigent care, although the total amount of indigent care provided may decrease if fewer patients overall are admitted.

4. **Describe the access by public or private transportation, including Applicant-sponsored transportation services, to the Applicant's service(s) or care if the project is implemented.**

   Transportation options in the Applicant's service area include personal/private transit by car, contracted transportation services, and public transportation. The Applicant understands the transportation barriers that some members of the service area face and currently has partnerships and contracts in place to support individuals in need. These partnerships include a contract with The Healthcare Consortium's Children and Adults Rural Transportation Service (CARTS) program, which provides Columbia County residents with non-emergency medical transportation. The service retrieves individuals from any location in Columbia County and delivers them to locations throughout the county and beyond. Clients who are enrolled in Medicaid must call a company called MAS to confirm eligibility for Medicaid transportation and receive prior authorization for the trip. CARTS operates 8:00am-4:00pm Monday through Friday, excluding holidays. Ambulette services are available for individuals requiring additional assistance. As a result of a recently conducted HEIA on the construction of an ambulatory surgical center in Catskill, NY, the Applicant has partnered with local government to increase the number and frequency of stops at hospital-run locations.

   Transportation to CMH within the Applicant's service area will remain unchanged. However, patients requiring care in Albany and their families may face transportation challenges. While emergency medical services will transport acute cases, families must rely predominantly on personal vehicles, creating potential barriers due to financial and time constraints. Public transportation options are limited to Amtrak service between

[22] Data provided by Applicant

Hudson and Albany and local bus routes within Albany, Columbia County, and Greene County.

5. **Describe the extent to which implementation of the project will reduce architectural barriers for people with mobility impairments.**

   The project will not cause architectural barriers for people with mobility impairments.

6. **Describe how implementation of the project will impact the facility's delivery of maternal health care services and comprehensive reproductive health care services, as that term is used in Public Health Law § 2599-aa, including contraception, sterility procedures, and abortion. How will the project impact the availability and provision of reproductive and maternal health care services in the service area? How will the Applicant mitigate any potential disruptions in service availability?**

   N/A

Meaningful Engagement

7. **List the local health department(s) located within the service area that will be impacted by the project.'**

   Columbia County Department of Health

   Greene County Department of Health

8. **Did the local health department(s) provide information for, or partner with, the Independent Entity for the HEIA of this project?**

   Several Columbia and Greene County government officials, including representatives from both Counties' Health Departments, participated in the Meaningful Engagement portion of this assessment.

9. **Meaningful engagement of stakeholders: Complete the "Meaningful Engagement" table in the document titled "HEIA Data Table". Refer to the Instructions for more guidance.**

   Please refer to attached spreadsheet titled "heia_data_tables_CMH_CAH.xlsx"

10. Based on your findings and expertise, which stakeholders are most affected by the project? Has any group(s) representing these stakeholders expressed concern the project or offered relevant input?

Current CMH patients and residents of Greene and Columbia Counties will be affected by this project. In particular, individuals with estimated stays of longer than 4 days and those needing intensive care will be most affected. Importantly, a majority of current CMH patients with long length of stays do not require hospital-level care and would be better served in long-term care facilities. While individuals requiring acute inpatient care and their families may in some cases be transferred to Albany for care that they previously would have been able to receive locally, the entire service area will benefit from the retention of the hospital, including the Emergency Department and the remaining medical/surgical beds.

Without this project, the hospital might be forced to close. CMH has had significant operating deficits over the past several years: $18 million in 2023, $13 million in 2024, and projected to be $10 million in 2025. Additionally, the average daily census for CMH's medical/surgical beds is 40- 50 inpatients, or approximately 78% of the staffed bed capacity for inpatient medical/surgical services.

The Applicant's goal is to leverage the reimbursement rate provided by CAH designation to reinvest in critical infrastructure at the hospital and outpatient services to meet the evolving needs of the local community.

All stakeholders wanted CMH to remain open and within the community. Many stakeholders had positive reactions to the project and believed that this project is a necessary step for the organization. Several stakeholders, including those supportive and not supportive of the project, also expressed concerns.

Stakeholders expressed the following concerns:

- **Job security, staffing, and training opportunities.** As noted above, staff were concerned about job loss. There were many questions and concerns about layoffs and relocations due to the reduced hospital capacity. Staff also wanted to understand the process for deciding which staff would be asked to stay or relocate. Community and staff leaders expressed concern about staff attrition if they are asked to relocate to Green Medical Arts, particularly if they do not have cars or do not wish to pay the bridge toll.
- **Patient access & community healthcare.** Patients, staff, and community leaders expressed concern about the reduced availability of local healthcare services and negative impact on community members who cannot travel to Albany. There were concerns about what would happen to patients needing more than 4 days of inpatient care, in particular current patients who have been at the hospital for an extended period.
- **EMS and ED capacity. C**oncerns about insufficient ambulance/EMS capacity for additional transfers and lack of available beds at receiving hospitals were raised. Staff noted that it is already difficult to transfer patients to AMC, and that CMH patients transferred to AMC currently experience long wait times.

- **Quality of care & patient safety.** There were concerns that patient care would suffer, and about the ability to stabilize critical care patients if ICU is reduced.
- **Impact on families and visitors.** Concerns arose about increased hardships for families traveling to distant hospitals with limited access to public transportation. It was additionally noted the importance of being close to loved ones during hospitalization, and worries about confusion managing travel and navigating larger, more complex facilities.
- **Increased patient costs.** Stakeholders were concerned about potential for patients to incur additional costs if required to transfer to other facilities, including transportation costs and inconsistent insurance coverage across facilities.
- **Communication issues.** Communication was one of the most common concerns brought forward by stakeholders. There was some mistrust among clinical staff about the accuracy of patient numbers/data presented by administrative staff. In addition, significant misinformation has been spread among the community, leading many to believe that the hospital is closing. Community leaders were concerned that without a proactive and comprehensive communication plan, there would be increased division and mistrust between the community and the hospital.
- **Regulatory and process concerns.** Stakeholders were concerned about what would happen to the hospital if it were not approved for critical access designation.
- **Pandemic/ emergency preparedness.** Some staff were concerned about reduced capacity in the event of another pandemic.
- **Impact on other facilities.** Some stakeholders were worried about overtaxing other hospitals, noting an already insufficient hospital bed capacity regionally.

11. How has the Independent Entity's engagement of community members informed the Health Equity Impact Assessment about who will benefit as well as who will be burdened from the project?

As part of our stakeholder engagement, we conducted interviews and focus groups with 41 individuals, including among leadership and staff, government officials, healthcare professionals, service providers, and community leaders. We also interviewed representatives from community-based organizations and the local departments of health. Surveys were sent to CMH donors, board members, employees, community members, patients, and families of current or former patients. We also attended three in-person town hall meetings, where CMH leadership presented the proposal to staff, physicians, and community members and addressed questions.

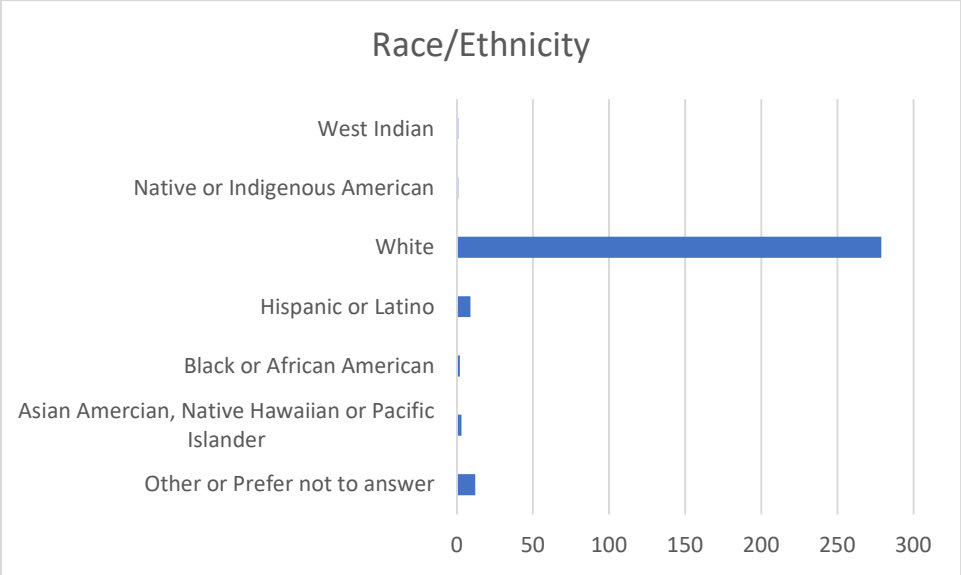
Interviews and survey responses helped us identify key considerations for the project, including motivation for the project, groups who would be most impacted, concerns, and suggestions. The town halls helped us identify key questions from community and staff, which indicated topics of most importance to these groups.

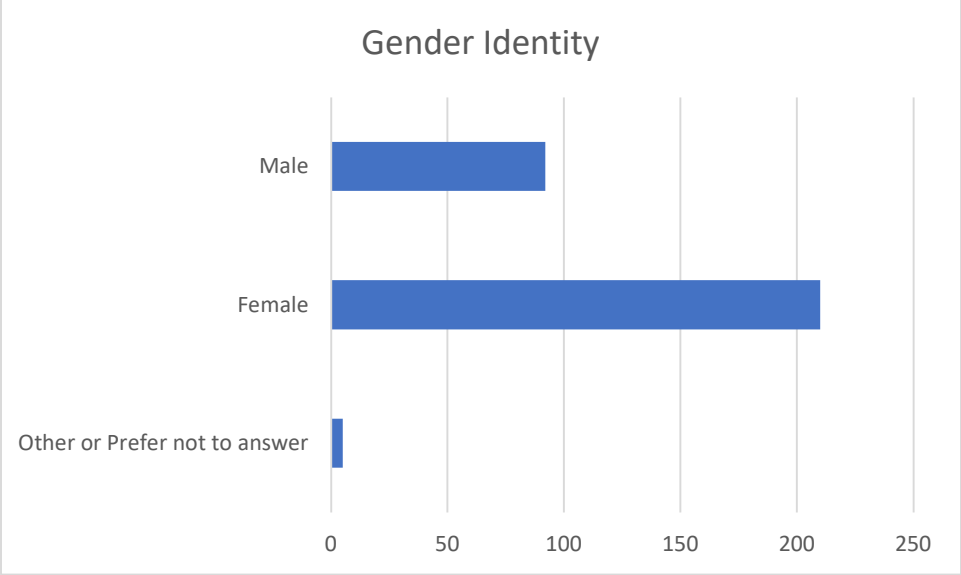
From the surveys, we received 185 responses from current or former patients and 123 responses from current CMH employees. Among the 308 responses we received, 44 (14%) were opposed to the project, 163 (53%) were supportive of the project, and 101 (33%) were neutral, unsure, or requested additional information.

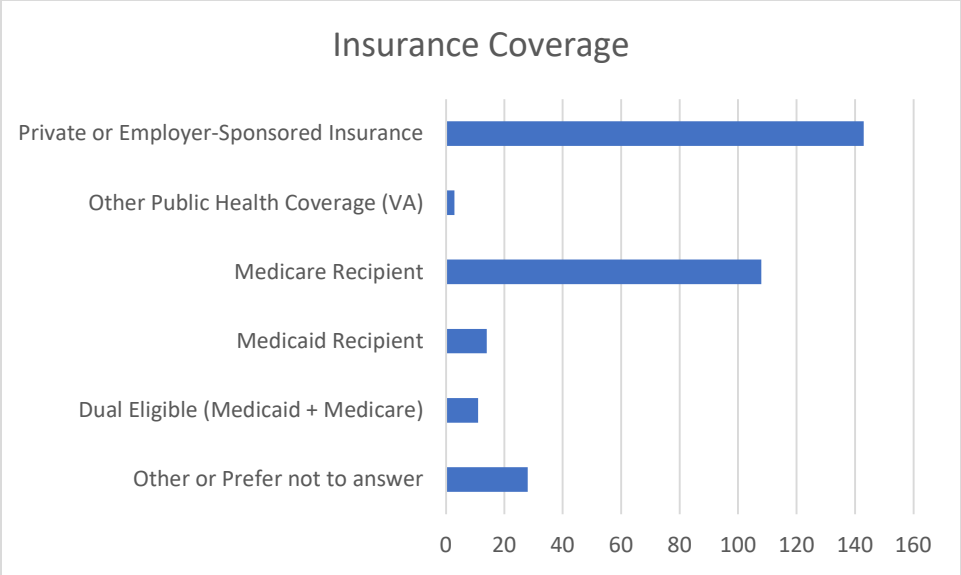
12. Did any relevant stakeholders, especially those considered medically underserved, not participate in the meaningful engagement portion of the Health Equity Impact Assessment? If so, list.

Our stakeholder engagement process involved working closely with CMH to identify and conduct comprehensive outreach to community-based organizations, staff, providers, and community members from which we sought feedback for the assessment. Among community survey respondents (N=185), more than 65% of were over 65 years of age, 5% identified as LGBTQIA+, and nearly 20% indicated that they were living with a disability and/or managing an infectious disease of chronic condition (e.g., diabetes).

Key demographics of all survey respondents (N=308):







STEP 3 – MITIGATION

1. **If the project is implemented, how does the Applicant plan to foster effective communication about the resulting impact(s) to service or care availability to the following:**
    a. **People of limited English-speaking ability**
    b. **People with speech, hearing or visual impairments**
    c. **If the Applicant does not have plans to foster effective communication, what does the Independent Entity advise?**

The Applicant has strict policies and procedures in place to ensure that all patients have access to certified interpreters. Staff utilize the NYS Language Identification Tool to assist them in identifying interpretation needs. The primary method of providing interpretation services is via dual handset telephones, and video interpretation is available to support needs for American Sign Language. Any additional interpretation needs are escalated to the Language Access Coordinator to ensure timely access to communication services for patients. All staff are required to complete annual education on language access services, including the proper procedure for accessing interpreters and providing interpretation services to individuals in care.

The evaluation of language access services is ongoing and conducted annually at a minimum. Evaluations include review of mandatory staff education completion rates, review of event reports and patient grievances related to language access services, and confirmation that adequate and functional equipment is in place to meet patient needs.

Lastly, the Applicant conducts ongoing review of language needs within the community by 1) using county-level data to identify primary languages used in students' homes, 2) encouraging staff to alert the Language Access Coordinator to any newly identified

interpretation or translation needs, and 3) identifying frequently used languages through review of translator service reports.

2. What specific changes are suggested so the project better meets the needs of each medically underserved group (identified above)?

The Independent Entity suggests the following changes so the project better meets the needs of medically underserved groups.

- **Ensure that transportation barriers do not negatively impact care or health outcomes as a result of this project.** Transportation was the most commonly expressed concern among stakeholders and was noted as a particular barrier for medically underserved groups. The Applicant should work with community leaders, politicians, and AMHS to develop strategies to ensure that patients and family members can access appropriate care and visiting hours. In addition, the Applicant should ensure that staff asked to relocate have means of transportation and offer support if they do not (e.g., reimbursement of tolls or a shuttle between GMA and the hospital).
- **Transparently address staff concerns.** At town halls and in survey responses, staff expressed significant concerns and stress about continued employment. The Applicant should continue to engage actively with and solicit feedback from staff and employees to assuage concerns and ease tensions. Plans to communicate with staff should include addressing concerns such as fears of layoffs, plans for relocation, intensive care, observation beds, and flex-beds.
- **Develop plans for workforce retention.** Worries among the staff or expectations of forced relocation may lead to increased attrition of staff – even if beliefs are unfounded. In addition to developing trust among staff through transparent communication, the Applicant should create a concrete plan for retaining as many staff as possible. This could include collaborating with the Columbia-Greene Workforce Development Board.
- **Address public misinformation.** As noted above and seen in survey responses, there has been widespread misinformation about the project. The Applicant should liaise with key community leaders and staff to develop a strong and cohesive communication plan that can strengthen its reputation and continue to grow its positive presence in the community. This should include utilizing social media, as stakeholders highlighted widespread misinformation across social media platforms.
- **Address questions about current and future long-term patients.** Many patients currently exceed the 4-day limit required by CAH designation. It was noted that the majority of these patients do not require the acute level of care that hospitals provide, but they are not able to be transferred or discharged. The Applicant should create and communicate a plan for current and future patients who need inpatient stays of longer than four days. Planning should include key experts such as the Performance Improvement Committee and clinical staff currently caring for these patients.

- **Create contingency plans if the ED is overcrowded.** Stakeholders expressed significant concerns about long ED wait times, both at CMH and AMC. They also expressed concerns about meeting med/surg bed needs in winter months, when occupancy increases significantly. For example, winter census often reaches 35–50 patients, exceeding the CAH cap. A concrete contingency plan for current and future needs of the population should be created and clearly communicated to all staff. One stakeholder suggested increasing the size of the ED to prevent ambulance blockages.
- **Focus on improving access to services across the healthcare continuum.** The Applicant should play to its strengths by improving and expanding primary care practices, enhancing post-acute and transitional care, and building on current health education programs. By increasing and improving outpatient and community-based services, it may be possible to reduce hospital admissions and readmissions.

3. How can the Applicant engage and consult impacted stakeholders on forthcoming changes to the project?

The Applicant has a strong and positive presence among the community services network within Columbia and Greene Counties and the surrounding catchment area, which can be leveraged to gain important feedback on the implementation of this project moving forward. The Applicant has existing collaborative relationships with a large network of community leaders, including healthcare providers, community services providers, political leaders, and local departments of health. Key partners include (but are not limited to) the Department(s) of Human Services, the Chamber of Commerce, the Columbia County Healthcare Consortium, the Columbia County Economic Development Corporation, the Columbia County Emergency Medical Services, and Greene County Legislature. These relationships can be leveraged to consult impacted stakeholders on forthcoming changes to the project.

The Applicant has held multiple Town Halls, which were accessible both in person and virtually, for employees and community members. The Applicant is planning to continue holding Town Halls throughout the application and implementation process, which will enable them to gather invaluable feedback from key stakeholders.

The Applicant has several mechanisms in place to consult patients and family members:

- Leaders aim to develop committees and workgroups which are representative of prevalent cultural groups within the service area. Participation by individuals with lived experience is viewed as a valuable resource, and as such current or previous service recipients are encouraged and invited to participate in workgroups when possible.
- Patient experience surveys are utilized to identify opportunities for improvement across service offerings.
- The Applicant convenes inpatient and outpatient Family Advisory Committees, which encourage open dialogue regarding the experiences of patients or families who have received services at CMH.

In addition to established methods of engagement, the Applicant could utilize social media platforms to communicate with the public and address misinformation.

4. How does the project address systemic barriers to equitable access to services or care? If it does not, how can the project be modified?

Across the organization, the Applicant has shown a dedication to ensuring equitable access to care:

- AMHS has a governance workgroup focused on reducing disparities in access, quality, and treatment outcomes. The workgroup is multidisciplinary and diverse with robust participation from each entity from the health system, including the CEO of CMH.
- The CMH Diversity, Equity, and Inclusion Leadership Committee plans to develop learning materials to educate managers and leadership on how to promote equitable access to care and engage employees in the continued development of a cultural environment that is inclusive for the CMH workforce and patients.

This project addresses systemic barriers to equitable access to services in the following ways:

- **Financial sustainability of essential local services.** The most fundamental barrier to healthcare access is absence of available services. Without CAH designation, CMH faces potential closure. Hospital closure would be devastating for the local community and would eliminate emergency and acute care access for a medically underserved, rural population. CAH designation addresses the systemic barrier of healthcare facility financial unsustainability in rural areas by providing Medicare and Medicaid reimbursement rates that reflect the cost of delivering care in low-volume settings. As such, this project will ensure the continued availability of acute, emergency, and behavioral health services within the local community.
- **Formalized access to specialized services.** Rural healthcare systems face systemic barriers to recruiting and retaining specialists for a variety of reasons. This project, by continuing to formalize CMH's affiliation with AMHS, will improve CMH patients' access to specialty care across multiple disciplines. If this project is leveraged to establish clear transfer protocols, care coordination pathways, and collaborative relationships with AMHS specialists, it can create a systematic approach to ensuring rural patients receive appropriate and high-quality care. Additionally, the planned specialty cardiac care center represents a strategic investment in a high-need specialty service that can be delivered locally, reducing the need for patients to be transferred for common cardiovascular conditions - while maintaining pathways to higher levels of care as needed.
- **Increased community awareness of available services.** The public attention generated by this proposal creates an opportunity to increase awareness of available services in the local community. Residents may not be fully aware of the primary care, preventive services, behavioral health programs, and planned ambulatory services CMH offers. Strategic community education efforts during the

implementation of this project may be able to increase the utilization of preventive and outpatient services, particularly among medically underserved populations. The project also has the potential to highlight transportation gaps in the region and encourage local and state governments to prioritize improvements in public transportation infrastructure.

STEP 4 – MONITORING

1. What are existing mechanisms and measures the Applicant already has in place that can be leveraged to monitor the potential impacts of the project?

The Applicant has several mechanisms in place that can be leveraged to monitor the potential impacts of the proposed project.

- **Community Health Assessment (CHA).** Every three years, CMH staff work with community groups conduct a comprehensive Community Health Assessment to actively engage community members and assess local health and social needs. This process involves rigorous research, stakeholder engagement, and data collection, ensuring a thorough understanding of the community's evolving health care challenges. CMH can leverage the findings from this assessment to evaluate whether the organization's services are effectively meeting community needs. By analyzing trends in service utilization, access barriers, and patient outcomes, CMH can make data-driven adjustments to enhance service delivery, address gaps, and ensure that the organization continues to align with community priorities.
- **Key metrics**. CMH currently tracks several quantitative measures that can be used to monitor impacts, such as
    - Average length of stay
    - Readmission statistics
    - Occupancy rate
    - Average daily census
    - Discharge outcomes, including linkage to outpatient services
    - Transfer rates
    - Patient outmigration
- **Performance Improvement Committee (PIC).** The PIC committee oversees all performance improvement initiatives, recommends allocation of resources, and coordinates communication of organization-wide performance improvement initiatives between medical staff, various departments, and the Board. The committee also assesses performance improvement activities annually.
- Patient feedback mechanisms are described in Step 3, Question 3.

2. What new mechanisms or measures can be created or put in place by the Applicant to ensure that the Applicant addresses the findings of the HEIA?

The Applicant can consider the following:

Data Monitoring and Analysis

- Develop a dashboard to easily compare patient demographics, referral patterns, transfers, service use, and outcomes.
- Analyze wait times, lengths of stay, outcomes, and readmission rates by demographic indicators and whether patients were treated exclusively at CMH or transferred to another hospital.
- Stratify reports by race, ethnicity, language, zip code, and social needs; include sexual orientation and gender identity when available.
- Continue to review patient demographics to ensure they are reflective of the service area.
- Use findings to refine policies promoting health equity and care quality.

Communication and Engagement

- Maintain open channels of communication between leadership, staff, and community partners, including sharing key findings.
- Engage community members to discuss experiences and evaluate needs.
- Monitor external partnerships (e.g., AMHS, transportation services, and local healthcare providers) for alignment and efficiency.

Training and Staff Support

- Ensure DEI training includes systemic racism and health equity impacts.
- Train staff on compassionate, culturally appropriate care and data collection practices, including trauma-informed and culturally sensitive approaches.

STEP 5 – DISSEMINATION

The Applicant is required to publicly post the CON application and the HEIA on its website within one week of acknowledgement by the Department. The Department will also publicly post the CON application and the HEIA through NYSE-CON within one week of the filing.

OPTIONAL: Is there anything else you would like to add about the health equity impact of this project that is not found in the above answers? (250 words max)

---------- SECTION BELOW TO BE COMPLETED BY THE APPLICANT ----------

SECTION C. ACKNOWLEDGEMENT AND MITIGATION PLAN

Acknowledgment by the Applicant that the Health Equity Impact Assessment was reviewed by the facility leadership before submission to the Department. This section is to be completed by the Applicant, not the Independent Entity.

I. Acknowledgement

I, Columbia Memorial Health, attest that I have reviewed the Health Equity Impact Assessment for the Critical Access Hospital Designation Application that has been prepared by the Independent Entity, Sachs Policy Group.

_____

Name

_____

Title

_____

Signature

_____

Date

II. Mitigation Plan

If the project is approved, how has or will the Applicant mitigate any potential negative impacts to medically underserved groups identified in the Health Equity Impact Assessment? (1000 words max)

Please note: this narrative must be made available to the public and posted conspicuously on the Applicant's website until a decision on the application has been made.

Columbia Memorial Hospital (CMH), the cornerstone sole provider of healthcare in Columbia and Greene counties, is undertaking an innovative transformation to preserve essential healthcare services while ensuring long-term financial sustainability. CMH intends to transition from its current rural referring hospital to a Critical Access Hospital (CAH) designation.

The HEIA process revealed several key concerns among stakeholders, including transportation, emergency department (ED) boarding, ICU reduction, seasonal surges, discharge delays, and misinformation.

Transportation

Transportation emerged as the most consistent concern, especially for the elderly, low-income and those without personal vehicles. This is not a new concern for our residents as many currently utilize several modes of transportation. Contracted transportation through CMH, public transportation, and EMS are used. CMH is evaluating how to expand partnerships to mitigate any future challenges. CMH has agreements with local County EMS for interfacility medical transportation. Columbia County EMS (CCEMS) will provide 24/7 Transportation Services for CMH patients. CCEMS responds to the facilities for pre-transport activities, care and treatment during transport, and one-way transportation to the patient's destination. CMH is working within the two counties, with government and EMS on transportation. CMH also contracts with the Healthcare Consortium, which provides non-emergency services. CMH patients utilize public transport systems and residents can access NYSDOT website for public transportation. To mitigate concerns of family visitation, CMH is evaluating a shuttle service for staff and patient visitations and evaluating a new position, transportation navigator. Creating dedicated transport routes between hospitals for periods of surge.

ED Holding

Emergency department holding patients was a concern. CMH has committed to ongoing efforts to eliminate holding. To address this, CMH can expand its current fast-track and low-acuity zones in the ED and create additional overflow spaces. We have also implemented Virtual provider in triage which is a robust use of a provider who utilizes telemedicine triage; this has already been trialed and has improved our throughput. The AMHS logistics center prioritizes patients by acuity and patient navigators work with AMHS to streamline patient flow. A surge plan for winter surges will be developed for seasonal increases in demand.

ICU Transition

Concerns were raised about the potential removal of ICU beds and the need for higher-acuity transfers. CMH currently sends the majority of its critical care patients to Albany Med, a tertiary care center. Our ICU provides level 1 support, which is basic life support, ventilation, and stabilization. CMH does not have in-house ICU coverage. This is why we send patients to tertiary care today. Our ICU average daily census is 2-4 patients. Given that CMH is remarkably close to a tertiary care center it is much safer to transfer patients with less than an hour away transport to the appropriate level of care. We are currently transferring to AMC with success. There are established critical care protocols, to manage patients requiring critical care. Our clinical staff will continue training in stabilization and code management. We will provide a formal step-down care model; this will provide the necessary care for our emergency patients appropriate for a critical access hospital.

Seasonal Surges

Seasonal surges and increase in census will be managed as we do today. We will continue to utilize our surge management policies and protocols to address concerns. AMHS will continue to collaborate with us on load-balancing to absorb future seasonal volume surges, which would help manage capacity. Additionally, pandemic-scenario modeling and contingency surge plans will provide preparedness for unexpected emergencies.

Discharge Delays

Today, inpatients at CMH face barriers to discharge due to guardianship delays and/or difficulty finding skilled nursing facility (SNF) placements. To reduce bottlenecks, CMH has begun a SNF coalition to address these issues, including behavioral health. We currently have a legal team working on our guardianship patients and we plan to hire a BH liaison to manage the flow of medically complex patients with behavioral health needs. CMH will continue to work with its outpatient centers, which include eighteen primary care services. CMH will provide access points for scheduling appointments, communicating with the healthcare team, language support, and health education. CMH's focus on primary care, ambulatory care and mental health management is key to caring for our communities.

Employee Recruitment and Retention

We will continue to work with CMH employees to review current plans and processes. To alleviate concerns about layoffs and relocation, we will continue to follow our collective bargaining agreement and be very transparent with our team. We will need more employees in the future; we need over thirty employees for geropsychiatry and over fifty employees for the expansion of our ambulatory surgery center. We will continue to recruit all clinical and non-clinical employees. CMH has legal agreements with colleges and engaged them in our plans for future clinical rotations, which will remain the same. We have developed a robust recruitment plan along with a retention planning; fostering a positive work culture, supporting professional growth, and adding more recognition programs.

Communication and Addressing Misinformation

The hospital is not closing and addressing that common misconception is key. This is a change in design that allows CMH to reinvest in our services. To rebuild trust we have a page on our website to improve transparent communication as well as ongoing media outreach, public forums, and collaborating closely with community leaders. The CMH current community advisory board will be expanded to advise on this change. CMH will continue to offer language services to multilingual patients. CMH will provide access points for scheduling appointments, communicating with the healthcare team, language support, and health education. Project communications will occur through various channels to ensure the communities stay informed including utilizing various visual and hearing impairment technology, and language preferences. Communication plan is attached.

CMH will continue to evaluate our quality indicators and ensure improvement in hospital and patient care outcomes. This is of utmost importance.

Columbia Memorial continues to focus on providing excellent access and care to the residents we serve in Columbia and Greene Counties we are committed to serving and this transformation will allow us to preserve services.

ADDITIONAL REQUEST FOR INFORMATION

Emergency Transportation and Patient Transfer Considerations

Safe and timely patient transportation remains a priority for Columbia Memorial Health (CMH). CMH works closely with the Columbia County EMS Coordinator, Albany Med Health System

partners, and other regional tertiary care providers to ensure patients who need a higher level of care are transferred safely, appropriately, and without unnecessary delay.

Available Columbia County EMS data indicates sufficient transport capacity to support clinically necessary transfers:

- Columbia County recorded 2,165 total transports in 2025, compared with 1,999 in 2024.
- Of the 2025 total, 913 transports were to Albany Medical Center.
- Albany Medical Center transports represented 5.4% of total county call volume, indicating capacity for additional transports if needed.
- Although Albany Medical Center is CMH's parent organization, it is not the only tertiary care destination for transferred patients. CMH's major transfer partners include Albany Medical Center Hospital, St. Peter's Health Partners, and Westchester Medical Center.

Transfer Coordination and Clinical Review

CMH is establishing a transportation coordinator role to strengthen transfer planning and coordination. CMH also remains connected to the AMHS Logistics Center and participates in shift-by-shift team calls to identify patients who may require a higher level of care.

As a rural community hospital, CMH regularly transfers patients to Albany Medical Center and other tertiary care facilities in the region when clinically appropriate. This practice will continue under any new designation, with patients screened, evaluated, and transferred based on clinical need.

EMS coordinators have reported that there are no capacity issues and have reviewed and supported our application. They have also not reported any delays in patient care nor evaluation or screening per federal laws. In addition, Columbia County EMS currently has a contract with CMH providing critical transport from the CMH emergency room to Albany Medical Center Hospital and any appropriate regional hospital. A first of its kind county-wide EMS system approach started in 2010 that reimburses pre-existing, local EMS agencies to strategically move around the county to ensure all residents and visitors have timely access to EMS care. It infuses $1 million into the EMS services via contracted services partnership with CMH for time sensitive emergencies, where CMH calls 911 and EMS responds just like they would for a 911 call. CMH Critical Transports has an average response time of 72 seconds and transport time of 37 minutes and 46 seconds. This contract provides access to eleven ambulances during the day and seven ambulances at night. (See attached report on Rural Ambulance services).

Based on CMH systemwide and annual volume analyses, the projected change would average fewer than one additional transfer per day to Albany Medical Center or another regional tertiary care facility. Patients will continue to be transferred based on patient acuity, clinical need, and patient preference. Patient transfers are determined by patient acuity and the need for the appropriate level of care, not by Critical Access Hospital designation. The table below summarizes annual transfers from CMH to Albany Medical Center Hospital.

Year_Number	ALBANY MEDICAL CENTER HOSPITAL
2021	826
2022	634
2023	793
2024	881
2025	1,114
2026	397

For 2026, CMH averages 2.72 transfers per day to Albany Medical Center, which annualizes to approximately 993 transfers. Annual transfer volume varies based on EMS travel conditions, patient acuity, services unavailable at CMH, tertiary and quaternary care needs, and seasonal respiratory illness trends. Current discharge data analyses demonstrate any additional transfers would be less than one patient per day in addition to our current transfer rates.

Regarding EMS wait times, AMC continues to treat this as a top priority. Year to date, AMCH is averaging a wait time/wall time (the time EMS waits to offload a patient) as follows:

- Average Turnaround time=12 minutes
- Median time=9 minutes

To support monitoring and transparency, Saratoga County EMS tracks hospital EMS wait times and publishes a monthly report.

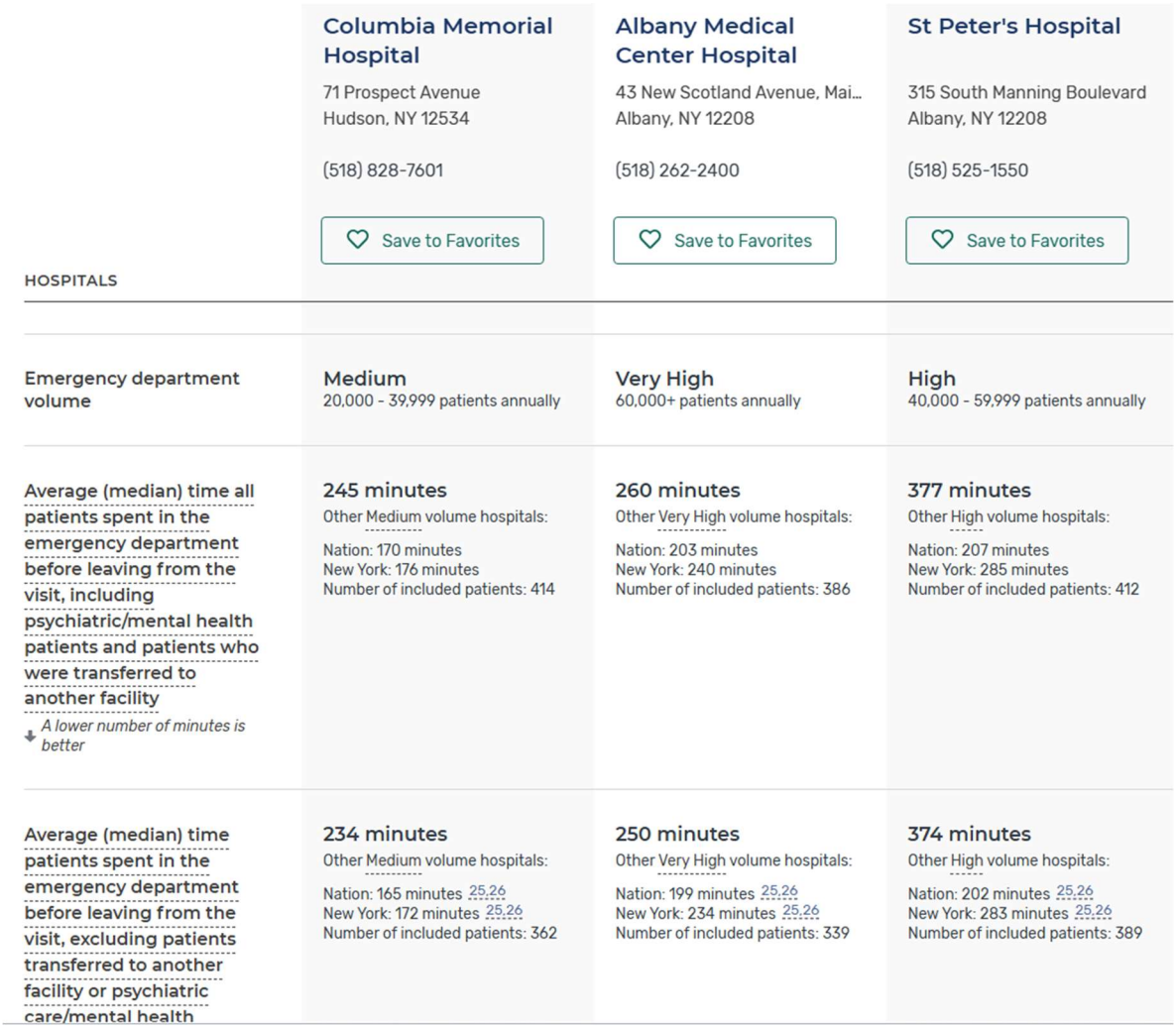
Overall, this table reflects a continued focus on freeing up ambulances as quickly as possible so they can return to the community and be available for the next emergency.

30 Day Stats for On Site Times >= 45 Minutes By Hospital
03/31/2026 Through 04/30/2026

Hospital	Total # of Occurences	Total # of All Visits	Normalized Occurences (# of occurrences per 20 visits)
Albany Med Peds	0	23	0
Albany Medical Center	7	380	0.4
Albany Memorial	0	73	0
Ellis Hospital	**14**	**293**	**1**
Glens Falls Hospital	0	2	0
Samaritan Hospital	6	217	0.6
Saratoga Hospital	4	568	0.1
St. Peter's Hospital	**27**	**367**	**1.5**
VA	0	13	0
Total	58	1936	All Hospital Average: 0.7

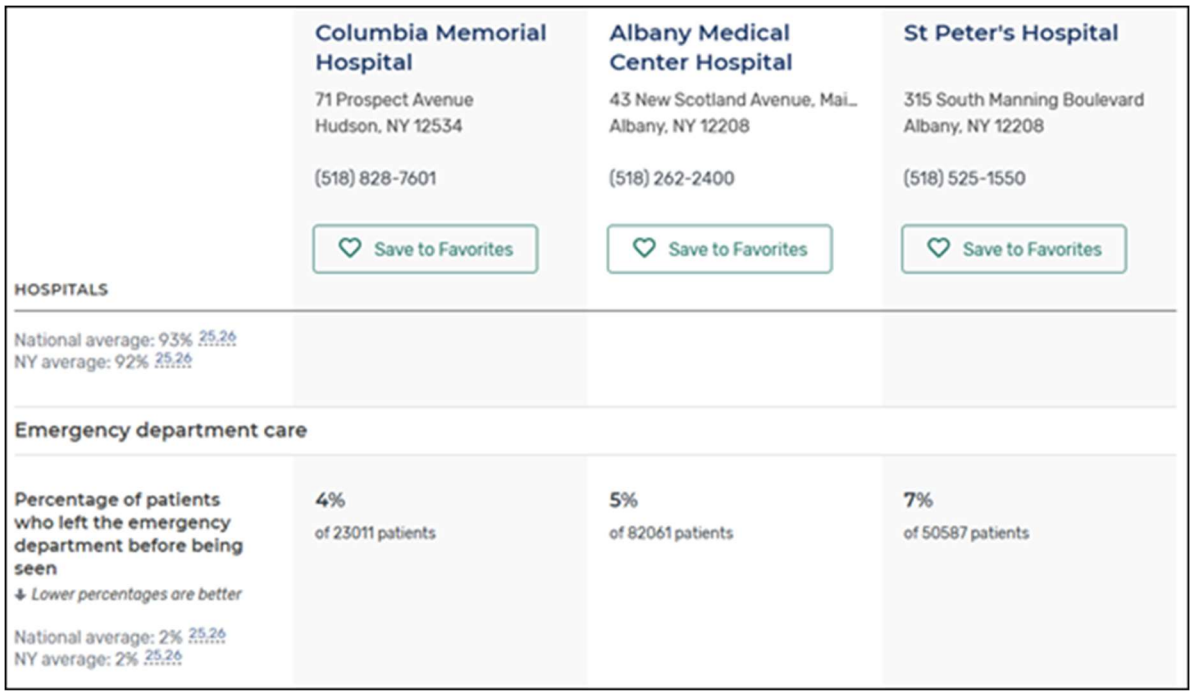
CMS-documented emergency department wait times reflect the overall time patients spend in the ED for evaluation and treatment, not simply the time spent waiting to be seen. These data

show that Albany Medical Center has lower ED times than the other major hospital in the Capital Region.



HOSPITALS	Columbia Memorial Hospital 71 Prospect Avenue Hudson, NY 12534 (518) 828-7601 Save to Favorites	Albany Medical Center Hospital 43 New Scotland Avenue, Mai... Albany, NY 12208 (518) 262-2400 Save to Favorites	St Peter's Hospital 315 South Manning Boulevard Albany, NY 12208 (518) 525-1550 Save to Favorites
Emergency department volume	**Medium** 20,000 - 39,999 patients annually	**Very High** 60,000+ patients annually	**High** 40,000 - 59,999 patients annually
Average (median) time all patients spent in the emergency department before leaving from the visit, including psychiatric/mental health patients and patients who were transferred to another facility *A lower number of minutes is better*	**245 minutes** Other Medium volume hospitals: Nation: 170 minutes New York: 176 minutes Number of included patients: 414	**260 minutes** Other Very High volume hospitals: Nation: 203 minutes New York: 240 minutes Number of included patients: 386	**377 minutes** Other High volume hospitals: Nation: 207 minutes New York: 285 minutes Number of included patients: 412
Average (median) time patients spent in the emergency department before leaving from the visit, excluding patients transferred to another facility or psychiatric care/mental health	**234 minutes** Other Medium volume hospitals: Nation: 165 minutes [25,26] New York: 172 minutes [25,26] Number of included patients: 362	**250 minutes** Other Very High volume hospitals: Nation: 199 minutes [25,26] New York: 234 minutes [25,26] Number of included patients: 339	**374 minutes** Other High volume hospitals: Nation: 202 minutes [25,26] New York: 283 minutes [25,26] Number of included patients: 389

The CMS left-without-being-seen (LWOBS) data also show that CMH and Albany Medical Center Hospital have lower LWOBS rates than other Albany hospitals.



HOSPITALS	Columbia Memorial Hospital	Albany Medical Center Hospital	St Peter's Hospital
	71 Prospect Avenue Hudson, NY 12534 (518) 828-7601 Save to Favorites	43 New Scotland Avenue, Mai... Albany, NY 12208 (518) 262-2400 Save to Favorites	315 South Manning Boulevard Albany, NY 12208 (518) 525-1550 Save to Favorites
National average: 93% 25,26 NY average: 92% 25,26			
Emergency department care			
Percentage of patients who left the emergency department before being seen ↓ *Lower percentages are better* National average: 2% 25,26 NY average: 2% 25,26	4% of 23011 patients	5% of 82061 patients	7% of 50587 patients

Albany Med remains able to support the projected increase of approximately one additional patient per day. Continued collaboration with CMH, along with coordination through our Logistics Center, positions us well to meet the needs of our community. This approach prioritizes timely patient movement, minimizes delays, and helps ensure access to the appropriate level of care, while keeping patient-centered care at the forefront.

Family Member and Visitor Considerations

1199 SEIU and local residents have raised concerns about patients who require tertiary care and the impact transfers may have on their families. CMH recognizes that transfers can create burdens for families and visitors, particularly when care must be provided outside the local rural community. Non-Emergency Transportation remains available through local bus service and Healthcare Consortium transportation for primary care visits and non-emergency mental health care.

Current Scope of Care and Transfer Support

CMH provides core hospital services, but not advanced tertiary or quaternary care. When patients require a higher level of care, CMH coordinates safe transport to the accepting facility.

Transportation Options for Families and Visitors

CMH leadership is working with regional transportation partners to identify transportation options for families and visitors. The CEO serves on the Greene County Transportation Advisory Committee and is working with the county transportation board to explore visitor transportation to Albany Medical Center and other Albany County facilities. For travel south toward New York City, rail and bus options may also be available.

ADDITIONAL REQUEST FOR INFORMATION

December 2023

Steps that will be taken if the Hospital does not receive CAH

AMHS has provided significant financial support to CMH for the past 18 months, including support for payroll and accounts payable. Without CAH designation, the health system would need to reassess the scope of services the hospital currently provides and its operating structure, up to and including an evaluation of a Rural Emergency Hospital designation. Other sources of fiscal support would also need to be identified for the hospital to achieve long-term sustainability.

Therefore, we believe that the most viable option for CMH, without any additional State or Federal financial subsidy would be the Critical Access designation.

CMH has always considered that the State certification process may provide flexibility through waivers to certain CAH eligibility requirements; knowing that this current structural model is unsustainable. CMH has reviewed alternative models. There is no realistic financial alternative then the critical access program—access to this federal program has prevented hospitals from discontinuation of healthcare services.

If CMH does not receive CAH designation, it could attempt to seek a Sole Community Hospital (SCH) designation. It is important to note, however, that any reimbursement increases stemming from CMH moving to the SCH designation would not be sufficient to cover the $10-20 million-dollar structural losses gap.

APPENDIX

ALBANY MED Health System
COLUMBIA MEMORIAL HEALTH

Critical Access Hospital
CMH Communications and Marketing Plan 2025-2026

SITUATION

Columbia Memorial Health (CMH) is the only hospital located within Columbia and Greene counties. The hospital and its thirty-seven outpatient- community locations are the primary source of care for the region's 111,000 residents. As the first affiliate of the Albany Med Health System, CMH and Albany Med have each made significant investments in operations in the CMH service area and expanded access to specialty care not previously available in this region.

Nevertheless, a cascade of factors has impacted CMH viability. The hospital's average daily census is between 40 and 50 patients; it is licensed for 192 beds. Medicare and Medicaid represent an overwhelming majority of the inpatient payer mix, which results in weaker reimbursement rates. Proximity to large cities has strained recruitment and retention efforts. Other health systems have lured away patients with higher financial means despite any investment in the two counties.
It also leaves CMH anticipating continued losses too great to overcome without significant reinvention.

CMH remains vital to the communities it serves. Without it, Columbia and Greene counties would become a health care desert. With the Albany Med Health System, CMH proposes a bold and innovative approach to maintaining an invaluable lifeline now and in the future. The plan calls for a reinvention of the main CMH campus as a critical access hospital (CAH) focused on the most critical services its patients require. To support this, CMH and Albany Med have also begun plans to create a new surgical center for same-day treatment at Greene Medical Arts (GMA), as well as investing in the burgeoning demand for behavioral health care in Hudson. A focus on primary care will also strengthen CMH's already solid presence in the market.

Crisis and community communications will focus on the evolution of the main CMH campus and the entire transformation plan—with access, respect for the community, and transparency as the guiding principles.

The following Communications and Marketing Plan addresses:

1. Strategy
2. Audiences
3. Objectives
4. Messaging
5. Tactics
6. Timeline and Tactics by Audience

OBJECTIVES

1. **KEY OBJECTIVE #1:** Positively convey the plan as fact based, data driven, and community focused. In other words, this is a very good thing for Columbia and Greene counties.
2. **KEY OBJECTIVE #2:** Transparently describe our commitment to the region.

3. **KEY OBJECTIVE #3:** Explain what a critical access hospital is and how services will continue.
4. **KEY OBJECTIVE #4:** Emphasize that the System is the regions only regionally governed, not-for-profit health system to underscore dedication and responsiveness to the region.
5. **KEY OBJECTIVE #5:** Highlight the net-new benefits to the southern market, i.e. an ambulatory surgery center and investment to mental health inpatient services and serve community need.

MESSAGING

1. CMH and the Albany Med Health System are investing in Columbia and Greene counites.
2. Based on data, we are responding to how the community currently uses CMH and optimizing the services it offers to match that demand.
3. Now, reinvention is necessary. We have a commitment to serve the community.
4. The System allows CMH to seamlessly transition patients to additional levels of care, if necessary, whether in Albany or at one of our member hospitals.
5. A critical access designation for CMH is an endorsement of the indispensable role it plays in a rural area.
6. There will be no closure, no layoffs, and no loss of essential services.
7. A new ambulatory surgery center at GMA brings with it brand-new operating spaces and allows patients to receive specialty care close to home with providers from Albany and Hudson.
8. We are also expanding the services we provide, particularly in cardiology and primary care.
9. This approach is innovative and exciting. It will take health care in the area to the next level.
10. Our plan will help with recruitment and retention efforts, which are historically challenging in rural areas.
11. The goal is long-term sustainability and growth.

TARGET AUDIENCES

1. External
    - Capital Region residents, particularly those in Columbia and Greene counties
    - Current and potential patients
    - Current and potential donors
    - Health care providers
    - First responders
    - Potential employees
    - Business, government, and community leaders
    - Media
2. Internal
    - System Board of Directors
    - Campus boards
    - Campus development committees
    - Physicians
    - Nurses
    - Staff

GEOGRAPHY

- Primary: Columbia, Greene, northern Dutchess and Northern Ulster counties, southern Rensselaer, and Albany counties.

- Secondary: Albany-Schenectady-Troy media market (Albany, Rensselaer, Saratoga, Schoharie, Schenectady, Washington, Saratoga, Warren, Hamilton, Montgomery, and Fulton counties).

STRATEGIES

1. Public relations
2. System and campus digital, social media pages, and websites
3. Media outreach
4. First responder outreach
5. Internal communications
6. System and campus publications
7. Collateral
8. Government relations
9. Community outreach

TACTICS AND RESPONSIBILITIES

TACTIC	RESPONSIBILITIES
OVERALL CAMPAIGN & DEVELOPMENT & MANAGEMENT	VP
Public and media relations	VP
Advertising	VP and Manager
Social media, website	VP and Manager
First responder outreach	Director of Communications
Internal publications and platforms	VP (System, with assignments to those responsible for *The System Story*, the System Board newsletter, Direct to Clinicians, etc.),
Collateral	VP /Manager
Government relations	CEO of CMH and CEO of AMHS
Community outreach	CEO of CMH and CEO of AMHS

1. **Public and media relations.**
    a. Media relations on the CAH application plan have begun. We have and will continue to honor all media opportunities to explain CMH's position
        i. CMH remains fully operational, with 24/7 emergency care at the center of its mission.
        ii. Patients will continue to access all CMH services as they do today — only with more investment in the care they use most.
        iii. CMH will complete a Health Equity Impact Assessment, including public town halls, staff meetings, and community surveys.
        iv. Under current reimbursement rules, CMH receives only 50 to 70 percent of the cost of care for 89 percent of patients, who have government insurance. As a critical access hospital, CMH would receive up to 101 percent of the cost of care, which will enable reinvestment in staff, services, and facilities.
        v. The critical access hospital application and Health Equity Impact Assessment will take six to 24 months and require state and federal review. No immediate

changes will occur. The process is deliberate, transparent, and designed to preserve local health care now and in the future.

b. Continued media inquiries will be used to respond to public concerns, which are currently ongoing.
c. A proactive approach will be taken as appropriate to share updates about scheduled town hall meetings, updates on the CAH application, and other opportunities to be transparent with our community.
d. Press releases and direct media engagement, interview opportunities
e. Website stories and information pages
f. Video recordings from meetings
g. Distinction between the CAH, behavioral health, and GMA plans

2. **Advertising.** Paid advertising should be used to alert the community about town halls, the hospital application process, and the transformation.
    a. Vehicles
        i. *Digital advertising*: Mix of display, television, radio, streaming audio, social media, and out-of-home advertising.
            → Banner ads, high impact banners, site takeovers.
            → :30, and :15 TV spots on YouTube and OTT (Amazon Fire, Chromecast, AppleTV, YouTube, Roku, Samsung Smart, gaming consoles, desktop computers, mobile phones, and tablets)
            → Social media (image, carousel, and video)
        ii. *Television*: :30, and :15 spots may run throughout the Albany-Schenectady-Troy DMA, but the core of any television spend will occur through Hudson Valley Cable and Spectrum (Valatie, Kinderhook, and Dutchess and Ulster counties).
        iii. *Radio and streaming radio*: Geographically targeted to the primary audience.
        iv. *Print*: *Daily Mail, Register Star*, *Chronogram*, and *Times Union* full- and half-page advertisements.
        v. *Out of home*: Billboards in high-traffic areas on interstate areas and major thoroughfares, restaurant placemats, tourism guides.
        vi. Full-page letters or editorials (as ads) from CMH/System leadership in papers, social media
        vii. Internally generated story content
3. **Social media and website (non-paid)**
    a. Facebook, Twitter, and Instagram
        i. Links to stories and press releases about the project
        ii. To be placed on CMH and Albany Med Health System social media pages
        iii. Explanations of how the CAH
        iv. Links to feature stories (on staff, space, technologies, services) and press releases on the Albany Med Health System website.
    b. Website
        i. Main landing page on the transformation plan including CAH specifics, GMA, behavioral health
        ii. Information about previous and upcoming town halls
        iii. Video recordings when available
        iv. Feature stories about how the CAH and GMA will sustain and elevate health care in the counties, and the new options residents have for care.
4. **First responder outreach**
    a. Talking points for EMS/police/fire liaisons
    b. Presentations to regional organizations and committees

c. Explanation about the need for transportation when patients require a higher level of care

5. **Internal publications and platforms**
    a. Letters to staff
    b. All-staff presentations on both campuses outlining the vision and goals
    c. Presentations, letters, feature stories, and collateral posted on campus Intranet pages
    d. Feature stories about the CAH plan, the new ambulatory surgical center, an investment in behavioral health in Hudson, and other relevant topics
    e. Regular updates on progress
    f. Signage on digital spaces as well as elevators, easels, and other areas.
6. **Collateral**
    a. One-pager on CMH current state
    b. Executive narrative
    c. New hospital profile one-pager
    d. Patient and community FAQ
    e. GMA one-pager
    f. GMA patient-facing brochure
    g. Direct email of stories to patients
7. **Community outreach**
    a. Community meetings
        i. Public Town Halls
        ii. Government presentations
    b. Foundation events
    c. Giveaways

TACTICS BY AUDIENCE

Audience	Media relations	Advertising	Social media and website	First responder outreach	Internal publications and platforms	Collateral	Community outreach
Area residents	✓	✓	✓		✓	✓	✓
Current and potential patients	✓	✓	✓		✓	✓	✓
Current and potential donors	✓	✓	✓			✓	✓
Health care providers	✓	✓	✓	✓	✓	✓	✓
First responders	✓	✓	✓	✓	✓		✓
Potential employees	✓	✓	✓	✓		✓	✓
Community leaders	✓	✓	✓		✓	✓	✓
Media	✓	✓	✓			✓	

Boards	✓	✓	✓		✓	✓	
Committees	✓	✓	✓		✓	✓	
Staff	✓	✓	✓		✓	✓	