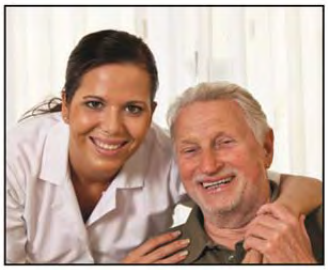
Catholic Health

Community Health Needs Assessment & Community Service Plan 2016 ASSESSMENT



MOUNT ST. MARY'S HOSPITAL • 5300 MILITARY ROAD • LEWISTON NY • 14092

NIAGARA COUNTY

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Leadership Welcome

Catholic Health

December 2016

Joseph D. McDonald
President & CEO
Catholic Health

Bart Rodrigues
SVP & Chief Mission Officer
Catholic Health

Dear Community Resident:

As one of the largest health care providers in Western New York, we continually look for ways to improve the health of those who reside in our community. To support this effort, we conduct a Community Health Needs Assessment (CHNA) every three years to understand the health concerns and issues faced by community residents. The latest Assessment is included here.

The assessment process was a collaborative effort between Catholic Health and other local organizations concerned about the health of our community including Catholic Medical Partners, Niagara County Department of Health, Buffalo State College, and the University at Buffalo. Additionally, we solicited input from other community organizations, individuals and groups. This input helped develop focused programs and services that best address the health and wellness needs of the people who rely on us for care.

The completed assessment provides the framework for our implementation plans which address the identified and prioritized community needs. One of the areas emphasized in our assessment and plan is the need to address health disparities in our community by improving access to care, especially for the poor and underserved. To that end, in 2015, Catholic Health provided more than $99 million in charity care and community benefit for the people of Western New York.

Catholic Health is committed to leading the transformation of health care in our community and to improving the health of its residents, enhancing the experience of patients and reducing the cost of care. Our commitment to quality is demonstrated by our achievement of the highest quality rankings in cardiac, vascular, orthopedics and women's services through government and third-party quality rating agencies. In addition, our commitment to help patients make informed health care decisions is evidence by our recently launched public website, www.knowyourhealthcare.org, which contains important health care quality information.

We look forward to working together with you and our community partners to improve the health and quality of life for the residents of Niagara County. We welcome you to learn more about Catholic Health by visiting www.chsbuffalo.org or calling HealthConnection at 716-447-6205.

Joseph D. McDonald
President & CEO
Catholic Health

Bart Rodrigues
SVP & CMO
Catholic Health

Gary Tucker
President & CEO
Mount St. Mary's Hospital

Executive Summary

Background

Mount St. Mary's Hospital is comprised of a 175-bed community hospital and a fully-licensed Child Care Center on its campus in Lewiston, NY. It also operates a Neighborhood Health Center clinic in the City of Niagara Falls and an off-site Outpatient Rehabilitation Center. In addition, medical specialties are offered at facilities on-campus and throughout the community.

Our Mission: ***We are called to reveal the healing love of Jesus to those in need.***

Mount St. Mary's Hospital employs more than 800 people and has about 200 volunteers.

Mount St. Mary's Hospital was formed in 1907 by the Sisters of St. Francis who came north from Buffalo to care for the sick and the poor. In 1997 the Sisters of St. Francis turned over sponsorship to the Daughters of Charity National Health System to continue in their tradition of excellence and service. In 2000 the Daughters of Charity merged with the Sisters of St. Joseph to create Ascension Health. Ascension Health is the largest not-for-profit healthcare system in the nation.

In July 2015, the sponsorship of Mount St. Mary's was transferred to Catholic Health of Buffalo.

Overview of Process

The 2016 Niagara County Community Health Needs Assessment began by bringing together the participants from the 2013 process. This included the Niagara County Department of Health, and representatives of the four hospitals in Niagara County: Mount St. Mary's, Niagara Falls Memorial, DeGraff Memorial, and Eastern Niagara. The process was coordinated by the P2 Collaborative of Western New York.

Initial meetings focused on evaluating activities from the 2013 CHNA's and the County Health Department's Community Service Plan priorities. Despite posting our 2013-16 report on our website and providing notice in the media, we did not receive any written input on the report. Subsequent sessions were devoted to developing a countywide questionnaire to survey residents and initiatives to gather as much relevant data as possible from surveys, interviews, and focus groups.

As part of this coordinated initiative, Mount St. Mary's worked to develop an updated three-year (2016-2018) Community Health Improvement Plan/Implementation Strategy (CHIP/IS) to continue the collaboration in our community to improve patient care, preventive services, overall health, and quality of life. Our input process covered many segments of the community including individual surveys, community organizations, local health officials and others of varying socioeconomic backgrounds.

The CHNA and CHIP/IS processes are linked directly to requirements specified by the Federal Internal Revenue Service and the New York State Department of Health. Under the Patient Protection and Affordable Care Act of 2010 (PPACA), the federal government (IRS) requires all state-licensed, tax-exempt hospitals to develop a Community Health Needs Assessment and Implementation Strategy to maintain their Internal Revenue Code Section 501(c)(3) tax-exempt status. Similarly, New York State requires hospitals and local health departments to collaborate within their community to identify local health priorities and plan and implement a strategy for local health improvement focused on the Prevention Agenda 2013-2018: New York State's Health Improvement Plan (Prevention Agenda).

Community Health Improvement Plan

Mount St. Mary's Hospital, as part of Catholic Health, is committed to addressing the significant health needs of our community. This is reflected in this updated three-year (2016-2018) Community Health Improvement Plan/Implementation Strategy (CHIP/IS). The plan began with the prioritization of the significant health needs challenges experienced by patients and families identified in the CHNA. Mount St. Mary's considered the importance placed on those needs by both New York State as outlined in the Prevention Agenda, by a local assessment community survey conducted by the Niagara County Department of Health (**ATTACHMENT B**), by a survey conducted by Mount St. Mary's targeting community organizations and groups in our primary service area, (**ATTACHMENT D & E**) and by other collected input that included targeted efforts in underserved areas of the community.

Mount St. Mary's then assessed its capabilities and resources with the potential to strengthen relationships with current partners and others in the community to select projects that had the greatest opportunity to reduce the health disparities and meet the needs of the residents of our community.

The progress of Mount St. Mary's CHIP/IS will be measured and reported annually to the community on the Mount St. Mary's/Catholic Health website in addition to paper copies which are available at our Hospital Information desk and our Neighborhood Health Center.

The Mount St. Mary's Hospital Website can be found at:

Mount St. Mary's Hospital: www.chsbuffalo.org/mountstmarys

Community Priorities Not Specifically Addressed

Through the needs assessment, numerous areas were identified as important and clearly impact the health of the community. Mount St. Mary's identified the "significant" needs as related to the New York State Department of Health Prevention Agenda priorities. Within the "priorities," Mount St. Mary's will address numerous health needs as described in the publicly available CHNA report.

Two priorities not specifically addressed in the implementation plan: Neighborhood Safety and Food/Water Safety. We did not address in our plan because of a lack of expertise and resources to effectively address each of the issues.

Identified Community Health Needs Themes

The programs that Mount St. Mary's has put in place to address its priorities involve participation and cooperation of numerous community groups and organizations. Mount St. Mary's will continue to support several health collaborative groups which include community partners, the Niagara County Health Department, academia, and local schools. These partners will be engaged throughout the years in an evaluation process to determine new areas of need or refine current service offerings.

IMPROVE HEALTH STATUS AND REDUCE HEALTH DISPARITIES

1) Reduce Healthcare Disparities in Vulnerable Populations Through "Trauma-Informed" Care

PREVENT CHRONIC DISEASES

2) Address Diabetes Management and Prevention
3) Stroke Prevention & Support

PREVENT HIV/STDs AND HEALTHCARE-ASSOCIATED INFECTIONS

4) Percentage of Adolescents with HPV immunization

PROMOTE HEALTHY WOMEN, INFANTS AND CHILDREN

5) Proportion of Infants who are Fed Breast Milk
6) Helping High Risk Moms to Prevent Prematurity and Address Opioid Dependence
7) Reduce Percentage of Pre-Term Births

PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE

8) Pediatric Care Coordination
9) Mental Health First Aid Training

NIAGARA COUNTY DEPARTMENT OF HEALTH – COMMUNITY HOSPITALS

10) Prevent Chronic Disease: Disparity – Mental Hygiene
11) Promote Mental Health and Prevent Substance Abuse

PROCESS AND METHODS

Satisfying the requirements of the IRS and DOH, Mount St. Mary's Hospital followed the process described below in completing its Community Health Needs Assessment and Community Health Improvement Plan/Implementation Strategy.

1. Establish the Assessment Infrastructure

An Internal Steering Committee was established that included representation from various segments of the organization. Members of the group from Mount St. Mary's who worked on the identification of internal priorities:

- Barbara Bucci, RN, BSN, Vice President – Patient Care Services
- Kerry Caldwell, RN, BSN, Corporate Nurse Educator
- Fred Caso, Director, Public Relations and Community Affairs
- Bernadette Franjoine, Vice President – Mission Integration
- Megan Kosmoski, Patient Educator, Diabetes
- Maryann Cogdill, RN, Director of Maternity Services
- Alexandra Murr, RN, Director – Education and Organizational Development
- Rosanne Schiavi, RN, BSN, Stroke Program Coordinator
- Sr. Nora Sweeney, DC, Social Worker
- Gary C. Tucker, President and Chief Operating Officer
- Patricia Villani, Director, Neighborhood Health Center

2. Defining the Purpose and Scope

In New York State (NYS), all not-for-profit hospitals are required to develop a Community Service Plan (CSP). The requirements of the CSP, while not identical, are very similar to those of the IRS Community Health Needs Assessment and Implementation Strategy. NYS requires that each organization, in cooperation with the local department of health and other providers in their county, collaboratively choose to work on two Prevention Agenda priority focus areas and address disparities in at least one of them. The NYS Prevention Agenda guided Mount St. Mary's in focusing its assessment efforts and in defining its service area as western Niagara County. It also helped to identify the most important health issues in the community, set priorities and align work with community partners.

3. Collect and Analyze Data **(Summary in ATTACHMENT B-C-D)**

Mount St. Mary's did significant outreach in the community and within the organization to collect input.

The primary data collection efforts included:

- Written Survey targeting local community organizations and non-profits that are active in the primary service area
- Written Survey targeting local block clubs and church groups active in the primary service area
- Focus Group at the Mount St. Mary's Neighborhood Health Center, located in the part of the service area with the lowest per capita income and underserved in a variety of ways
- Focus Group at Mount St. Mary's Hospital involving associates
- Input from Focus Groups conducted throughout Niagara County by Niagara County DOH
- Written Request for input from physicians at Mount St. Mary's
- Written Survey conducted by Niagara County Department of Health that was countywide, but also with the ability to gather input from our primary service area.

4. Identify Resources/Community Collaboration

The Mount St. Mary's Internal Steering Committee reached out to a cross-section of the hospital's partners and organizations that represent the broad interests of the community and have expertise in public health, and human service needs/delivery to help identify the health needs in the community. These included members of the Creating a Healthier Niagara Falls Collaborative and Healthy Behaviors Work Group:

- Connie Desmarais, Family and Children's Services of Niagara
- Kara Donovan, Niagara County Office of the Aging
- Pamela Fox, American Diabetes Association
- Myrla Gibbons-Doxey, Niagara County Department of Mental Health
- Darcy Hughes, Buffalo-Niagara YMCA
- Robin Meiser/Lynne Neveu, Planned Parenthood of Niagara
- Lora Naples, Native American Community Services
- Rev. Mark Perkins, Isaiah 61 Project
- Ezra Scott, Jr., Roswell Park Cancer Institute/Niagara Falls City Council
- Kristen Grandinetti, Niagara Falls School District/Niagara Falls City Council

Other groups included:

- Mom's Net
- Family and Children's Services of Niagara
- Heart, Love & Soul Food Pantry
- Project Connect Niagara

5. Prioritization of Community Needs

Prioritization of the health needs identified in the 2016 CHNA began by considering the degree of alignment with the New York State Prevention Agenda framework. Significant health needs represented within the New York State Prevention Agenda are:

A. Improvement of Health Status and Reduction of Health Disparities
B. Promote a Healthy and Safe Environment
C. Prevent Chronic Disease
D. Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections
E. Promote Healthy Women, Infants, and Children
F. Promote Mental Health and Prevent Substance Abuse

To further guide prioritization of the identified community health needs, Mount St. Mary's also considered:

- Internal capability to support initiatives
- Community collaboration opportunities
- Meaningful impact
- Alignment with values
- Human Service readiness to advance projects

6. Create Implementation Strategy and Monitor Progress

Priority areas identified through the needs assessment were used to focus community benefit planning for the next three years. An Implementation Strategy has been developed which includes the focus areas, goals, and objectives for addressing the prioritized significant community health needs and addresses the two collaboratively chosen Prevention Agenda priorities. Within the Implementation Strategy are plans which constitute roadmaps for how the priorities will be addressed. These plans include specific actions to be taken, collaborations that will be instituted and targets to measure success. A dashboard with implementation plan measures will be used to communicate and gauge progress throughout the three-year duration.

To facilitate the accomplishment of these goals Catholic Health made an intentional decision of allocating one percent of its net income from previous year, for projects related to community needs.

Mount St. Mary's will also maintain engagement with its community partners by establishing work plans for collaborative efforts to achieve annual targets. The Mount St. Mary's Internal Steering Committee has established a monthly meeting to continue to discuss and track progress of the implementation plans and collaborative efforts with community partners.

7. Board Approval and Public Availability of the CHNA/IS Plan

The final Mount St. Mary's CHNA will be presented to the Catholic Health Ministry Services Board.

The CH Hospital Board of Directors reviewed and approved the IS Plans for each of its hospitals on December 15, 2016.

Reports have been published electronically on the Catholic Health/Mount St. Mary's Hospital website with hard copies available at the hospital and the Mount St. Mary's Neighborhood Health Center.

Overview of Mount St. Mary's Hospital

Mount St. Mary's Hospital is comprised of a 175-bed community hospital and a fully-licensed Child Care Center on its campus in Lewiston, NY. It also operates a Neighborhood Health Center clinic in the City of Niagara Falls and an off-site Outpatient Rehabilitation Center. In addition, medical specialties in Otolaryngology, Primary Care, General Surgery and Orthopedics are offered at facilities on-campus and throughout the community. Mount St. Mary's serves as the Medical Provider for the PACE Program in Niagara Falls. Our Mission*: We are called to reveal the healing love of Jesus to those in need.*

Staff at Mount St. Mary's includes more than 200 physicians with privileges, 200+ RN's and LPN's, 30 allied health professionals and numerous employees in supporting roles. In all, Mount St. Mary's Hospital and Health Center employs more than 800 people and has about 200 volunteers.

Mount St. Mary's Hospital was formed in 1907 by the Sisters of St. Francis who came north from Buffalo to care for the sick and the poor. In 1997 the Sisters of St. Francis turned over sponsorship to the Daughters of Charity National Health System to continue in their tradition of excellence and service. In 2000 the Daughters of Charity merged with the Sisters of St. Joseph to create Ascension Health. Ascension Health is the largest not-for-profit healthcare system in the nation.

In July 2015, the sponsorship of Mount St. Mary's was transferred to Catholic Health of Buffalo.

An important component of the service provided to the community by Mount St. Mary's involves our association with Catholic Medical Partners (CMP), Mount St. Mary's and Catholic Health's physician partners. This is a physician-led independent practice association with a network of over 1,000 physicians of which one-third are primary care providers. CMP is driven to improve care delivery in the community through its member physicians.

Catholic Health Charity Care

One of the fundamental reasons for the creation of Catholic Health was to ensure the continued viability of faith-based health care to meet the needs of residents in Western New York. Integral to this effort is caring for the needs of those who are poor and disadvantaged. In the Niagara community, Mount St. Mary's activities and services at its Neighborhood Health Center and collaboration at the Heart, Love and Soul Food Pantry are two prime examples of this commitment to those in need. Other initiatives are undertaken through active involvement and leadership in community organizations such as Family and Children's Services of Niagara, the Creating a Healthier Niagara Falls Collaborative, and others.

Each year, Catholic Health touches tens of thousands of community residents through community health education programs, health screenings, clinical and support services, and community support activities. In Niagara County these initiatives have included day-long screenings at the hospital, outreach at community events from downtown Niagara Falls to Wheatfield, among others. Mount St. Mary's and Catholic Health will continue to meet community needs by providing charity care and Medicaid services, in addition to various other community benefit programs, including community health improvement, community benefit operations, health professions education, community building, as well as, cash and in-kind contributions. In 2015 Catholic Health provided $99.5 million in charity care, of which MSM contributed $8.7 million.

Mount St. Mary's/Catholic Health (CH) Mission, Vision and Values

Mount St. Mary's/Catholic Health's mission :
We are called to reveal the healing love of Jesus to those in need

1. ***2020 VISION***
   Inspired by faith and committed to excellence, Catholic Health will lead the transformation of healthcare in their communities.

2. ***CATHOLIC HEALTH VALUES***
   - **A. Reverence**
     We honor the value of each individual we encounter at Catholic Health.
     - Be an exceptional example of our Mission
     - Show courtesy to everyone through warm, welcoming words and gestures.
     - Collaborate to foster our Mission and Values.
     - Care for and strengthen our healing ministry and all the resources entrusted to us.
     - Look for the face of God in everyone we meet.
   - **B. Compassion**
     We commit to walking with others through both joy and suffering.
     - Be a transforming, healing presence in the communities we serve.
     - Extend a welcoming hand to all patients, residents, families and associates.
     - Reach out unconditionally in the spirit of the Good Samaritan.
     - Show kindness when we help others.
     - Offer empathy, tenderness and respect to those in need.
   - **C. Justice**
     We dedicate ourselves to treat all people with respect, dignity and fairness.
     - Advocate for persons who are poor and vulnerable.
     - Be accepting and understanding of people who need our help.
     - Recognize and affirm each individual's contributions.
     - Be honest and ethical in all dealings.
     - Honor the uniqueness of each individual and maintain an inclusive environment.
   - **D. Excellence**
     We commit to exceed the expectations of our patients, residents, their families, and all the people we meet at Catholic Health.
     - Envision a future filled with hope.
     - Foster a high quality workplace.
     - Seek opportunities for professional and personal growth.
     - Be faithful to their Mission and Values.
     - Provide the highest quality of care and service.

COMMUNITY SERVED

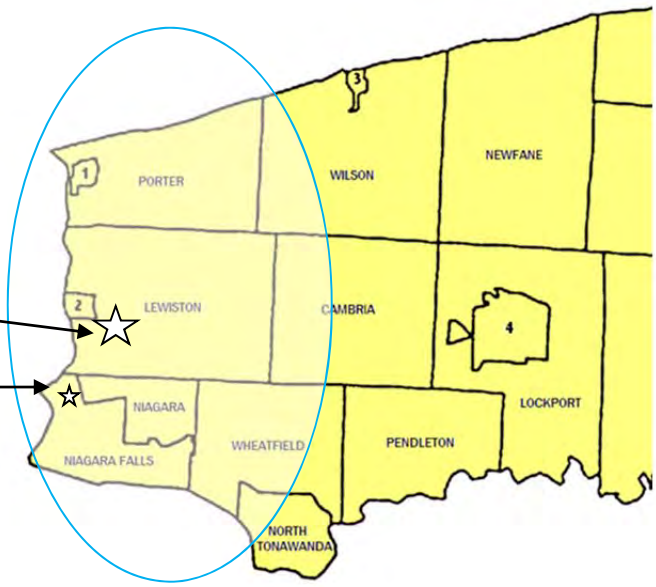
1) COMMUNITY SERVED

A) AREA SERVED:

The Primary Service Area for Mount St. Mary's is generally described as Western Niagara County.

Eighty-Five percent of our patients come from this area.

Services are provided at the **main hospital campus** in Lewiston and the **Neighborhood Health Center** in the City of Niagara Falls.



B) DEMOGRAPHICS:

Detailed demographics of the community from US Census and other data are included in the report.

C) EXISTING HEALTH CARE FACILITIES:

There are two community hospitals in our Primary Service Area –

Mount St. Mary's Hospital, 5300 Military Road, Town of Lewiston NY

Niagara Falls Memorial Medical Center, 621 Tenth Street, City of Niagara Falls NY

Demographic Summary

A Community Hospital, Mount St. Mary's is part of Catholic Health (The System), a not-for-profit integrated healthcare delivery system that operates four acute care operations in Erie County and one in Niagara County. The primary service area for Mount St. Mary's is Western Niagara County. U.S. Census Bureau data is available for all of Niagara County. A demographic profile of Niagara County and our community is summarized below.

Demographics

Population

- The total population of Niagara County has decreased by 1.8% from 2010 to 2015 from 216,469 to 212,652.
- Of this amount, about 100,000 people reside in the hospital's Primary Service Area.
- The overall population size is expected to remain stagnant through 2021.
- The population of individuals aged 65 or greater has increased by 1.8% between the years 2010 to 2015 from 15.9% of the population to 17.7% of the population.
- 51.3% female
- 22.4% rural
- The median household income in Niagara County is $49,091
- 13.4% of the residents of Niagara County are deemed to live in "poverty."

NOTE: 2015 Federal Poverty Levels are defined as Household of

1 = $11,770 2 = $15,930 3= $20,090 4 = $24,250
5 = $24,410 6 = $32,570 7 = $36,730 8 = $40,890

Race / Ethnicity

- The population of Niagara County is predominantly white, representing 88.1% of the population.
- The Black or African American race represents 7.2% of the population.
- The next largest population segment is Hispanic/Latino representing 2.8%.
- A small portion, 1.1% are Native Americans, and most are in our primary service area.
- Less than 1% described as not proficient in English

Health Insurance Coverage

- Approximately 92.8% of the Niagara County under the age of 65 has some form of health insurance coverage, leaving the remaining 7.2% uninsured.

Employment/Unemployment

- Currently there is a 4.4% unemployment rate among the population in the labor force in Niagara County. This rate was lower than both the New York State unemployment rate of 4.7% and national unemployment rate of 4.9%.

Sources: *census.gov; countyhealthranking&roadmaps*

Community Resources

Systems and Access to Care

The Niagara County health care system is centered on work by four community hospitals: Mount St. Mary's Hospital (of Catholic Health), Niagara Falls Memorial Medical Center (independent), DeGraff Memorial Hospital (Kaleida Health) and Eastern Niagara/Lockport Memorial Hospital (affiliated with Kaleida Health). Another important provider that impacts the community is Roswell Park Cancer Institute, a national cancer center.

Other Community Providers

Another important health care provider organization in Niagara County is a Federally Qualified Health Center. Supplementing these providers is a broad range of other community organizations providing various health services and resources. The DSRIP Community Health Needs Assessment conducted in 2014 prepared a comprehensive inventory of those resources.

Western New York Community Health Needs Assessment 2014

Delivery System Reform Incentive Payment (DSRIP) Program - VOLUME ONE

On broad composite measures of health status as framed by the New York State "Prevention Agenda" Western New York does relatively poorly. Across sub-categories of chronic disease, health status disparities, creating a healthy and safe environment, preventing HIV, sexually transmitted diseases and other infectious diseases, promoting mental health and preventing substance abuse, and promoting the health of women, infants and children, the region performs generally below par.

The region's poorest ranking comes in the sub-group for HIV and STDs. However, Erie County and to a lesser extent, Niagara County, account for the bulk of the problem. This includes low rankings for HIV prevention, new cases of HIV, and disparities in HIV rates for Black and Hispanic persons.

The region also has a relatively low composite ranking for the subgroup for chronic diseases with higher incidences of hospitalization for **complications of diabetes**, complications of juvenile diabetes and for heart attacks. Rates for emergency room visits for asthma and by persons 0-4 years old for asthma are also above average compared with the rest of upstate New York.

For chronic diseases and causal behaviors, a few hotspots appear in the data. Orleans and Niagara County have a very high for percentage of adults who smoke. Genesee County ranked at the bottom compared with both WNY and similar counties statewide for complications from juvenile diabetes.

Niagara County had a similar ranking with regard to **adult diabetes**. The region also ranked poorly in the sub-group for promoting a healthy and safe environment with measures for **ED visits as a result of falls**, ED visits due to occupational injuries, and ED visits resulting from assault-related injuries. WNY was also at the bottom in terms of the number of jurisdictions approving the Climate Smart Communities pledge and the proportion of workers who use alternative forms of transportation or work from home. For promoting mental health and preventing substance abuse the region also did poorly but based on a relatively small number of indicators. WNY had low rankings for age-adjusted suicide rate and binge drinking.

The composite score for promoting the health of women, infants and children was somewhat better than the others.

Evaluation of Implementation Strategy Impact (2013-16) ATTACHMENT C

In addition to two projects prioritized by the Niagara County Department of Health and embraced by Mount St. Mary's and other community hospitals for collaborations, Mount St. Mary's also elected to pursue projects meeting other identified needs.

A. Niagara County DOH Collaborative Priorities

Shared Priority #1

- Prevent Chronic Disease – increase access to high-quality chronic disease preventive care and management in clinical and community settings.
- Goal – promote use of evidence based care to manage chronic disease
- Disparity – mental health, women

Results

- Eastern Niagara/Lockport Hospital – increase the percentage of adults screened for diabetes in the Hospital's Reflections Recovery Unit by 20%.
- DeGraff Memorial – Increase the percentage of women screened for cardiovascular disease at their annual OB/GYN visits from zero to 60%.
- Mount St. Mary's – increase the percentage of adult patients with chronic disease who receive mental health screening at the Neighborhood Health Center from current level of approx. 10% up to 50%. Mount St. Mary's baseline of 18% in January 2014. Achieved a level of 70% in the summer of 2016.
- Niagara Falls Memorial – increase the percentage of adult health home members diagnosed with both schizophrenia and diabetes whose blood glucose is in good control

MOVING FORWARD

Mount St. Mary's will continue its screening for mental health on an on-going basis as part of our normal activities at our Neighborhood Health Center and other Primary Care clinics.

Shared Priority #2

Promote a Healthy and Safe Environment

- Goal – reduce falls among vulnerable populations

Results

- By 12/31/17, reduce the rate of fall-related hospitalizations in the population aged 65+ by 10% to achieve a Niagara County rate of 184.1 per 10,000 residents
- Mount St. Mary's had a baseline of 20.6% in November 2013. With efforts that included community presentations, education to patients and others, in early 2016, the rate was reduced to 19.4%. Although target not achieved, progress has been made and education is part of our on-going, regular process, including changes to our EMR in Primary Care.

MOVING FORWARD

Mount St. Mary's will continue to make preventing falls among seniors part of our educational outreach initiatives. We have regular outreach at local senior centers and nursing homes where we provide the information on preventing falls. It is also part of our discharge planning for those patients at risk.

B. Mount St. Mary's Hospital Identified Priorities 2013-16

CH Assessment of 2013 Community Health Improvement Plan as of September 2016

Priority 1 - Chronic Disease (Cardio/Cancer/Stroke/Diabetes)

Provide education and community screenings

Mount St. Mary's will conduct a series of free community screenings throughout the year to address the identified priorities of Chronic Diseases of Cardiology, Cancer and Diabetes.

- Free Community Lipid Panel Screenings each February
- Free Community PSA Screening each June
- Free Free HgbA1C, Glucose and BP Screening at various health fairs
- Site of past Free Digital Mammography Screening in cooperation with the Niagara County Cancer Awareness Program
- Promote and conduct Smoking Cessation Workshops
- Active participant in Mommie & Me Tobacco Free program in Center for Women

Tracking (2013 thru 2015)

- BP Screenings increase from 50% to 54%
- ACE/ARB increase from 67% to 69%
- Lipid Screening saw 204 participants in 2016
- PSA Screening saw 159 participants in 2016
- Chest Pain Accreditation saw Door-to-Needle time reduced to 27 minutes
- Smoking Prevention: 100% of patients received smoking assessment and 100% of patients Id'd as smokers were provided information on NYS Quitline; Quarterly education programs provided

MOVING FORWARD

Mount St. Mary's will continue its free community screening programs, tobacco education, and has invested in staff persons to provide nutrition and diabetes education.

Priority 2: Healthy Mothers, Healthy Babies, Healthy Children

Improve Birth Outcomes and Educate the Public

Mount St. Mary's conducted a series of community programs throughout the year to address the priorities of Healthy Mothers, Healthy Babies, Healthy Children

- **Coordination of Moms Net™** is a network of agencies that provide education services and referrals to women in Niagara County. It is designed to help mothers and mothers-to-be, to learn more about health and wellness during and after their pregnancy.
- 100% of moms screened for smoking
- 100% of moms screened for Safe Environment/Domestic Violence
- Domestic Violence Training at Neighborhood Health Center
- "Feeling Safe" Domestic Violence Training for MSMH Social Workers
- 100% of patients provided vaccination information at clinic
- Total of elective deliveries <39 weeks = 0 (2014 and 2015)
- Compliance with Handling All Neonatal Deliveries Safely (HANDS) 100% (2014 and 2015)
- Extensive Outreach and Participation for Breastfeeding and Lactation Services, including establishment of a Lactation Room.

MOVING FORWARD

Mount St. Mary's will continue its screening initiatives with moms, continue to implement the HANDS program and has invested in a Lactation Coordinator.

Priority 3: Concern Physical Activity and Nutrition (Obesity)

Decrease Co-Morbidities due to Obesity

Coordination of CHEERS Program

(Choosing Healthy Eating and Exercise RoutineS for healthier life)

Childhood obesity is a health problem reaching epidemic proportions throughout the United States. The Program teaches children a simple healthy eating plan, which they can easily internalize and use throughout their lives. By engaging parents in the Program sessions and homework assignments, their participation in the selection of foods, exercise and other aspects of the curriculum can be encouraged and supported.

Measures include:

- Diabetes Education Data
- BMI Report
- Coordination of CardioCraze Community Walk
- Reduce Obesity in Children and Adults
- Outreach to Heart, Love & Soul

Mount St. Mary's conducted a series of community programs throughout the year to address the priorities of Healthy Mothers, Healthy Babies, Healthy Children

- Education Program Accredited by The American Assoc of Diabetes Educators
- Host of monthly Diabetes Support Group
- Healthy Eating Program at Neighborhood Health Center (Cooking Demos)
- BMI assessed on 100% of patients
- Coordination of CardioCraze Community Wellness Walk 2015 = 180 participants
- CHEERS Program 97 participants in 2015
- Heart Love & Soul:
  - Care Coordination
  - Nutritionist
  - Health Fairs

MOVING FORWARD

Mount St. Mary's will continue to provide health information at the Heart, Love and Soul Food Pantry and at other community health fairs and events. The structured CHEERS Program is not being continued.

2016 Community Health Improvement Plan

The Process

Summary

Starting in January 2016, Mount St. Mary's Hospital individually, and collectively with the Niagara County Department of Health and three other local hospitals (Niagara Falls Memorial, Eastern Niagara, and DeGraff Memorial), conducted a Community Health Needs Assessment (CHNA) to better understand the health needs of the community we serve and to fulfill the requirements of both the Internal Revenue Service (IRS) and the New York State Department of Health (DOH).

To ensure the assessment was comprehensive, we began with consideration of the projects in the previous cycle, in addition to input from the public and several community organizations.

Our outreach for Mount St. Mary's included a mail survey to area:

- Community and Service Organizations
- Local Block Clubs
- Area Churches

We also conducted focus groups/surveys at:

- Mount St. Mary's Neighborhood Health Center
- Mount St. Mary's Hospital Associates
- Mount St. Mary's Hospital Medical Providers

In addition, as part of our work with the Niagara County Department of Health, we aggressively supported a written and online survey from County residents. Of the more than 2,200 responses to the survey received from the Niagara County DOH (goal was 2,000), more than 1,100 were from residents of the Primary Service Area of Mount St. Mary's.

In considering our strategy for 2016-2018, we took into account all of this information.

Patient Protection and Affordable Care Act of 2010

Under the Patient Protection and Affordable Care Act of 2010 (PPACA), the federal government requires all state-licensed, tax-exempt hospitals to develop a Community Health Needs Assessment and Implementation Strategy to maintain their Internal Revenue Code Section 501(c)(3) tax-exempt status. Specific requirements include:

1. Input from the community and public health experts
2. Collaboration with other organizations
3. Description of the community served by Catholic Health
4. Description of the process and method used
5. Description of the prioritized health needs identified
6. Description of how the hospital plans to meet the identified health needs

New York State Prevention Agenda

Since 2009, New York State has required hospitals and local health departments to collaborate within their community to identify local health priorities and plan and implement a strategy for local health improvement focused on the Prevention Agenda 2013-2018: New York State's Health Improvement Plan (Prevention Agenda).

This collaborative approach is designed to improve the health status of New Yorkers and reduce health disparities through increased emphasis on prevention. Requirements of New York State 2016-2018 plan include:

1. Define the community served
2. Align investments in evidence-based interventions to the Prevention Agenda
3. Assess and select at least two of the Prevention Agenda's priorities to address collaboratively with community organizations and the local health department
4. Describe the evidence-based interventions that will be implemented to address those priorities and the health disparity of interest

Catholic Health's assessment represents an internal collaboration across its facilities, and collaboration with external organizations in the community, to identify the health needs of the community and develop a strategy for addressing them. The systematic process used helped identify significant health needs across Catholic Health's Erie County service area including among vulnerable and under-represented populations. It also helped identify ways in which continued collaboration could improve patient care, preventive services, overall health, and quality of life.

Process

1. Establish the Assessment Infrastructure

An Internal Steering Committee was established that included key players from throughout Mount St. Mary's that included representation from Community Clinics, Mission, Marketing, Community Education, Finance, and Services Lines. The Internal Steering Committee reviewed IRS & DOH requirements and established the project timeline and work plan. Active participation of the hospital representatives on the Internal Steering Committee meets the requirements for a joint assessment.

2. Defining the Purpose and Scope

In New York State (NYS), all not-for-profit hospitals are required to develop a Community Service Plan (CSP). The requirements of the CSP, while not identical, are very similar to those of the IRS Community Health Needs Assessment and Implementation Strategy. One of the NYS requirements is that each organization, with the local department of health and other providers in their county, collaboratively choose to work on two Prevention Agenda priority focus areas and address disparities in at least one of them. The Prevention Agenda guided Mount St. Mary's in focusing its assessment efforts and in defining its service area as Western Niagara County. It also helped to identify the most important health issues in the community, set priorities and align work with community partners.

3. Collect and Analyze Data

Mount St. Mary's solicited and collected data both from a specific survey targeting community organizations and agencies in our Primary Service Area, and cooperatively with the Niagara County Department of Health and other local hospitals for a survey or residents county wide.

Our data collection and analysis process included:

- disseminating a 31 question survey (Appendix A) developed by the Niagara County Department of Health/P2 Collaborative to County residents;
- disseminating a 4 question survey (Appendix B) devised by Mount St. Mary's to community organizations, churches, block clubs; and,
- facilitating group discussions with community services, public health and human services experts

The different surveying methods ensured a broad representation of various population segments.

Utilizing this variety of sources to develop the health needs assessment ensured the inclusion of persons who represent the broad interest of the community and have special expertise in, or knowledge of, public health issues and concerns. It also provided for the inclusion of input from members of medically underserved, low-income, uninsured or other disparate populations, and organizations that represent these groups. See **Attachments D & E** for the participants and results.

Identify Resources/Community Collaboration

The Mount St. Mary's Community Needs Assessment Group and Community Relations Department reached out to a cross section of the hospital's associates to facilitate identifying individuals who, and organizations that, represent the broad interests of the community and have expertise in public health, to help identify the health needs in Western Niagara County.

4. Prioritization of Community Needs

The community health needs identified throughout this process required prioritization. The first step in the prioritization process was to use the New York State Prevention Agenda as a framework within which to align the community health needs. Significant health needs represented within the New York State Prevention Agenda are:

A **Improvement of Health Status and Reduction of Health Disparities**

B **Promote a Healthy and Safe Environment**

C **Prevent Chronic Disease**

D **Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections**

E **Promote Healthy Women, Infants, and Children**

F **Promote Mental Health and Prevent Substance Abuse**

5. Create Implementation Strategy and Monitor Progress

Priority areas identified through the needs assessment were used to focus community benefit planning for the next three years. An Implementation Strategy has been developed which includes the focus areas, goals, and objectives for addressing the prioritized significant community health needs and addresses the two collaboratively chosen Prevention Agenda priorities. Within the Implementation Strategy are plans which constitute roadmaps for how the priorities will be addressed. These plans include specific actions to be taken, collaborations that will be instituted and targets to measure success. A dashboard with implementation plan measures will be used to gauge progress throughout the three-year duration.

Mount St. Mary's will maintain engagement with its community partners by establishing work plans for collaborative efforts to achieve annual targets. The Mount St. Mary's Internal Steering Committee will continue to meet to discuss and track progress of the implementation plans and collaborative efforts with community partners.

6. Board Approval and Public Availability of the Community Health Needs Assessment/Community Service Plan

- ✓ The Final Report and supporting information will be communicated to the Catholic Health Board of Directors for Approval.
- ✓ Once approved, the report will be published electronically on the Mount St. Mary's/ Catholic Health website with hard copies available upon request at the main Information Desk in the hospital's Main (South) Lobby.

7. Overall Evaluation Process

Conversations regarding concerns in communities and organizations across Niagara County shared several priority themes:

- Strongest: access to fresh food and health care, level of engagement of community members in healthy lifestyle and accountability for own health, education for youth, healthy family units, unemployment and underemployment, transportation, safe neighborhoods, substance abuse and behavioral health

- Top health issues: Cancer, heart disease, diabetes
    - Need to address obesity in all age groups, especially in low-income neighborhoods, to reduce incidence of chronic disease and/or management of condition

- Significant within Heart, Love & Soul and low-income neighborhoods: safe, affordable housing and transportation

- Shared across human service agencies: housing, transportation, lifestyle choices and behaviors

Dialogue regarding opportunities to improve health from community members and organizations in Niagara County:

- Urgent concern for rising number below or at poverty level. Broaden view of healthcare services to meet vulnerable where they are at, stabilize their living situation so can advance. Opportunity to work collaboratively to help people reach a better, more stable place in life for themselves. Helping to change the community in a most tangible way.
    - Well-being of community has great influence on how healthy we are
    - Return to focus of caring for others in neighborhood, concern for welfare of others

- Leverage strengths in community – dedicated service agencies, proven success rates, high impact. Collective impact and positive change driven by various community sectors to address specific social challenge, advance principles of social justice.
    - Majority of what affects health outside of physician practice and health system
    - Need for community response to problems, more coordinated advocacy

- Need housing plus support, affordable housing and easy access to whatever help that is needed to stay safe and healthy, reduce visits to hospital. Strong link between housing and health (unstable housing = unstable health/less likely to address health needs). Housing as a means to facilitate access to health services, significant effect on social determinants (housing is most basic and powerful social determinant of health). Influence and investment in stable housing can reduce health care costs and emergency room/inpatient admissions/readmissions.
    - Need access to providers, hospital based services, pharmacies
    - Investment in community, housing listed as highest of needs, help low income residents live better

- Need more programming and education closer to where community lives, bring health education to schools (parents and students); provide health fairs in less traditional settings (parent-teacher conferences).
    - Update information about SDI, HIV, HPV, healthy relationships, values, self-image

- MSM reliable, trustworthy partner, quality services and positive patient experience, well-positioned with CH, compassionate culture with strong focus on mission, vision, and values, already present in critical service areas.
    - Level of readmissions that are out of hospitals' control, attributable to communities the hospitals serve
- Significant community need surrounding lack of behavioral health and substance abuse treatment resources
    - Provide Behavioral Health First Aid Training for associates and community
    - Presence of treatment and socioeconomic barriers:

2015 and 2016 foundational efforts to advance collaboration in anticipation of community service plans:

- Building and strengthening of relationships with current community partners; Family & Children's Services of Niagara, HANCI/PACE, Niagara Falls City School district, Niagara County Department of Health, American Diabetes Association, Niagara University, Heart, Love & Soul, Opportunities Unlimited of Niagara, members of Niagara County CHIP/CSP workgroup, local faith communities, Niagara County Council on Elder Abuse, Niagara County Re-Entry Task Force.
- Leadership role: Creating a Healthier Niagara Falls Collaborative Leadership Council, Chair for CHNF Healthy Behaviors community work group, NYS Mentoring program at Cataract Elementary School

2016 – 2018 plans/goals:

- Recognition that significant community health needs also exist within CH for Erie County, ability to cross counties planning strategy and efforts

- Maintain stakeholder engagement through quarterly meetings with representatives from Niagara County hospitals (P2 Collaborative as facilitator) and monthly meetings for CHNF Healthy Behaviors community work group.

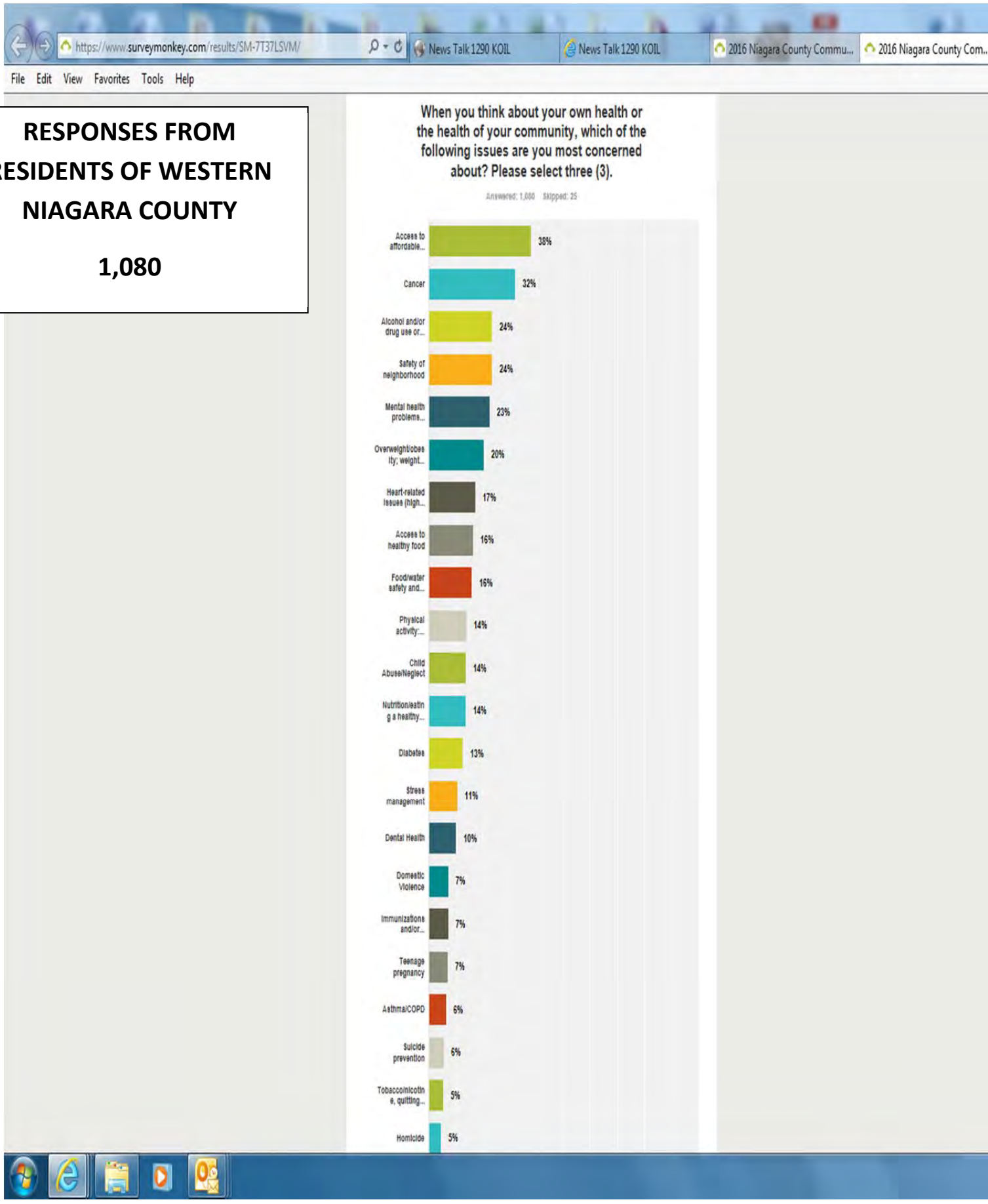
- Each Community Service Plan to include advocacy component to address social determinants of health and population health, special attention to health equity
    - Create community action plans to address disparities that exist
    - Integrate cultural competency, minimization of poverty

- Develop solutions that combine community health and economics

- Be guided by following goals:
    - Improve access to healthcare
    - Promote health and wellness in our community
    - Provide and promote physical activity or other healthy lifestyle behaviors
    - Improve safety in our community
    - Address alcohol, tobacco, substance abuse, or other unhealthy behaviors
    - Support family well-being in our community
    - Improve quality of life in our community

RESPONSES FROM RESIDENTS OF WESTERN NIAGARA COUNTY

1,080



Public Participation – Survey Results

Information was obtained mainly through a mail survey to community organizations and churches and individual interviews with hospital volunteers. In addition, Mount St. Mary's surveyed members of its community internally, through its board of associates' volunteers, St. Francis Guild volunteers, and general hospital volunteers, at focus groups, and in a mailing to community service organizations. Focus group participants represented a broad range of individuals and organizations in the community including those with HIV/AIDS, mental health disorders, drug addiction, the poor and the underserved in general

More than 2,000 surveys were collected from residents of Niagara County. Major findings as to key health issues from the Countywide Survey were:

COUNTYWIDE RESULTS	%	MSMH SERVICE AREA RESULTS	%	STRATEGIES SELECTED
Access to Affordable Care	42%	Access to Affordable Care	38%	① ③ ⑦
Cancer	30%	Cancer	32%	④
Alcohol and/or drug use	23%	Alcohol and/or drug use	24%	⑥ ⑧
Mental Health Problems	22%	Mental Health Problems	23%	⑨
Neighborhood Safety	22%	Neighborhood Safety	24%	
Overweight/Obesity	19%	Overweight/Obesity	20%	
Heart-Related Issues	19%	Heart-Related Issues	17%	
Food/Water Safety	17%	Food/Water Safety	16%	
Access to Healthy Food	15%	Access to Healthy Food	16%	
Physical Activity	15%	Physical Activity	14%	
Nutrition/Eating Healthy	13%	Nutrition/Eating Healthy	14%	⑤
Child Abuse/Neglect	12%	Child Abuse/Neglect	14%	
Diabetes	11%	Diabetes	13%	②
Dental Health	10%	Dental Health	10%	
Stress Mgmt, Domestic Violence, Asthma, Teenage Pregnancy, Smoking	<10%	Stress Mgmt, Domestic Violence, Asthma, Teenage Pregnancy, Smoking	<10%	

Strategies were selected based on Community Survey, MSMH ability to address and expertise, collaborative opportunities, and whether the priority is being addressed by others or not.

STRATEGIES (2016-2018)

① **Reduce Healthcare Disparities in Vulnerable Population Through "Trauma-Informed" Care**
② **Diabetes Management and Prevention**
③ **Stroke Prevention & Support**
④ **Percentage of adolescent females with HPV immunization**
⑤ **Proportion of infants who are fed breast milk**
⑥ **Helping High Risk Moms to Prevent Prematurity and Address Opioid Dependence**
⑦ **Reduce Percentage of Pre-Term Births**
⑧ **Pediatric Care Coordination**
⑨ **Mental Health First Aid Training**

2016-18 Identified Priorities

The programs that Mount St. Mary's has put in place to address its priorities involve numerous community groups and organizations. Mount St. Mary's will continue to support several health collaborative groups which include community partners, the Niagara County Health Department, academia, and local schools. These partners will be engaged throughout the years in an evaluation process to determine new areas of need or refine current service offerings.

IMPROVE HEALTH STATUS AND REDUCE HEALTH DISPARITIES

PREVENT CHRONIC DISEASES

PREVENT HIV/STDs AND HEALTHCARE-ASSOCIATED INFECTIONS

PROMOTE HEALTHY WOMEN, INFANTS AND CHILDREN

PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE

Mount St. Mary's Hospital Project 1:
Reduce Healthcare Disparities in Vulnerable Population Through "Trauma-Informed" Care Practices

Designated Mount St. Mary's Project Leaders: Bernadette Franjoine, VP Mission Integration, Mount St. Mary's
Catholic Health Leadership Sponsor/Support: Bart Rodrigues, VP Mission Integration, Catholic Health

NYS Prevention Agenda: Improve Health Status and Reduce Health Disparities; supports DSRIP cultural and structural competency initiatives and community response with regard to Access to Affordable Care.

Goal(s) addressing community need:

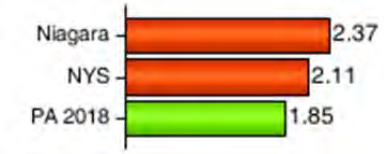
Our focus group conversations with various local health and human service agencies as well as community members highlighted the importance of improving access to care and care outcomes for the poor and disadvantaged to improve population health. These populations are more likely to have higher levels of chronic diseases, are less likely to utilize wellness visits, and have poorer health outcomes than the general population. Some organizations in area have instituted trauma-informed care practices to provide better support and engagement with vulnerable communities. In Erie County most recent health indicators indicate that premature death rate (<75 years) for general population is 37.9%, but for blacks is 60.4%, Asian/Pacific Islanders 58.6%, Hispanics 67%. In Niagara County the premature death rate (<75 years) for general population is 40.6% for the general population, 61.4% for blacks, 70.6% for Asian/Pacific Islanders, and 57.1% for Hispanics.

Project's Target Population:

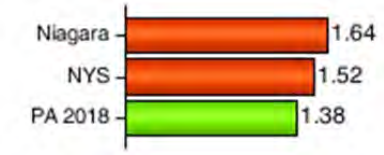
Members of Erie and Niagara County vulnerable communities including, but not limited to: those who suffer from behavioral health or substance abuse problems, are part of racial or religious minorities, are part of the Medicaid population, are immigrants, identify as Lesbian, Gay, Bisexual or Transgender or are HIV positive.

Outcome Objectives: Improve 2018 Niagara County Prevention Agenda (PA) Indicators goals

PA 2.1 - Preventable hospitalizations: Ratio of Black non-Hispanics to White non-Hispanics



PA 2.2 - Preventable hospitalizations: Ratio of Hispanics to White non-Hispanics



Track hospital specific preventable hospitalization and work to reduce preventable hospitalization from 2016-2018

Project Process Measures:

Year 1 (2016): creation of advisory group; (2) inventory existing cultural and structural competency initiatives.

Year 2 (2017):): (1) continue ad hoc advisory group meetings (2) continue inventory of existing cultural and structural competency initiatives; (3) conduct a gap assessment (4) develop implementation plan based on gap assessment results.

Year 3 (2018): (1) implement the plan.

Project Interventions / Strategic Activities by year and by site:	**Year 1 (2016):** (1) develop an advisory group that includes community partners (such as UB School of Social Work's Institute of Trauma and Trauma Informed Care, P2, Evergreen, Catholic Charities, Niagara County health and human service agencies). (2) Conduct organizational assessment to identify gaps (3) begin organizational trainings on principles trauma and trauma-informed care 4) coordinate efforts with Erie County	**Year 2 (2017**(1) continue participation in ad hoc advisory groups (2) continue inventory of existing cultural and structural competency initiatives; (3) participate in a gap assessment (4) support implementation plan based on gap assessment results.	**Year 3 (2018):** (1) support and act on implementation plan.
MSMH Resources Necessary:	**Year 1 (2016):** Seek funding through CH Community Benefit Grant up to $20,000 per year. Collaborate with Erie County to utilize funds for UB Institute of Trauma and Trauma Informed Care to conduct organizational assessment, trainings for staff and develop champion program which includes follow up workshops with champions from 2016-2018	**Year 2 (2017):** Seek funding through CH Community Benefit Grant up to $20,000 per year.	**Year 3 (2018):** Seek funding through CH Community Benefit Grant up to $20,000 per year.
Collaboration: Who and how each partner will interact to affect the project goal	**Year 1 (2016):** Participation in ad hoc advisory group with the following: University of Buffalo School of Social Work's Institute of Trauma and Trauma Informed Care, Catholic Charities, Evergreen and others. Work with existing initiatives helping to support cultural competency and care such as the DSRIP Structural Competency Initiative and Home Care's Medicaid trauma-informed care training programs.	**Year 2 (2017):** Continue work with existing partners to identify opportunities for implementing action plan.	**Year 3 (2018):** Continue to work with existing partners and identify new partners.

Mount St. Mary's Hospital Project 2:
Diabetes Management and Prevention

Designated Mount St. Mary's Project Leaders: Megan Kosmoski, Diabetes Educator, Mount St. Mary's Hospital

NYS Prevention Agenda Link:
Community response with regard to Diabetes and Overweight/Obesity
Promote Healthy Women, Infants and Children
Improve Health Status and Reduce Disparities
Increase Access to Care with Focus on Poor and Vulnerable communities
Increase Access to High Quality Chronic Disease Preventative Care and Management
Prevent Chronic Disease

Goal(s) addressing community need:

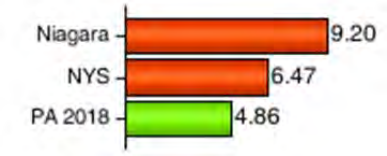
Diabetes is a national health epidemic with almost 30 million Americans diagnosed and another 89 million Americans having pre-diabetes. According to the CDC (Centers for Disease Control), as of 2013, 9.5% of Niagara County residents have been diagnosed with diabetes. Glucose management and reaching/maintaining a healthy weight is paramount to preventing diabetes, diabetes related complications and mortality. Education is the key to helping patients prevent and manage chronic condition. Patients must have a clear understanding of the disease process, medications used for treatment, prevention of complications, monitoring blood glucose and problem solving. With this knowledge, patients can live longer, more healthful lives and utilize fewer healthcare dollars in emergency room visits, cardiac care, dialysis, etc.

Project's Target Population:

All patients, additional focus for education and resources at the Neighborhood Health Center to assist those who may have transportation and access difficulties.

Outcome Objectives:
Improve 2018 Niagara County Prevention Agenda (PA) Indicators goals

PA 22 - Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years



Track rate of hospitalizations to reduce preventable hospitalization from 2016-2018.

Project Process Measures:

Year 1 (2016):
Identify baseline, establish process to communicate/raise awareness among associates and community stakeholders. Create advisory board, provide certification training for Diabetes Educator, educate the medical community on Diabetes Prevention Program (including National Health Institute trials that proved weight loss and exercise reduce risk by up to 58%), create a "call to action" to enroll patients into program.

Year 2 (2017): Host DPP at NHC utilizing external resource, partner with local farms to provide healthy options in primary care setting, expand number of providers offering DPP, support efforts for providers to track improved A1C numbers for enrollees. Review program for opportunities to increase participation/access to services, evaluate other social service programs that could support, consider additional community partners, rebuild gestational diabetes classes.

Year 3 (2018): Host DPP at MSM Hospital and NHC utilizing internal and external resources, pilot support group for ongoing healthy weight management and behaviors, increase enrollment into DPP. Review program for opportunities to increase participation/access to services, evaluate other social service programs that could support, consider additional community partners, track monthly metrics, and collaborate with community outreach wellness events.

Project Interventions / Strategic Activities by year and by site:	**Year 1 (2016):** Develop advisory board that includes internal and external stakeholders, provide training for Diabetes Educator, engage providers and additional community members, develop multi-year plan for program and data tracking, provide inpatient and outpatient education programs. Collaborate to develop communication mechanism / process to raise awareness with special attention to our associates who could qualify and address medical needs	**Year 2 (2017):** Host program at NHC to include education and healthy meal at each session, address transportation for participants, identify additional provider and community members (Faith Community Nursing and Creating a Healthier Niagara Falls coalition, engage local growers to provide produce to areas without access, host food preparation demonstrations). Collaborate with associates to review program outcomes, identify opportunities to increase participation (especially preventative health care and OB patients), and host information table.	**Year 3 (2018):** Host two programs (MSM Hospital and NHC) to include healthy meal at each session, address transportation for participants, identify additional provider and community members (Niagara Falls School System), host food preparation demonstrations, pilot support group. Collaborate with associates to review program outcomes, identify opportunities to increase participation (especially preventative health care and OB patients), host information table/ screening, evaluate community educational opportunity.
MSMH Resources Necessary:	**Year 1 (2016):** $3,500: $2,500 to cover certification course, $1,000 for marketing and printed materials, and Catholic Health Diabetes Educator.	**Year 2 (2017):** $6,000: $5,000 to cover cost of meals at each session, $1,000 for marketing and printed materials, and Catholic Health Diabetes Educator.	**Year 3 (2018):** $9,000: $8,000 to cover cost of meals at each session, $1,000 for marketing and printed materials, and Catholic Health Diabetes Educator
Collaboration: Who and how each partner will interact to affect the project goal	**Year 1 (2016):** American Diabetes Association, Niagara County Department of Health, CH Diabetes Educator, Associates, community stakeholders, medical staff.	**Year 2 (2017):** Creating a Healthier Niagara Falls, YMCA, YWCA, senior and community centers, housing authority and churches, Associates, community stakeholders, medical staff (primary care, OB), case management, faith community nursing.	**Year 3 (2018):** Niagara Falls School System, Associates, community stakeholders, medical staff (primary care, OB), case management, faith community nursing.

Mount St. Mary's Hospital Project 3:
Stroke Prevention and Support

Designated Mount St. Mary's Project Leader: Rosanne Schiavi, Stoke Program Coordinator, Mount St. Mary's Hospital
Catholic Health Leadership Sponsor/Support: Holly Bowser, VP Neuroscience Service Line

NYS Prevention Agenda Link:
Community response with regard to Access to Affordable Care and Heart-Related Issues
Improve Health Status and Reduce Disparities
Increase Access to Care with Focus on Poor and Vulnerable communities
Increase Access to High Quality Chronic Disease Preventative Care and Management
Prevent Chronic Disease

Goal(s) addressing community need:	Raise awareness of stroke signs and symptoms. Reduce the number of strokes in WNY with special attention to those at high risk and/or underserved populations of the community. Provide post stroke support through community group workshops and educational events. Education, particularly to the underserved, in stroke prevention through health assessments, healthy eating habits and active life style.
Project's Target Population:	Adults (18+), special attention to underserved communities in Niagara County. Support for patients and/or families who have suffered a stroke.
Outcome Objectives:	Provide information to the community enhance awareness of stroke risk factors and improve response rate/effectiveness of treatment at Mount St. Mary's

Project Process Measures:	**Year 1 (2016):** Identify baseline, establish process to communicate/raise awareness among associates and community stakeholders, create multi-year plan for screening/education sessions, to include stroke support group.	**Year 2 (2017):** Review hospital programs for opportunities to increase participation/access to services, establish stroke support group, evaluate other social service programs that could support, consider additional community partners, track monthly metrics, host 4 screening/education/support group sessions.	**Year 3 (2018):** Review hospital program for opportunities to increase participation/access to services, evaluate other social service programs that could support, consider additional community partners, track monthly metrics, host 5 screening/education/support group sessions, collaborate with community outreach wellness events.
Project Interventions / Strategic Activities by year and by site:	**Year 1 (2016):** Collaborate to develop metrics to track monthly, develop communication mechanism / process to raise awareness with special attention to our associates who could qualify and address medical needs, include strategy for underserved population.	**Year 2 (2017):** Collaborate with associates to review program outcomes, identify opportunities to increase participation (especially preventative health care, Neighborhood Health Center patients), host information table and screening/ education events, evaluate inclusion of additional community partners (faith community nursing), consider alternative patient contact method/material.	**Year 3 (2018):** Collaborate with associates to review program outcomes, identify opportunities to increase participation (especially preventative health care, Neighborhood Health Center patients), host information table and screening/ education events, evaluate inclusion of additional community partners (faith community nursing), collaborate with community outreach events.

MSMH/DDCH Resources Necessary:	**Year 1 (2016):** Mission on the Move, patient care services, case management, rehab and CMP care coordinator associates.	**Year 2 (2017):** Mission on the Move, patient care services, case management, rehab and CMP care coordinator associates.	**Year 3 (2018):** Mission on the Move, patient care services, case management, rehab and CMP care coordinator associates
Collaboration: Who and how each partner will interact to affect the project goal	**Year 1 (2016):** Associates, community stakeholders, medical staff, American Heart/Stroke Association.	**Year 2 (2017):** Associates, community stakeholders, medical staff, faith community nurses, American Heart/Stroke Association.	**Year 3 (2018):** Associates, community stakeholders, medical staff, faith community nurses, American Heart/Stroke Association.

Mount St. Mary's Hospital Project 4:
Percentage of Adolescents with HPV Immunization

Designated Mount St. Mary's Project Leaders: Patricia Villani, Neighborhood Health Center; Bernadette Franjoine, Mission Integration

NYS Prevention Agenda Link:
Community response with regard to Access to Affordable Care, with special mention of Cancer services
Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated infections
Promote Health Women, Infants and Children
Improve Health Status and Reduce Disparities

Goal(s) addressing community need:	The NYS Immunization Information System (NYSIIS) indicated that 11,291 Niagara County adolescents 10-19 years of age (39.3%) have initiated the HPV vaccine series since 2006. Of those who have initiated the series, only 6,498 individuals (22.6%) have completed it. The current completion rate for vaccines initiated by Niagara County providers is 57.6%. This means, fewer than 4 out of 10 Niagara County adolescents have received one dose of HPV vaccine and approximately half of those who start the series go on to complete it and become fully immunized. If we consider just the completion rate, the disparity becomes clear: only 22.6% of Niagara County adolescents are protected against HPV infection.
Project's Target Population	Males and Females Ages 11-17.
Outcome Objectives:	By December 2018, achieve 50% initiation rate for HPV Immunization

	Year 1 (2016):	**Year 2 (2017):**	**Year 3 (2018):**
Project Process Measures:	Creation of advisory group, establish process to review HPV vaccination rates	Nursing/clinical staff CME that address HPV vaccination, include community organizations that are connected to target population, goal 40% initiation rate	Continue program, integrate additional community members, goal 50% initiation rate, evaluate strategy to address completion rate
Project Interventions / Strategic Activities by year and by site:	schedule consult with Niagara County Department of Health (immunization program nurses), establish/ distribute parent survey/education in waiting room for nurse review with patient, formulate plan with advisory group (to include pediatricians, pediatric care coordinator, medical director).	Nursing/clinical staff CME that address HPV vaccination, include community organizations that are connected to target population (including those who serve vulnerable youth, provide supportive housing), continue education/ surveying/material distribution, host "back to school vaccine clinic" event.	Continue program, integrate additional community members (include broader City of Niagara Falls population, schools), host screening of "Someone You Love" video, incorporate viewing into educational session/ community health event.

MSMH Resources Necessary:	**Year 1 (2016):** $4,000 to cover gift card incentive for patient education, printed material, marketing	**Year 2 (2017):** $8,000 to cover gift card incentive for patient participation, printed material, marketing (to include community vaccine clinic event).	**Year 3 (2018):** $8,000 to cover gift card incentive for patient participation, printed material, marketing (to include community vaccine clinic event and video program/education).
Collaboration: Who and how each partner will interact to affect the project goal.	**Year 1 (2016):** Niagara County Department of Health, HPV Vaccine Coalition of Niagara County, American Cancer Society, Roswell Park, Human Service agencies, Niagara Falls Schools	**Year 2 (2017):** Niagara County Department of Health, HPV Vaccine Coalition of Niagara County, American Cancer Society, Roswell Park, Human Service agencies, Niagara Falls Schools. Identify additional partners who serve vulnerable target population.	**Year 3 (2018):** Niagara County Department of Health, HPV Vaccine Coalition of Niagara County, American Cancer Society, Roswell Park, Human Service agencies, Niagara Falls Schools. Identify additional partners who serve target population on regular basis (school system and parent associations).

Mount St. Mary's Hospital Project 5:
Donor Breast Milk for Newborns who Fail to Thrive and are in the ICU

Designated Mount St. Mary's Project Leaders: Maryann Cogdill, Director of Maternity Services, Mount St. Mary's Hospital
Catholic Health Leadership Sponsor/Support: Aimee Gomlak, VP Women's Services

NYS Prevention Agenda Link: Improve Health Status and Reduce Health Disparities

Goal(s) addressing community need:

Mount St. Mary's and CH's maternity hospitals will become licensed depots for donor human milk. Breastfeeding mothers who have an excess supply of breast milk can donate milk to one of the three hospitals after a free blood test and a thorough screening interview by the New York State (NYS) Milk Bank. Donor milk is then frozen on site and shipped to the Milk Bank for processing, pasteurization, and distribution to newborns in need. Increase proportion of infants who are fed any breast milk in Erie County. CH's rates as of March 2016 (SOCH 74.0%; MHB 78.4%; MSM 65.0%) outpace the general community rates as indicated below.

Project's Target Population

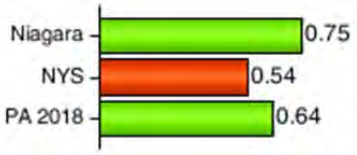
Mothers in Niagara County who are producing excess breast milk. Mothers who cannot produce breast milk or who choose not to breast feed. Newborns who fail to thrive, are in the NICU, or have other needs, including attention to those from underserved communities.

Outcome Objectives: Improve 2018 Niagara County Prevention Agenda (PA) Indicators goals

PA 33 - Percentage of infants exclusively breastfed in the hospital

PA 33.1 - Exclusively breastfed: Ratio of Black non-Hispanics to White non-Hispanic

PA 33.2 - Exclusively breastfed: Ratio of Hispanics to White non-Hispanics



Track hospital specific exclusively breastfeed babies and work to increase breastfeeding rate (most currently available).

Project Process Measures:

Year 1 (2016):
Get Milk Depot program up and running.

Year 2 (2017):
Maintain program at MSMH and other 2 sites in CH, assess engagement from Neighborhood Health Center community.

Year 3 (2018):
Consider feasibility and desirability of expanding the depot program to the primary care sites that have pediatrics: Ken-Ton and MCCC. Determine Go/No Go. Also consider becoming a distribution site for milk as well.

Project Interventions / Strategic Activities by year and by site:	**Year 1 (2016):** Enlist support from staff and develop a system-wide policy/procedure for being a depot and receiving donor milk. Apply to NYS DOH to add human milk to each hospital's tissue bank license. Develop marketing materials to advertise each site as a depot. Be approved by DOH (anticipated 4Q16) and purchase freezers/thermometers. Have a staff in-service and roll out program at each site.	**Year 2 (2017):** Continue staff education. Do a presentation at the Sister's Baby Cafe on the program and how moms can donate. Share the program at OB/GYN departmental meetings and let physicians know that CHS is partnered with the NY Milk Bank and to prescribe human milk to newborns in need. Present at WNY Breastfeeding Coalition meetings.	**Year 3 (2018):** Meet with staff to determine feasibility and desirability. If Go, repeat roll out from 2016. Determine if distribution of human milk is an option.
MSMH/CH Resources Necessary:	**Year 1 (2016):** Current staff and space is sufficient to implement program. Many meetings held w NY Milk Bank, with written policy and procedure, and to develop what the program will look like at each site. NEED CHNA funds for the freezers = approximately $1,500 for 3 ($500 each).	**Year 2 (2017):** Existing staff hours and physician time for in-services and dept. meetings. Advertise in CHS newsletters. Present at CHS Wide Management meeting to share concept and educate all staff across system.	**Year 3 (2018):** If expanding to primary care sites, two additional freezers would be needed ($1,000).
Collaboration: Who and how each partner will interact to affect the project goal.	**Year 1 (2016):** NY Milk Bank: do presentation on becoming a depot; submit the NYS DOH tissue bank licensing form for each hospital site to become a depot	**Year 2 (2017):** Catholic Medical Partners: educate OB and Pediatric offices and encourage prescriptions for donor human milk.	**Year 3 (2018):** No new partners needed. NY Milk Bank would repeat presentations and meetings, this time with primary care staff if expanding the program.

Mount St. Mary's Hospital Project 6:
Helping High Risk Moms to Prevent Prematurity and Address Opioid Dependence

Designated Mount St. Mary's Project Leaders: Maryann Cogdill, Director of Maternity Services, Mount St. Mary's Hospital
Catholic Health Leadership Sponsor/Support: Aimee Gomlak, VP Women's Services

NYS Prevention Agenda Link: Improve Health Status and Reduce Health Disparities

Goal(s) addressing community need:

Attempt to reduce prematurity in WNY. Increase physician's knowledge of care and treatment of dependent pregnant women and newborns. Increase access to care for dependent pregnant women as there is shortage of PMDs and OBGYNs able to prescribe buprenorphine and naloxone (Suboxone(R)). Connect pregnant women to support options. Reduce low birth weight and pre-term births as moms who usually use drugs may also be smoking, not eating well, under stress, in poor social situations, etc.

Project's Target Population

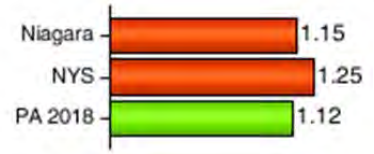
Health care providers, pregnant women, OBGYNs, PMDs in Niagara and County, New York, all of childbearing population in Niagara County, with special attention to those in underserved communities.

Outcome Objectives: Improve 2018 Niagara County Prevention Agenda (PA) Indicators goals

32 - Percentage of preterm births

32.1 - Premature births: Ratio of Black non-Hispanics to White non-Hispanics

32.2 - Premature births: Ratio of Hispanics to White non-Hispanics



Track percentage of preterm births to reduce from 2016-2018.

Project Process Measures:

Year 1 (2016):
Support efforts to encourage OB/GYNs (in CMP) to participate in buprenorphine waiver training.
Educate OBGYN providers on triggers of prematurity.

Year 2 (2017):
Support efforts to Increase waiver training opportunities.
Implement policies and education to nurses, providers to, as well as programs to address prematurity.

Year 3 (2018):
Support efforts to Increase waiver training opportunities.
Implement policies and education to RNs, providers to, as well as programs to address prematurity.

Project Interventions / Strategic Activities by year and by site:	**Year 1 (2016):** Provide education to MSMH associates about all of these issues to raise awareness. Use newsletters, etc. Educate all OB providers on March of Dimes indicators for Prematurity. Encourage physician participation in waiver training. Offer incentives and referrals. Support application with PCSS-MAT to host another waiver training in 2017 (CME).	**Year 2 (2017):** Provide education to MSMH associates about all of these issues to raise awareness. Use newsletters, etc. Encourage less smoking in patients, increase use of 17P for appropriate patients. Support efforts to host another waiver training. Educate physicians on other opportunities available to become certified (online and/or self-study learning).	**Year 3 (2018):** Provide education to MSMH associates about all of these issues to raise awareness. Use newsletters, etc. Encourage less smoking in patients, increase use of 17P for appropriate patients. Continue to educate on availability of waiver training.
MSMH Resources Necessary:	**Year 1 (2016):** Dr. Paul Updike ARTC to host training WSL/physician liaison. Identify funds for new providers to become certified.	**Year 2 (2017):** Dr. Paul Updike CHS Legal ARTC/WSL to host training	**Year 3 (2018):** Dr. Paul Updike CHS Legal ARTC/WSL to host training
Collaboration: Who and how each partner will interact to affect the project goal.	**Year 1 (2016):** Niagara County Human Service agencies – share program information to support target populations.	**Year 2 (2017):** Niagara County Human Service agencies – share program information to support target populations; Catholic Medical Partners. CMP - Help get the word out to physicians on training opportunities and BPPN/UL CHW program. BPPN/UL - Enlist CHWs to provide outreach.	**Year 3 (2018):** Niagara County Human Service agencies – share program information to support target populations; Catholic Medical Partners, - education BPPN/UL - process improvement and feedback

Mount St. Mary's Hospital Project 7:
Reduce Percentage of Pre-Term Births

Designated Mount St. Mary's Project Leaders: Maryann Cogdill, Director of Maternity Services, Mount St. Mary's Hospital Services

NYS Prevention Agenda Link:
Community response with regard to Access to Affordable Care
Promote Healthy Women, Infants and Children
Improve Health Status and Reduce Disparities
Increase Access to Care with Focus on Poor and Vulnerable communities
Increase Access to High Quality Chronic Disease Preventative Care and Management

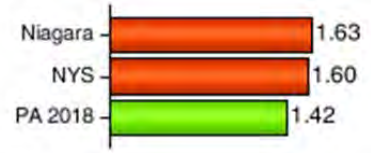
Goal(s) addressing community need: NYSDOH 13.5% Niagara County. Identify risk factors and community information. Standardization of care or preterm labor and labor assessment tools.

Project's Target Population All of the childbearing population in Niagara County, special attention to those in underserved communities.

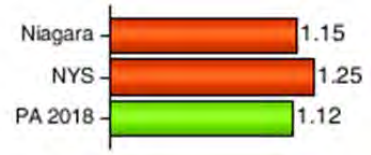
Outcome Objectives: Improve 2018 Niagara County Prevention Agenda (PA) Indicators goals

32 - Percentage of preterm births

32.1 - Premature births: Ratio of Black non-Hispanics to White non-Hispanics



32.2 - Premature births: Ratio of Hispanics to White non-Hispanics



Track percentage of preterm births to reduce from 2016-2018.

Project Process Measures:

Year 1 (2016):
Identify baseline, establish process to communicate/raise awareness among associates and community stakeholders, investigate feasibility for MSM to become site for March of Dimes

Year 2 (2017):
Review women's services program for opportunities to increase participation/access to services, plan for March of Dimes site designation (pre-term initiative), evaluate other social service programs that could support, consider additional community partners, track monthly metrics.

Year 3 (2018):
Review program for opportunities to increase participation/access to services, complete work for March of Dimes site designation, evaluate other social service programs that could support, consider additional community partners, track monthly metrics, collaborate with community outreach wellness events.

Project Interventions / Strategic Activities by year and by site:	**Year 1 (2016):** Mandatory education for OB providers and nurses on March of Dimes PLAT Program. (PLAT = Preterm Labor Assessment and Treatment). Trinity national standard.	**Year 2 (2017):** 100% audited charts of preterm labor for 100% adherence to national standards. Community education and risk factors identified in community setting.	**Year 3 (2018):** Ongoing community education on preterm labor and identifying preterm risk factor.
CH Resources Necessary:	**Year 1 (2016):** Netlearning program for providers.	**Year 2 (2017):** Netlearning Program for providers and office practice associates	**Year 3 (2018):** Netlearning Program for providers and office practice associates
Collaboration: Who and how each partner will interact to affect the project goal.	**Year 1 (2016):** Associates, community stakeholders, medical staff, March of Dimes	**Year 2 (2017):** Associates, community stakeholders, medical staff, March of Dimes, Family & Children's Services of Niagara, Native American community.	**Year 3 (2018):** Associates, community stakeholders, medical staff, March of Dimes, Family & Children's Services of Niagara, Native American community.

Mount St. Mary's Hospital Project 8:
Pediatric Care Coordination (Mental Health and Substance Abuse)

Designated Mount St. Mary's Project Leaders: Pediatric Care Coordinator at Neighborhood Health Center and Patricia Villani

NYS Prevention Agenda Link:
Community response with regard to Access to Affordable Care, Alcohol and Drug Use, and Mental Health Problems
Promote mental, emotional and behavioral well-being in communities
Promote Health Women, Infants and Children
Improve Health Status and Reduce Disparities
Increase Access to Care with Focus on Poor and Vulnerable communities
Increase Access to High Quality Disease Preventative Care and Management

Goal(s) addressing community need:	Over 40% of children in Niagara Falls live in poverty and consequently are at increased risk of mental illness compared to economically stable peers. In three years, 75% of pediatric and obstetrical patients (1,750 patients) will be screened with an evidence based behavioral health tool. Those identified at low risk will receive brief intervention. Those screened at moderate-high risk will receive linkage and referral to behavioral or substance use treatment services. Patients and their families will also receive human services assessment and linkage to support and improve behavioral health outcomes.
Project's Target Population	Current Neighborhood Health Center patient base: 1,700 pediatric and 600 OB patients.
Outcome Objectives:	75% of patients receive screening, intervention or referral. 75% of physicians positively assess model and care delivery. 20% of identified patients show improvement.

Project Process Measures:	**Year 1 (2016):**	**Year 2 (2017):**	**Year 3 (2018):**
	Establish plan with following goals: 1) Integrate early behavioral health screening , intervention and referral into primary and obstetrical care to improve maternal and child health (2) positively affect the family unit and promote healthy behaviors by raising patient awareness and providing support to achieve health outcomes and self-management (3) reduce the stigma associated with seeking mental healthcare by incorporating into primary care setting, identify evidence based screening tool, train associates, EMR/reporting and referral process finalized	50% of target patients receive screening and intervention or referral. 50% of physicians positively assess model and care delivery.	75% of patients receive screening, intervention or referral. 75% of physicians positively assess model and care delivery. 20% of identified patients show improvement.

Project Interventions / Strategic Activities by year and by site:	**Year 1 (2016):** Hire pediatric care coordinator, select screening tool, design screening, risk stratification and referral process, train clinical staff, prepare registry and reporting, engage external treatment providers, design communications.	**Year 2 (2017):** Launch program for eligible patients, provide quarterly reporting, meet regularly with internal and external providers to review outcomes and make adjustments, address project sustainability.	**Year 3 (2018):** Continue program for eligible patients, provide quarterly reporting, meet regularly with internal and external providers to review outcomes and make adjustments, address and facilitate project sustainability.
MSMH Resources Necessary:	**Year 1 (2016):** Funding, Care Coordinator, IT and Communications resources, NHC & MSM leadership, Laptop and office supplies	**Year 2 (2017):** Funding, Care Coordinator, IT and Communications resources Community Social Worker, NHC & MSM leadership, office supplies.	**Year 3 (2018):** Funding, Care Coordinator, IT and Communications resources, Community Social Worker, NHC & MSM leadership, office supplies.
Collaboration: Who and how each partner will interact to affect the project goal.	**Year 1 (2016):** Summit Pediatrics, Dr. Thota – care providers. Catholic Charities, Family Service of Niagara – referral resources.	**Year 2 (2017):** Summit Pediatrics, Dr. Thota – care providers. Catholic Charities, Family Service of Niagara – referral resources.	**Year 3 (2018):** Summit Pediatrics, Dr. Thota – care providers. Catholic Charities, Family Service of Niagara – referral resources.

Mount St. Mary's Hospital Project 9:
Mental Health First Aid Training

Designated Kenmore Mercy Project Leaders: Bernadette Franjoine and Kerry Caldwell, Mount St. Mary's Hospital
Catholic Health Leadership Sponsor/Support: Sandy Spencer, VP, Clinical Education and Professional Development; (Phyllis Dunning, DSRIP Director of Clinical Programs)

NYS Prevention Agenda Link:
Community response with regard to Access to Affordable Care and Mental Health Problems
Promote Mental Health and Prevent Substance Abuse
Addresses the recommendation for employers, businesses and unions to educate employees about risk factors and warning signs of MEB disorders and ways to access support services through employee health insurance. Mental Health First Aid is recognized by SAHMSA as an evidence-based practice and is on the list of recommended interventions for the NYS prevention agenda goal #2.2 Prevent and reduce occurrence of mental, emotional and behavioral disorders among youth and adults.

Goal(s) addressing community need:

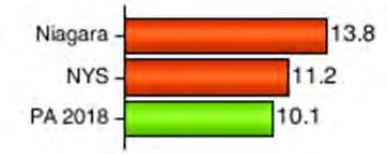
Community Health Needs Assessment Focus Groups identified need for mental health first aid training to help increase awareness and give tools to first line providers, community members, and to help make mental health first aid training as common as CPR training. This ties in strongly with the DSRIP initiatives of promoting Mental Emotional and Behavioral Health, and would align with concerns as identified by Niagara County stakeholder and resident communities.

Project's Target Population

Catholic Health Physicians, Nurses, and other front line staff interacting with patients, key community stakeholders (Firefighters, EMS, Catholic Charities, Community Centers, etc), and general community

Outcome Objectives:

PA 42 - Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month



Reduce Niagara County percentage over a 3 year period from 2013-2014.

Project Process Measures:

Year 1 (2016): Develop Implementation Plan. Identify Mental Health First Aid (MHFA) trainers across Catholic Health.

Year 2 (2017): (1) Develop a steering committee (2) Conduct a gap assessment (3) Develop implementation plan.

Year 3 (2018): Continue implementation plan.

Project Interventions / Strategic Activities by year and by site:

Year 1 (2016): Identify associates who are certified MHFA trainers. Identify additional community partners (P2 Collaborative, Niagara County Hospitals, and Creating a Healthier Niagara Falls.

Year 2 (2017): (1) Participate in steering committee (2) support gap assessment (3) support development of implementation plan.

Year 3 (2018): Support implementation plan.

CH Resources Necessary:	**Year 1 (2016):** none	**Year 2 (2017):** Associate participation on steering committee; other resources to be determined.	**Year 3 (2018):** TBD.
Collaboration: Who and how each partner will interact to affect the project goal.	**Year 1 (2016)** Clinical Education will identify Community Partners and programs providing MHFA training.	**Year 2 (2017):** Same.	**Year 3 (2018):** Same.

Mount St. Mary's Hospital – Niagara County Project 10:
Prevent Chronic Disease, Disparity: Mental Hygiene

Designated Mount St. Mary's Project Leaders: Bernadette Franjoine, Mount St. Mary's Hospital

NYS Prevention Agenda Link:
Promote use of evidence- based care to manage chronic disease.

Goal(s) addressing community need:

Community Health Needs Assessment Focus Groups identified need for mental health first aid training to help increase awareness and give tools to first line providers, community members, and to help make mental health first aid training as common as CPR training. This ties in strongly with the DSRIP initiatives of promoting Mental Emotional and Behavioral Health, and would align with concerns as identified by Niagara County stakeholder and resident communities.

Project's Target Population

Adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition.

Outcome Objectives:

By December 31, 2018 educate providers/associates and establish programming for adults with arthritis, asthma, cardiovascular disease, or diabetes in partnership with NCDOH to raise awareness regarding educational resources for referral and participation.

Reduce Disparity:

By December 31, 2018 include evidence-based care for chronic disease prevention and management programs to 80% of individuals with depression

Project Process Measures:

Year 1 (2016): Develop Implementation Plan.	**Year 2 (2017):** educate providers/associates and establish programming for adults with arthritis, asthma, cardiovascular disease, or diabetes in partnership with NCDOH to raise awareness regarding educational resources for referral and participation.	**Year 3 (2018):** educate providers/associates and establish programming for adults with arthritis, asthma, cardiovascular disease, or diabetes in partnership with NCDOH to raise awareness regarding educational resources for referral and participation. Include evidence-based care for chronic disease prevention and management programs to 80% of individuals with depression.

Project Interventions / Strategic Activities by year and by site:	**Year 1 (2016):** Educate providers/associates regarding recent studies and data on chronic disease. Reconvene with NCDOH and MSMH Care Management to review NCDOH evidence-based programs and opportunity to reduce re-hospitalization by 3/17.	**Year 2 (2017):** Educate providers/associates regarding recent studies and data on chronic disease. Support new Diabetes Educator to establish diabetes education programs, to include gestational diabetic patients. Conduct 2 outreach sessions to community providers and senior centers to inform of program offerings, and to coordinate referral system into Diabetes Education by 12/31/17. Partner with NCDOH, Niagara County hospitals and ADA to host diabetes prevention classes at the Neighborhood Health Center by 12/31/17.	**Year 3 (2018):** Educate providers/associates regarding recent studies and data on chronic disease. Support new Diabetes Educator to establish diabetes education programs, to include gestational diabetic patients. Partner with NCDOH, Niagara County hospitals and ADA to host diabetes prevention classes at the Neighborhood Health Center. Continue use of depression screening tool at Article 28 primary care clinics to identify patients with depression through 12/31/18. Increase screening percentage to 80% by 12/31/17 and 90% by 12/31/18.
CH Resources Necessary:	**Year 1 (2016):** Support for Diabetes Educator	**Year 2 (2017):** Support for Diabetes Educator	**Year 3 (2018):** Support for Diabetes Educator
Collaboration: Who and how each partner will interact to affect the project goal.	**Year 1 (2016)** Niagara County Department of Health; American Diabetes Association; Neighborhood Health Center.	**Year 2 (2017):** Niagara County Department of Health; American Diabetes Association; Neighborhood Health Center.	**Year 3 (2018):** Niagara County Department of Health; American Diabetes Association; Neighborhood Health Center.

Mount St. Mary's Hospital – Niagara County Project 11:
Promote Mental Health and Prevent Substance Abuse

Designated Mount St. Mary's Project Leaders: Bernadette Franjoine, Mount St. Mary's Hospital; and Karen Hogan, Clearview Treatment Services

NYS Prevention Agenda Link:
Promote Mental, Emotional and Behavioral Health (MEB).
Prevent Substance Abuse
Strengthen Infrastructure

Goal(s) addressing community need: Community Health Needs Assessment Focus Groups identified need to advance substance abuse programs and outreach to the general population.

Project's Target Population General populations, especially those with mental health needs and identified substance abuse problems.

Outcome Objectives: Provide trauma-informed approach education to Niagara County hospital associates and local community organizations by 12/31/17. Increase number of hospital associates trained to 30% by 12/31/18; Offer appropriate level of mental health services information to 80% of individuals who have positive depression screens by 12/31/18; Increase number of public awareness, outreach and educational efforts to change attitudes, beliefs and norms towards excessive alcohol and prescription opiate use; Support integration of MEB health within chronic disease prevention strategies. Establish MEB stakeholder involvement across Niagara County initiatives by 12/31/17 and increase by 10% by 12/31/18.

Project Process Measures:	**Year 1 (2016):** Develop Implementation Plan.	**Year 2 (2017):** Provide trauma-informed approach education to Niagara County hospital associates and local community organizations; Establish MEB stakeholder involvement across Niagara County.	**Year 3 (2018):** Increase number of hospital associates trained to 30%; Offer appropriate level of mental health services information to 80% of individuals who have positive depression screens; Increase number of public awareness, outreach and educational efforts to change attitudes, beliefs and norms towards excessive alcohol and prescription opiate use; Support integration of MEB health within chronic disease prevention strategies. Increase MEB stakeholder involvement across Niagara County initiatives by 10%.

Project Interventions / Strategic Activities by year and by site:	**Year 1 (2016):** Begin organization and planning process	**Year 2 (2017):** Participate in an advisory board with Niagara County Hospitals and evaluate resources. Train associates on available mental health services and facilitate patient referrals Educate providers/associates on alcohol and substance abuse and host community outreach events Provide mental health education materials at 100% of health fairs and events of MSMH Add mental health on-site resources at Neighborhood Health Center	**Year 3 (2018):** continue 2017 initiatives and provide mental health education materials at 100% of activities and Neighborhood Health Center
CH Resources Necessary:	**Year 1 (2016):** Staffing and participation	**Year 2 (2017):** Staffing and participation	**Year 3 (2018):** Staffing and participation
Collaboration: Who and how each partner will interact to affect the project goal.	**Year 1 (2016)** Niagara County Department of Health; Niagara County hospitals; P^2 Collaborative.	**Year 2 (2017):** Niagara County Department of Health; Niagara County hospitals; P^2 Collaborative.	**Year 3 (2018):** Niagara County Department of Health; Niagara County hospitals; P^2 Collaborative.

COMMUNITY INFORMATION

ATTACHMENT A

COMMUNITY INFORMATION

A. Our Community

Our community is comprised of Niagara County, New York and a portion of Grand Island, which is in Erie County, New York. The following describes Niagara County's demographics and health indicators relative to New York State.

Overall Population = 216,000 (approximately 110,000 are in MSMH Primary Service Area)

- 16% of residents are over the age of 65
- 22% of residents are below the age of 18
- 7% of residents are African American and 2% are Hispanic
- Median Household Income is $45,545, which is 20% below the state average
- 12% of population is illiterate

Highlights of Health Indicators for Niagara County:

- Niagara County ranks 59th (out of 62 counties) in New York State in "Health Outcomes"
- 15% of residents are considered in poor or fair health
- 26% of residents smoke
- 27% of residents consider themselves obese
- 17% of residents consider their alcohol use as excessive
- 9% of residents are diabetic
- 16% of residents are uninsured
- 83% of residents have been screened for diabetes
- 69% of residents have been screened for mammograms
- 18% of residents believe there is inadequate social support
- 34% of children live in single-parent households

B. Service Area

The Primary Service Area (PSA) for Mount St. Mary's is Western Niagara County and Grand Island, Erie County. The PSA, more particularly, is comprised of the City of Niagara Falls; the townships of Grand Island, Wheatfield, Niagara, Lewiston, Youngstown and Wilson; and the villages of Lewiston, Youngstown and Wilson. The Secondary Service Area (SSA) includes the remainder of Niagara County, most notably the cities of Lockport and North Tonawanda.

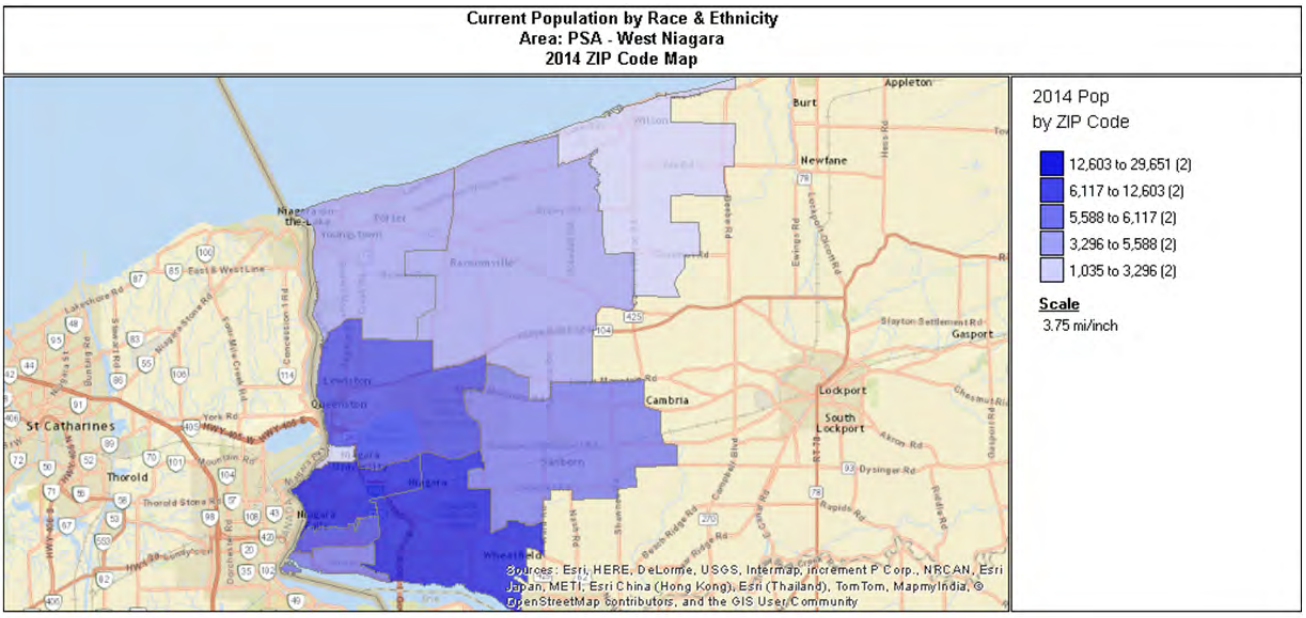
C. Market Characteristics – Demographic/Socioeconomic Trends

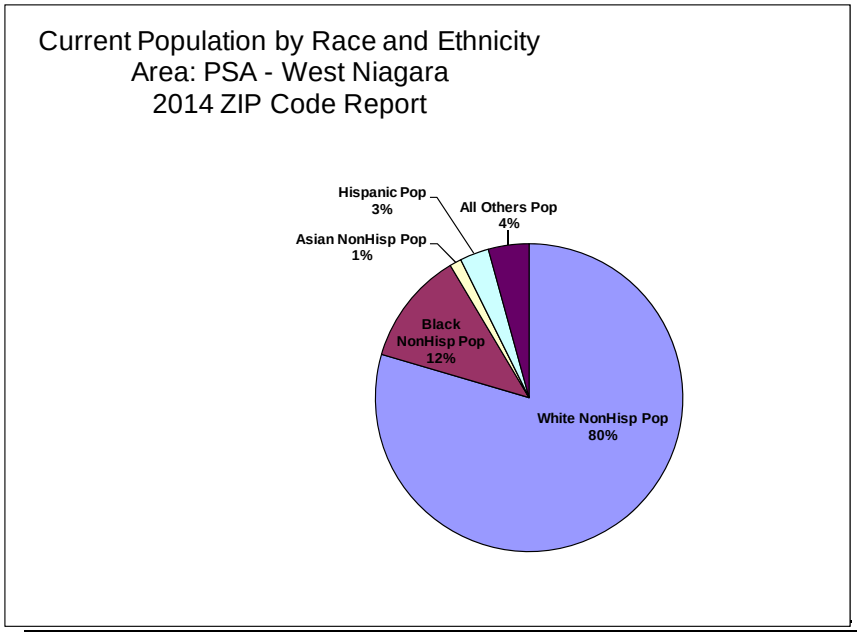
Population – The population growth in our Primary and Secondary Service Areas has been negligible in the past 30 years. The population of the City of Niagara Falls (where 50% of our patients reside) has declined from over 110,000 in 1960, to 55,000 in the 2000 census, to just 50,200 in the 2010 census.

Population Changes in Niagara County:				
Age Cohort	2010 (Current Year)	2015 (Forecast Year)	Difference	% Change
0-17	24,898	22,820	-2,078	-8.30%
18-34	26,629	27,483	854	3.20%
35-64	47,754	45,831	-1,923	-4.00%
65+	19,478	20,960	1,482	7.60%
Source: Demographic Forecaster, Thompson Reuters				

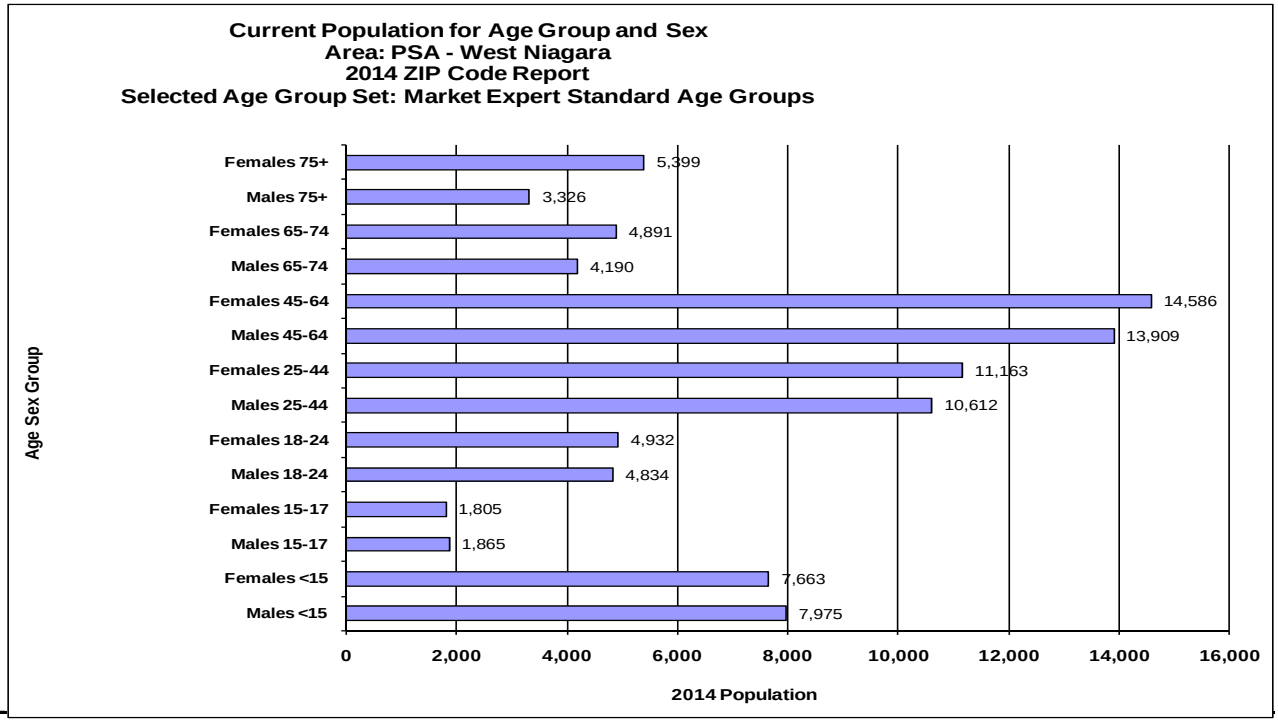
Market Diversity – Mount St. Mary's market is comprised of predominately Caucasians and African-Americans. The growth in the Hispanic population has been limited to the rural areas.

			White		Black		Asian					
		2014	Non-Hispanic		Non-Hispanic		Non-Hispanic		Hispanic		All Others	
ZIP Code	ZIP City Name	Population	Population	%Across	Population	%Across	Population	%Across	Population	%Across	Population	%Across
14092	Lewiston	11,254	10,446	92.8%	118	1.0%	119	1.1%	229	2.0%	342	3.0%
14109	Niagara Univ	1,035	899	86.9%	51	4.9%	14	1.4%	43	4.2%	28	2.7%
14131	Ransomville	5,535	5,238	94.6%	39	0.7%	15	0.3%	129	2.3%	114	2.1%
14132	Sanborn	6,117	5,585	91.3%	100	1.6%	23	0.4%	102	1.7%	307	5.0%
14172	Wilson	3,296	3,141	95.3%	23	0.7%	9	0.3%	59	1.8%	64	1.9%
14174	Youngstown	5,588	5,326	95.3%	15	0.3%	41	0.7%	117	2.1%	89	1.6%
14301	Niagara Falls	12,603	7,241	57.5%	3,506	27.8%	278	2.2%	669	5.3%	909	7.2%
14303	Niagara Falls	5,668	3,188	56.2%	1,584	27.9%	70	1.2%	318	5.6%	508	9.0%
14304	Niagara Falls	29,651	26,346	88.9%	1,097	3.7%	521	1.8%	699	2.4%	988	3.3%
14305	Niagara Falls	16,403	9,867	60.2%	5,022	30.6%	115	0.7%	602	3.7%	797	4.9%
		97,150	77,277	79.5%	11,555	11.9%	1,205	1.2%	2,967	3.1%	4,146	4.3%





2014 Demographic Snapshot										
Area: PSA - West Niagara										
Level of Geography: ZIP Code										
DEMOGRAPHIC CHARACTERISTICS										
			Selected Area	**USA**				**2014**	**2019**	**% Change**
2010 Total Population			98,997	308,745,538			**Total Male Population**	46,711	46,077	-1.4%
2014 Total Population			97,150	317,199,353			**Total Female Population**	50,439	49,663	-1.5%
2019 Total Population			95,740	328,309,464			**Females, Child Bearing (15-44)**	17,900	17,447	-2.5%
% Change 2014 - 2019			-1.5%	3.5%						
Average Household Income			$56,522	$71,320						
POPULATION DISTRIBUTION										
	Age Distribution							**Income Distribution**		
Age Group	**2014**	**% of Total**	**2019**	**% of Total**			**2014 Household Income**	**HH Count**	**% of Total**	**USA % of Total**
0-14	15,638	16.1%	14,821	15.5%			**<$15K**	6,724	16.0%	13.3%
15-17	3,670	3.8%	3,404	3.6%			**$15-25K**	5,985	14.2%	11.2%
18-24	9,766	10.1%	9,184	9.6%			**$25-50K**	11,359	27.0%	24.4%
25-34	11,219	11.5%	11,803	12.3%			**$50-75K**	7,651	18.2%	17.9%
35-54	24,700	25.4%	21,904	22.9%			**$75-100K**	4,536	10.8%	11.9%
55-64	14,351	14.8%	14,829	15.5%			**Over $100K**	5,859	13.9%	21.3%
65+	17,806	18.3%	19,795	20.7%						
Total	**97,150**	**100.0%**	**95,740**	**100.0%**			**Total**	**42,114**	**100.0%**	**100.0%**
EDUCATION LEVEL							**RACE/ETHNICITY**			
			Education Level Distribution					**Race/Ethnicity Distribution**		
2014 Adult Education Level			**Pop Age 25+**	**% of Total**			**Race/Ethnicity**	**2014 Pop**	**% of Total**	**USA % of Total**
Less than High School			1,876	2.8%			**White Non-Hispanic**	77,277	79.5%	62.1%
Some High School			5,932	8.7%			**Black Non-Hispanic**	11,555	11.9%	12.3%
High School Degree			25,148	36.9%			**Hispanic**	2,967	3.1%	17.6%
Some College/Assoc. Degree			21,416	31.5%			**Asian & Pacific Is. Non-Hispanic**	1,232	1.3%	5.1%
Bachelor's Degree or Greater			13,704	20.1%			**All Others**	4,119	4.2%	3.0%
Total			**68,076**	**100.0%**			**Total**	**97,150**	**100.0%**	**100.0%**



Poor and Vulnerable Populations – Because unemployment rates remain high, the PSA's median income remains low. However, median household income varies widely in each community:

Town of Lewiston (Location of Hospital)	$59,719
Town of Niagara	$42,029
Town of Porter	$59,338
City of Niagara Falls (Location of Health Center)	$31,336
Niagara County	$45,749
United States	$51,425

Uninsured Individuals in Niagara County:
2012: % of Total Population
Uninsured Individuals: Ages 0-19: 7.2% Ages 0-65: 15.6%
2012: % of Total Households
Household Income: $0 - 14,999 Niagara Falls = 22.3%

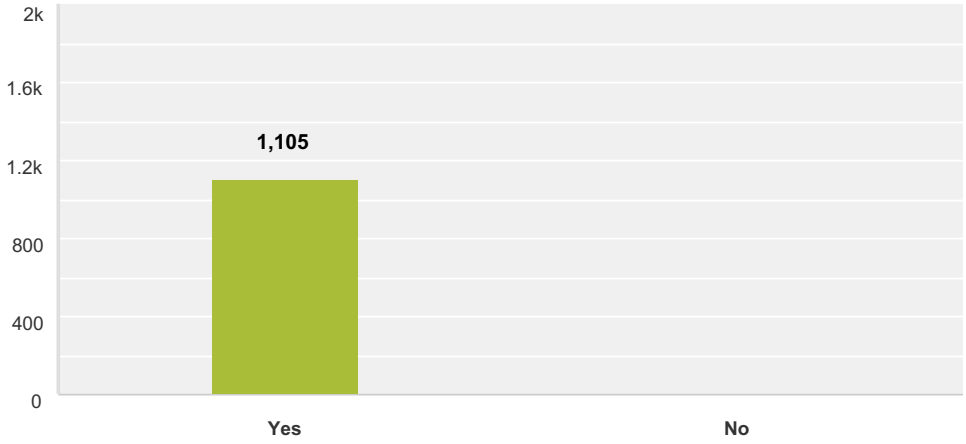
As the Affordable Care Act implementation begins, we anticipate the number of uninsured persons to decline significantly between now and 2015 because of Medicaid expansion in our state and increased access to health insurance in the market.

NIAGARA COUNTY SURVEY 2016

ATTACHMENT B

Q1 Are you a Niagara County resident?

Answered: 1,105 Skipped: 0

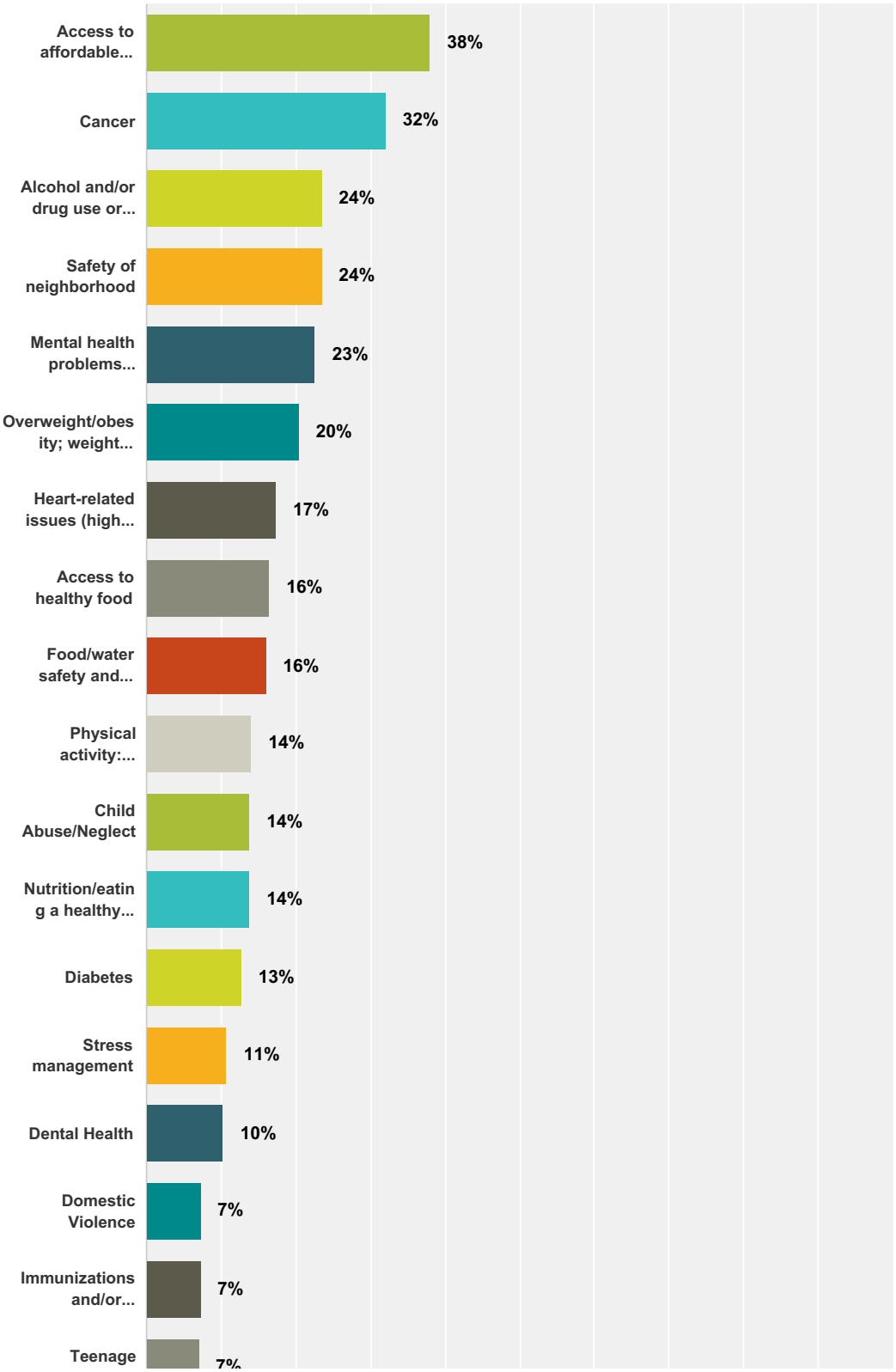


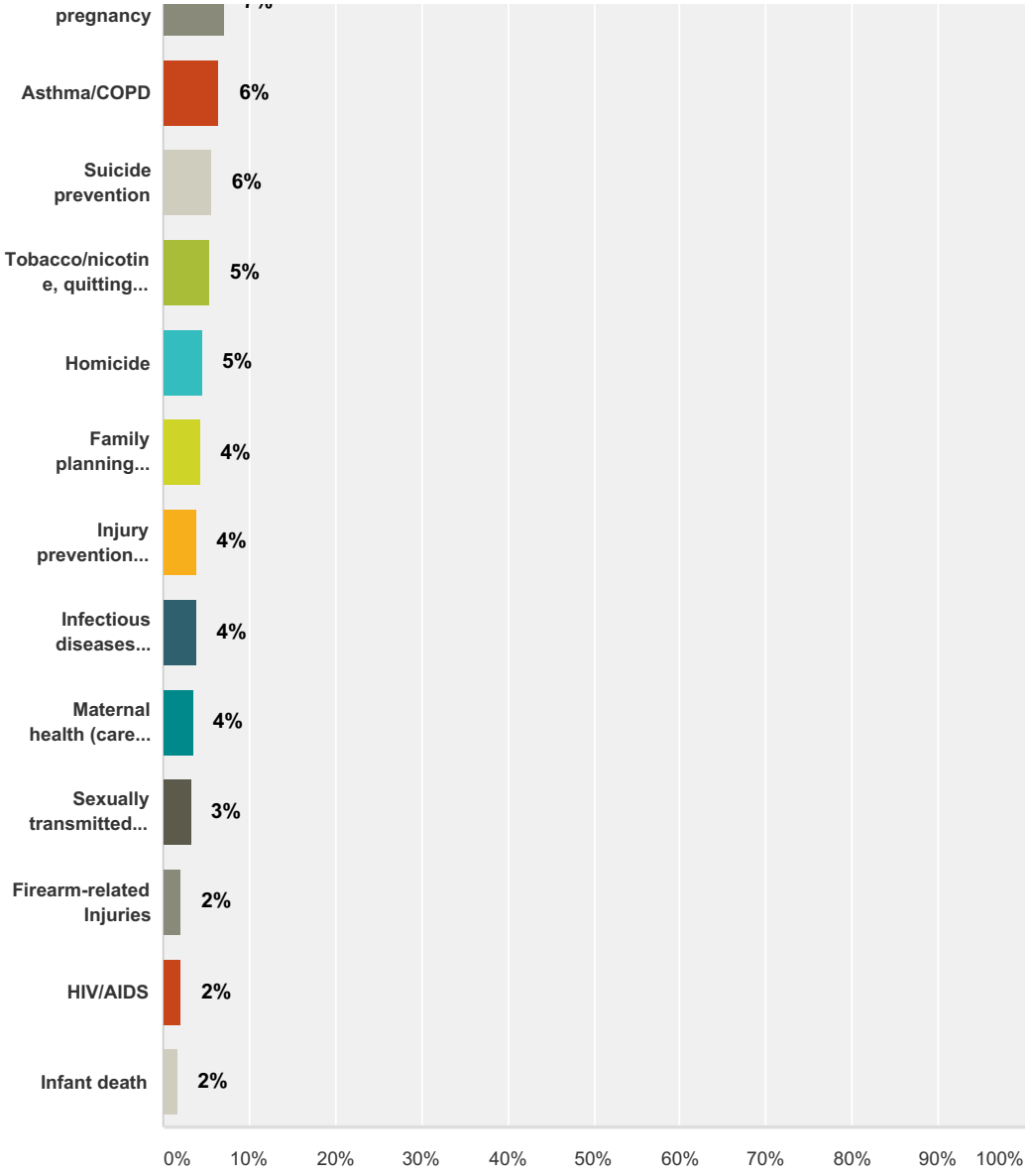
Q2 What is your ZIP code?

Answered: 1,105 Skipped: 0

Q3 When you think about your own health or the health of your community, which of the following issues are you most concerned about? Please select three (3).

Answered: 1,080 Skipped: 25



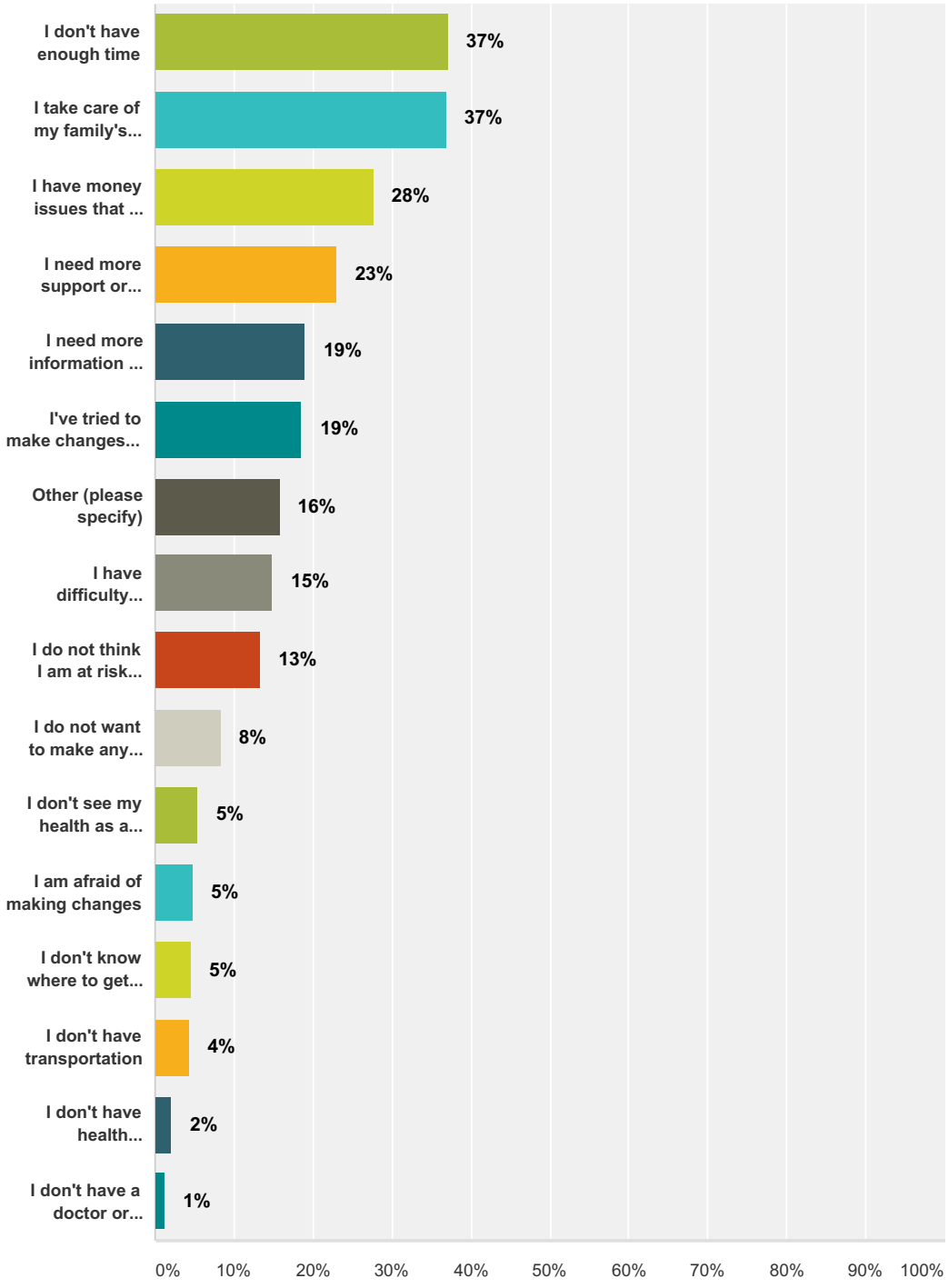


Answer Choices	Responses	
Access to affordable healthcare	**38%**	410
Cancer	**32%**	348
Alcohol and/or drug use or addiction	**24%**	255
Safety of neighborhood	**24%**	255
Mental health problems (depression, anxiety...)	**23%**	244
Overweight/obesity; weight management	**20%**	220
Heart-related issues (high blood pressure, heart disease, or stroke)	**17%**	188
Access to healthy food	**16%**	177
Food/water safety and quality	**16%**	173
Physical activity: fitness and exercise	**14%**	152

Child Abuse/Neglect	**14%**	149
Nutrition/eating a healthy diet	**14%**	149
Diabetes	**13%**	137
Stress management	**11%**	115
Dental Health	**10%**	110
Domestic Violence	**7%**	80
Immunizations and/or prevention of infectious disease (such as the flu)	**7%**	78
Teenage pregnancy	**7%**	77
Asthma/COPD	**6%**	69
Suicide prevention	**6%**	60
Tobacco/nicotine, quitting smoking	**5%**	58
Homicide	**5%**	50
Family planning (pregnancy prevention)	**4%**	47
Injury prevention (falls, motor vehicle safety, etc.)	**4%**	43
Infectious diseases (hepatitis, TB..)	**4%**	43
Maternal health (care for moms during and after pregnancy)	**4%**	39
Sexually transmitted infections	**3%**	36
Firearm-related Injuries	**2%**	23
HIV/AIDS	**2%**	23
Infant death	**2%**	18
Total Respondents: 1,080		

Q4 In your life right now, what things keep you and your family from being healthier? Please select three (3).

Answered: 960 Skipped: 145

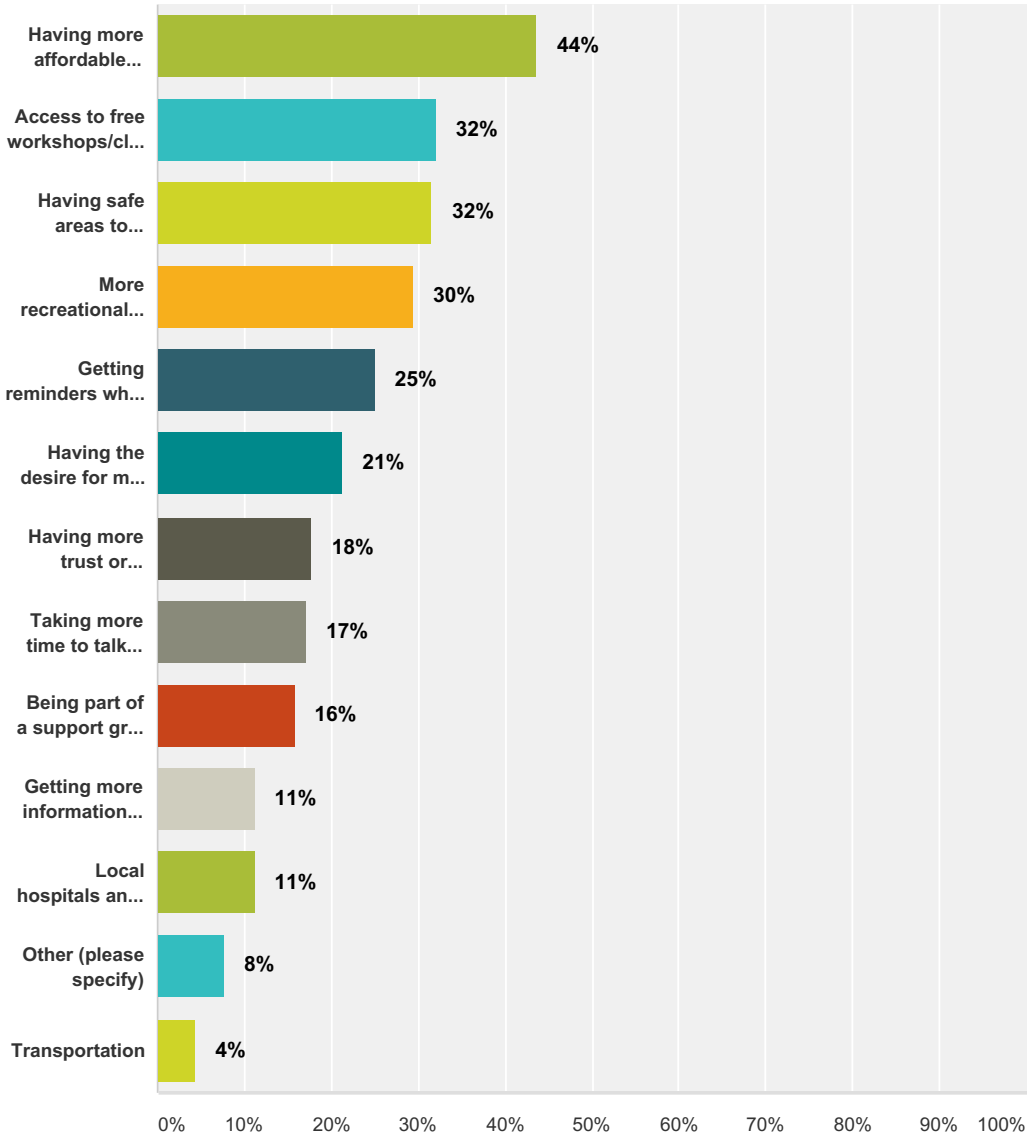


Answer Choices	Responses	
I don't have enough time	37%	356

I take care of my family's health and well-being more than my own	**37%**	354
I have money issues that get in the way	**28%**	266
I need more support or encouragement	**23%**	220
I need more information on how to make healthier changes	**19%**	182
I've tried to make changes before and it didn't work	**19%**	178
Other (please specify)	**16%**	152
I have difficulty trusting the medical system	**15%**	143
I do not think I am at risk for any health problems	**13%**	129
I do not want to make any changes	**8%**	80
I don't see my health as a high priority	**5%**	52
I am afraid of making changes	**5%**	47
I don't know where to get help	**5%**	44
I don't have transportation	**4%**	42
I don't have health insurance	**2%**	20
I don't have a doctor or healthcare provider	**1%**	12
Total Respondents: 960		

Q5 In the future, what might help you make healthy changes in your life? Please select three (3).

Answered: 979 Skipped: 126

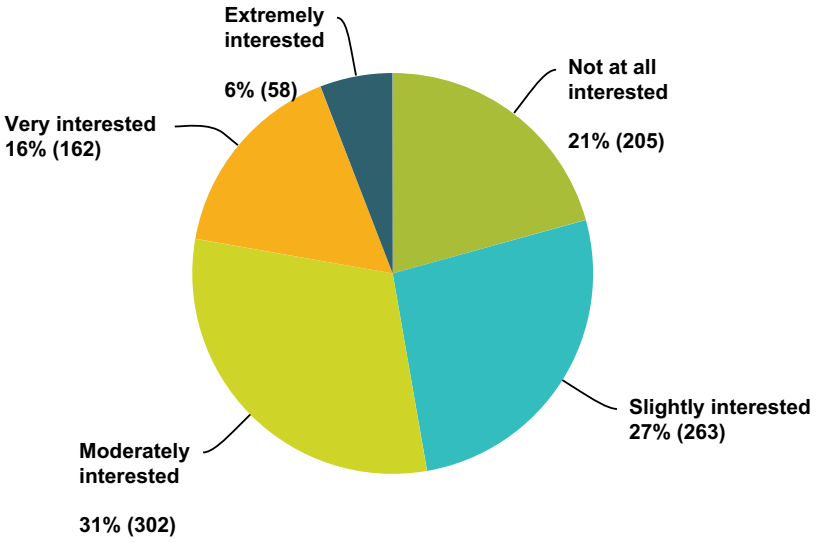


Answer Choices	Responses	
Having more affordable fresh fruits and vegetables or more healthy food choices at local convenience stores	**44%**	427
Access to free workshops/classes in your community on exercise, diet, stress reduction, chronic disease management, and/or quitting smoking.	**32%**	314
Having safe areas to exercise within your community	**32%**	309
More recreational/sports opportunities that are appropriate to your age and skill level	**30%**	289
Getting reminders when you are due for certain tests (such as annual doctor visits)	**25%**	245
Having the desire for me and my family to be healthier	**21%**	209

Having more trust or comfort with the medical system	**18%**	174
Taking more time to talk with healthcare professionals (doctors, nurses, counselors, etc.)	**17%**	168
Being part of a support group that supports and encourages healthy habits (example: a local church, the YMCA)	**16%**	155
Getting more information from social media, internet, newspapers and TV	**11%**	110
Local hospitals and businesses offering free health screenings (blood pressure, etc.)	**11%**	110
Other (please specify)	**8%**	75
Transportation	**4%**	43
Total Respondents: 979		

Q6 How interested are you or members of your family to attend free or low-cost health promotion programs in the community (such as disease self-management classes, nutrition classes or blood pressure screening clinics)?

Answered: 990 Skipped: 115

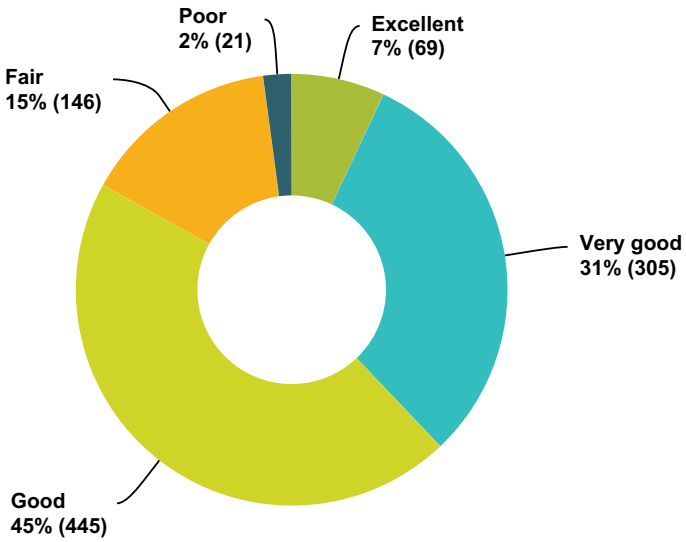


Q7 We are interested in what you are proud of in your community. What are some existing services or characteristics in the community that support the health and well-being of you and your family? Tell us in the space below.

Answered: 427 Skipped: 678

Q8 Would you say that in general your health is —?

Answered: 986 Skipped: 119



Q9 Thinking about your physical health, which includes physical illness and injury, forhow many days during the past 30 days was your physical health not good?

Answered: 946 Skipped: 159

Answer Choices	Responses	
None	41%	386
1	7%	67
2	10%	98
3	8%	74
4	3%	31
5	5%	50
6	2%	16
7	3%	28
8	1%	6
9	0%	2
10	5%	43
11	0%	2
12	0%	3
14	2%	17
15	2%	18
16	0%	1
17	0%	3
19	0%	1
20	2%	21
21	0%	2
22	0%	1
23	0%	2
25	1%	7
27	0%	1
28	0%	3
29	0%	4
30	5%	48
Don't Know/ Not Sure	1%	11

Total	**946**

Q10 Now thinking about your mental health, which includes stress, depression, and problemswith emotions, for how many days during the past 30 days was your mental health notgood?

Answered: 943 Skipped: 162

Answer Choices	Responses	
None	**47%**	440
2	**8%**	72
3	**7%**	65
5	**7%**	64
10	**6%**	57
1	**5%**	47
15	**4%**	39
30	**3%**	29
7	**3%**	27
20	**3%**	27
4	**2%**	19
25	**1%**	12
8	**1%**	9
14	**1%**	7
6	**1%**	6
Don't Know/ Not Sure	**1%**	6
21	**0%**	4
12	**0%**	3
26	**0%**	2
9	**0%**	1
11	**0%**	1
16	**0%**	1
17	**0%**	1
22	**0%**	1
24	**0%**	1
28	**0%**	1
29	**0%**	1

Total	**943**

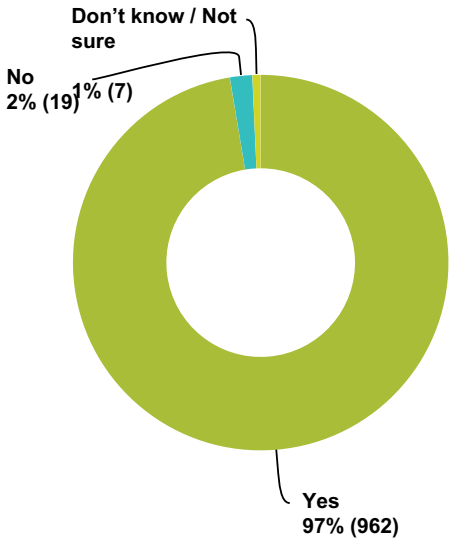
Q11 During the past 30 days, for about how many days did poor physical or mental healthkeep you from doing your usual activities, such as self-care, work, or recreation?

Answered: 941 Skipped: 164

Answer Choices	Responses	
None	56%	527
1	8%	79
2	6%	58
3	5%	51
5	5%	47
10	4%	37
30	3%	27
15	2%	23
4	2%	21
7	2%	18
20	1%	14
14	1%	8
6	1%	7
25	1%	7
16	0%	3
Don't Know/ Not Sure	0%	3
8	0%	2
12	0%	2
11	0%	1
17	0%	1
21	0%	1
22	0%	1
23	0%	1
27	0%	1
28	0%	1
Total		**941**

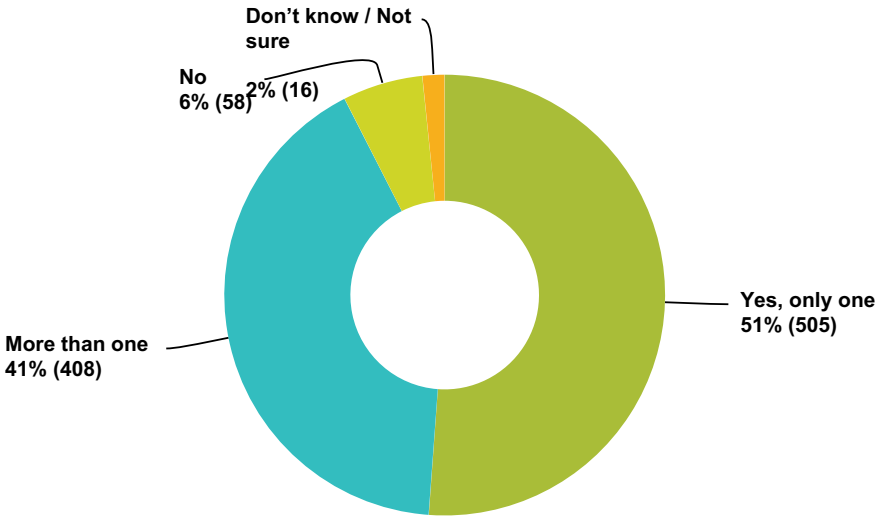
Q12 Do you have health insurance?

Answered: 988 Skipped: 117



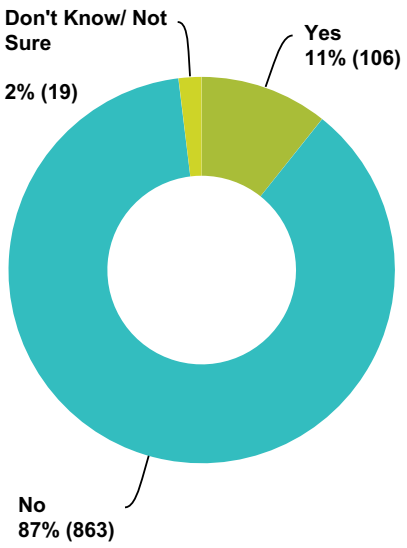
Q13 Do you have one person you think of as your personal doctor or health care provider?

Answered: 987 Skipped: 118



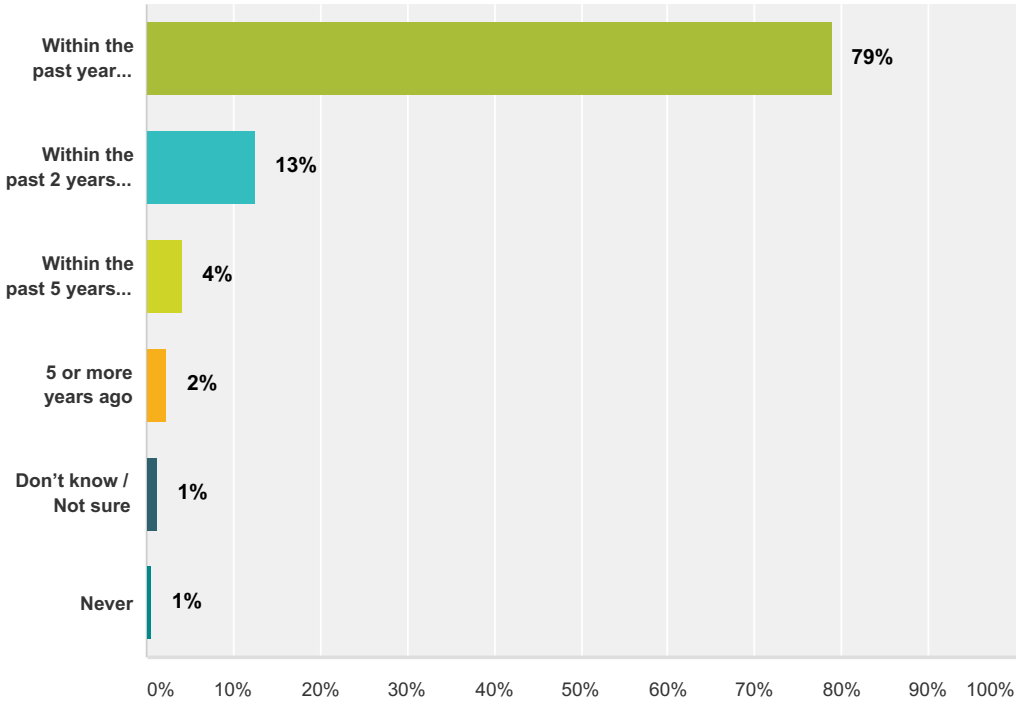
Q14 Was there a time in the past 12 months when you needed to see a doctor but could notbecause of cost?

Answered: 988 Skipped: 117



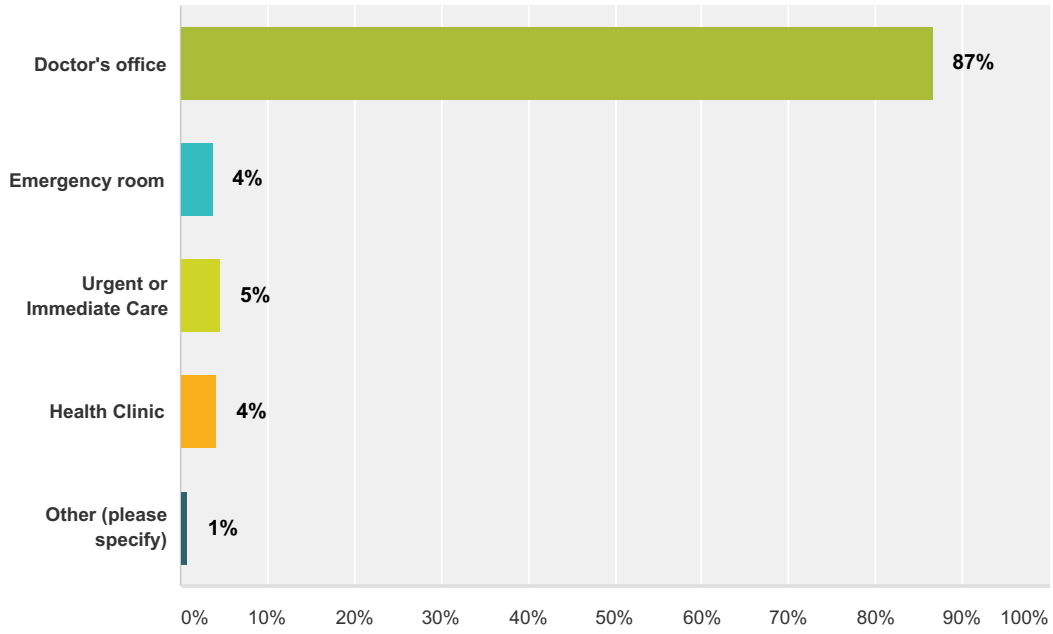
Q15 About how long has it been since you last visited a doctor for a routine checkup? Aroutine checkup is a general physical exam, not an exam for a specific injury, illness, orcondition.

Answered: 984 Skipped: 121



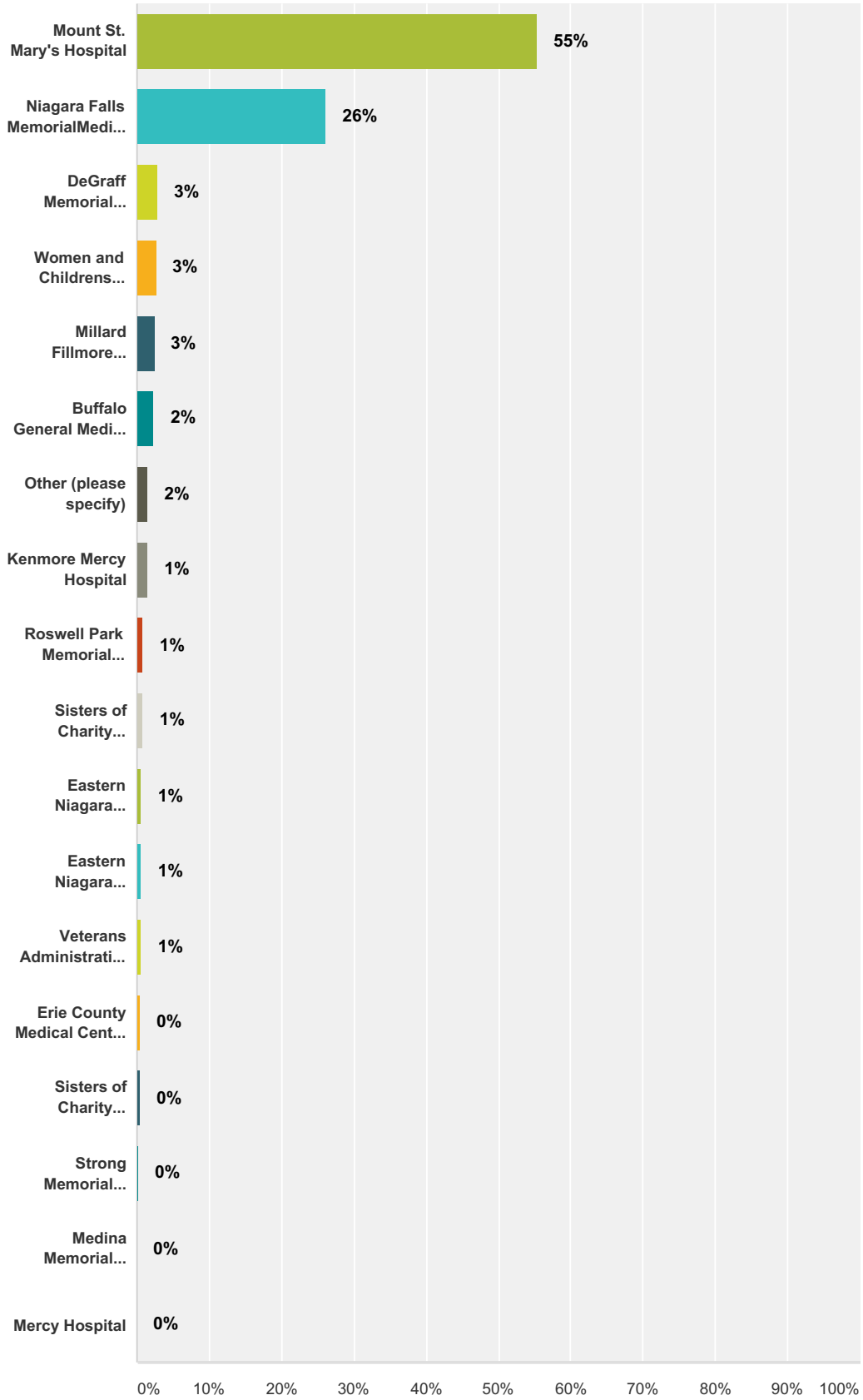
Q16 When you seek medical care, where do you usually go?

Answered: 976 Skipped: 129



Q17 If you go to the hospital, from which hospital do you or your family members get most of your care? Hospitals are listed alphabetically.

Answered: 964 Skipped: 141

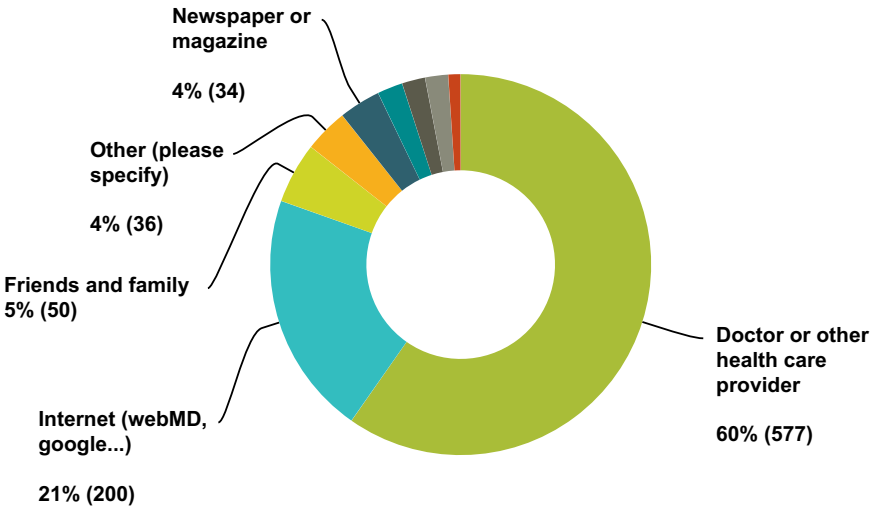


Answer Choices	Responses	
Mount St. Mary's Hospital	55%	534

Niagara Falls MemorialMedical Center	**26%**	251
DeGraff Memorial Hospital	**3%**	29
Women and Childrens Hospital of Buffalo	**3%**	26
Millard Fillmore Suburban	**3%**	25
Buffalo General Medical Center	**2%**	22
Other (please specify)	**2%**	15
Kenmore Mercy Hospital	**1%**	14
Roswell Park Memorial Institute	**1%**	8
Sisters of Charity Hospital	**1%**	8
Eastern Niagara Hospital, Lockport	**1%**	7
Eastern Niagara Hospital, Newfane	**1%**	7
Veterans Administration Western NY Healthcare System	**1%**	6
Erie County Medical Center (ECMC)	**0%**	4
Sisters of Charity Hospital – St. Joseph Campus	**0%**	4
Strong Memorial Hospital	**0%**	2
Medina Memorial Hospital	**0%**	1
Mercy Hospital	**0%**	1
Total		**964**

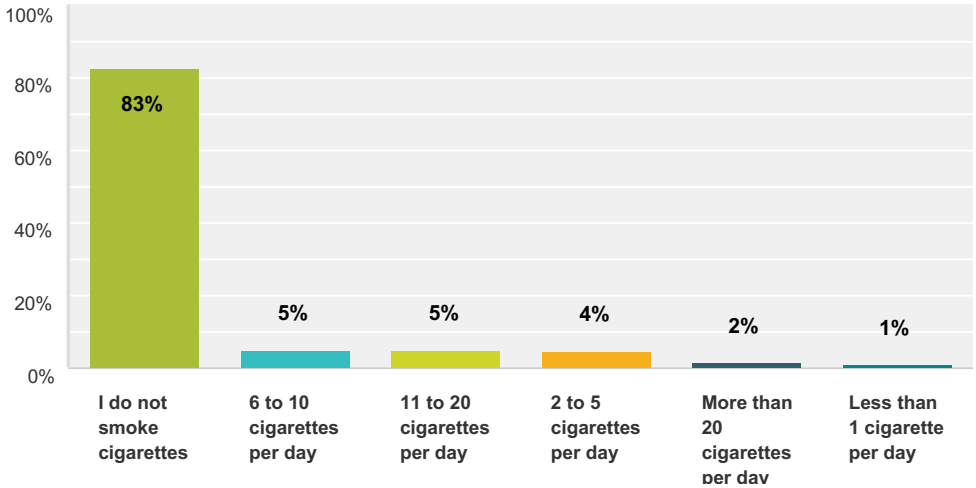
Q18 Where do you get most of your health information?

Answered: 966 Skipped: 139



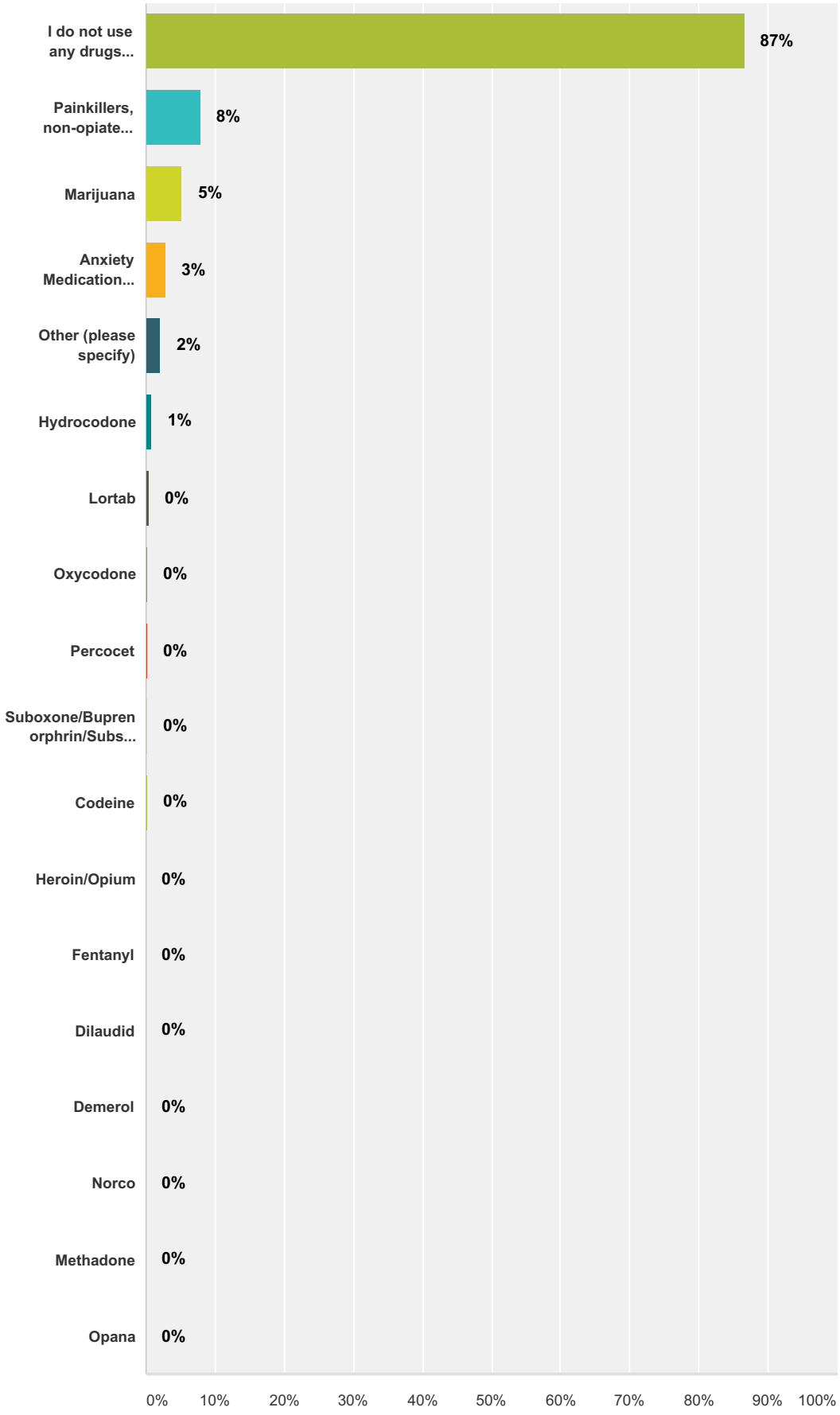
Q19 During the past 30 days, on the days you smoked,how many cigarettes did you smoke per day?

Answered: 983 Skipped: 122



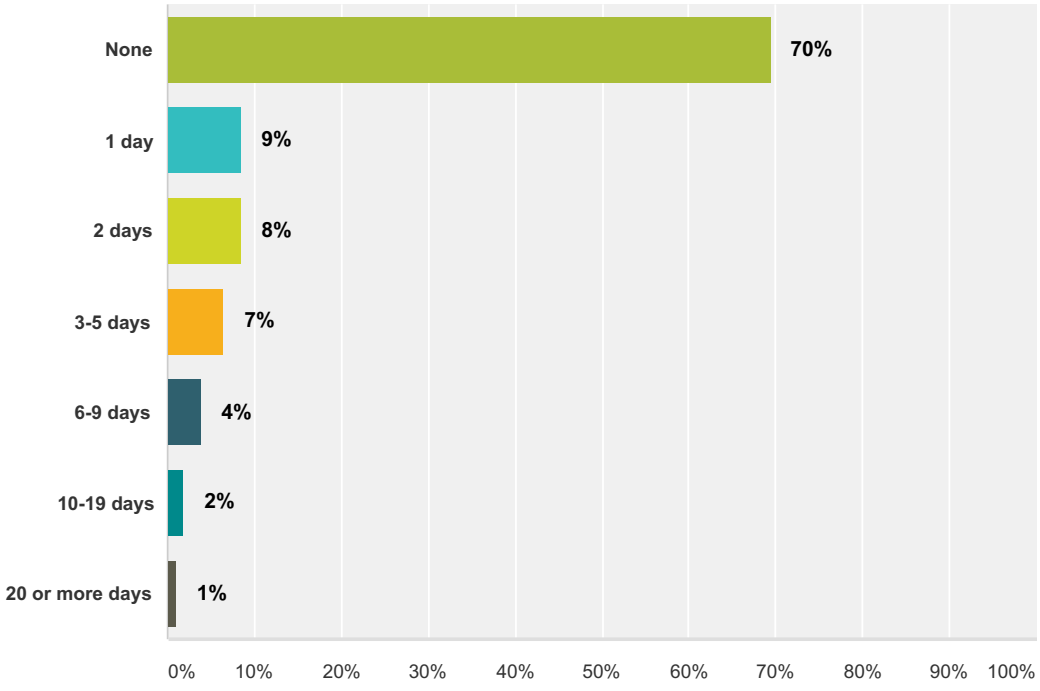
Q20 During the past 30 days, what drugs have you used recreationally? (Choose all that apply) *Please be truthful, your anonymity is guaranteed*

Answered: 967 Skipped: 138


I do not use any drugs...
87%
Painkillers, non-opiate...
8%
Marijuana
5%
Anxiety Medication...
3%
Other (please specify)
2%
Hydrocodone
1%
Lortab
0%
Oxycodone
0%
Percocet
0%
Suboxone/Buprenorphrin/Subs...
0%
Codeine
0%
Heroin/Opium
0%
Fentanyl
0%
Dilaudid
0%
Demerol
0%
Norco
0%
Methadone
0%
Opana
0%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

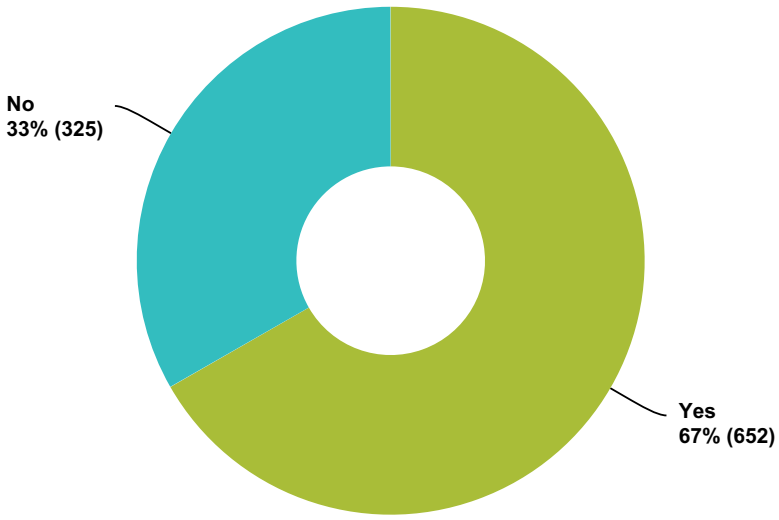
Q21 One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with oneshot of liquor. How many times during the past 30 days didyou have 5 or more drinks on an occasion?

Answered: 981 Skipped: 124



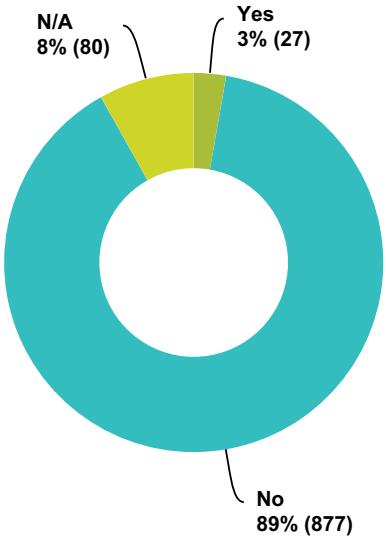
Q22 Are you aware of the medication Naloxone (Narcan)?

Answered: 977 Skipped: 128



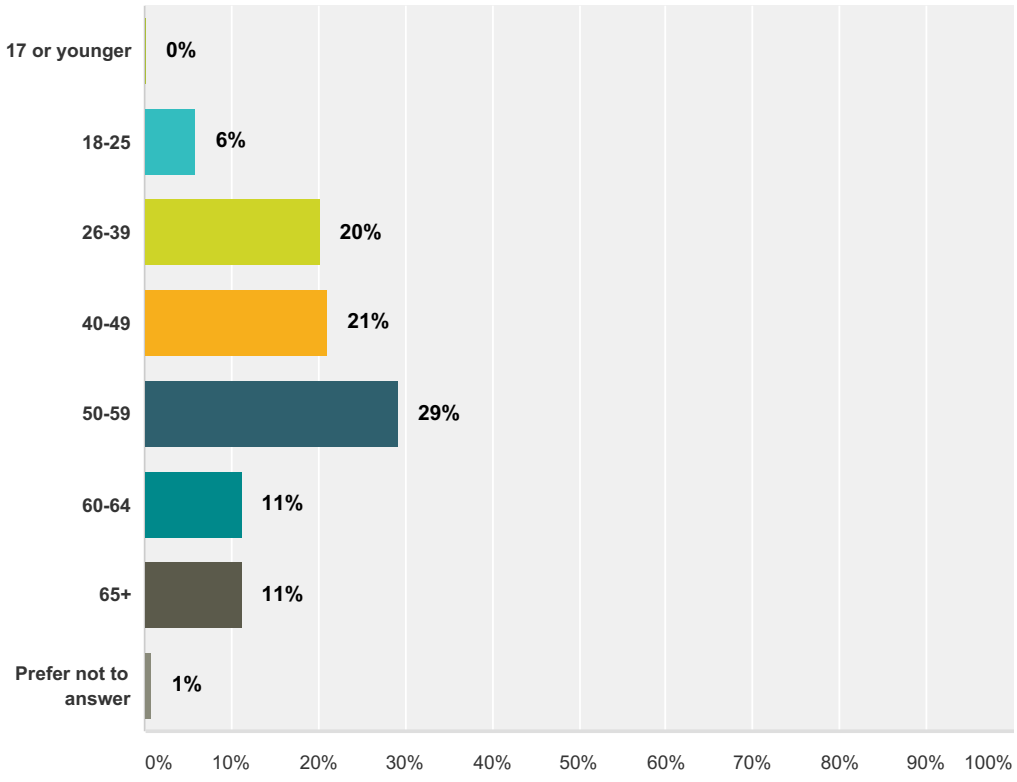
Q23 Have you ever administered Naloxone (Narcan)?

Answered: 984 Skipped: 121



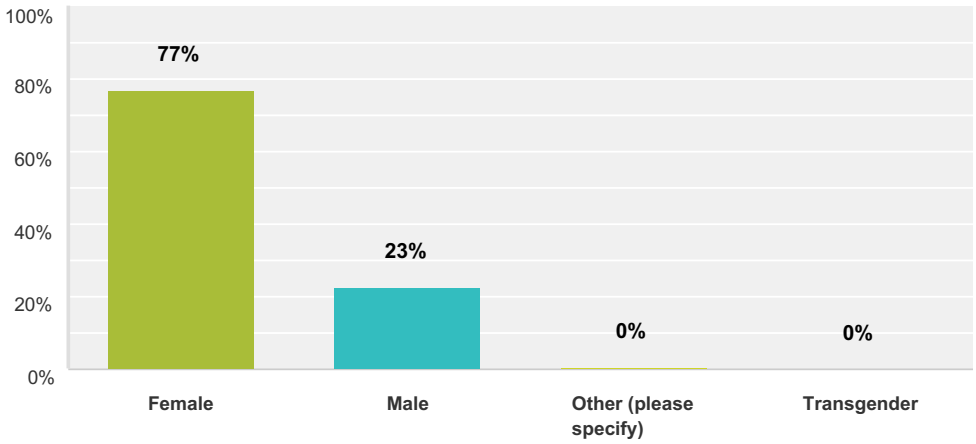
Q24 What is your age?

Answered: 975 Skipped: 130



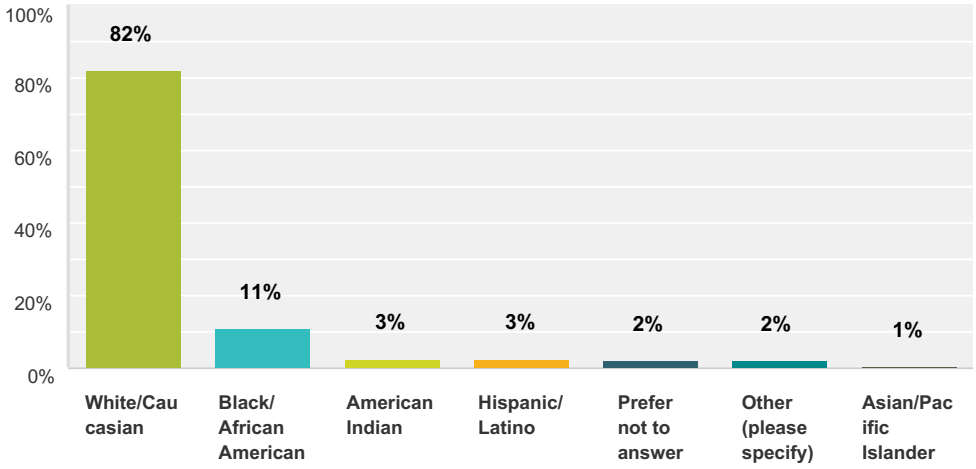
Q25 What is your current gender identity? (Check all that apply)

Answered: 977 Skipped: 128



Q26 Which one or more of the following would you say is your race? Select all that apply.

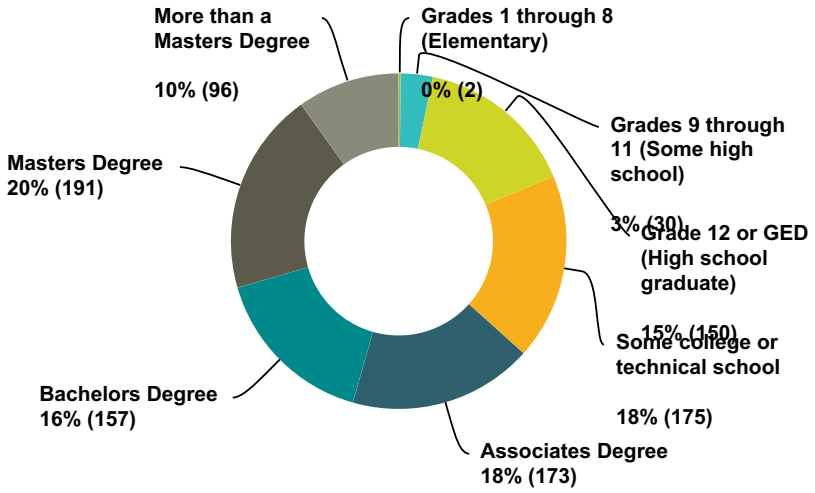
Answered: 971 Skipped: 134



Answer Choices	Responses	
White/Caucasian	82%	798
Black/ African American	11%	106
American Indian	3%	25
Hispanic/Latino	3%	25
Prefer not to answer	2%	21
Other (please specify)	2%	19
Asian/Pacific Islander	1%	7
Total Respondents: 971		

Q27 What is the highest grade or year of school you completed?

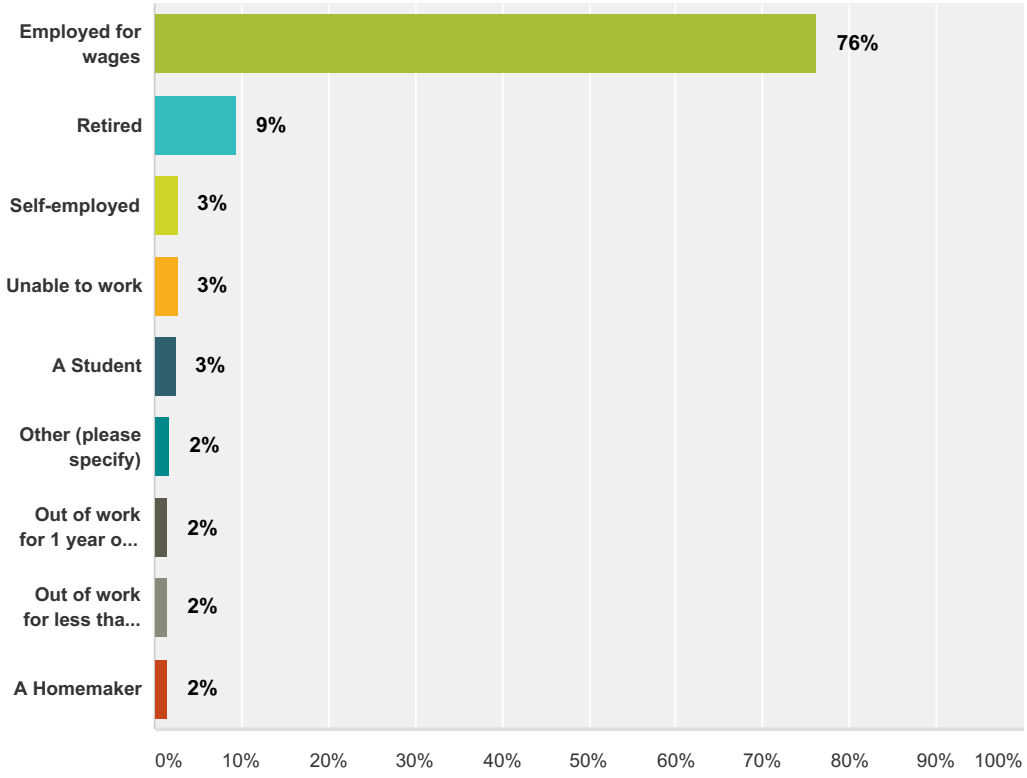
Answered: 974 Skipped: 131



Answer Choices	Responses	
Grades 1 through 8 (Elementary)	0%	2
Grades 9 through 11 (Some high school)	3%	30
Grade 12 or GED (High school graduate)	15%	150
Some college or technical school	18%	175
Associates Degree	18%	173
Bachelors Degree	16%	157
Masters Degree	20%	191
More than a Masters Degree	10%	96
Total		974

Q28 Are you currently…?

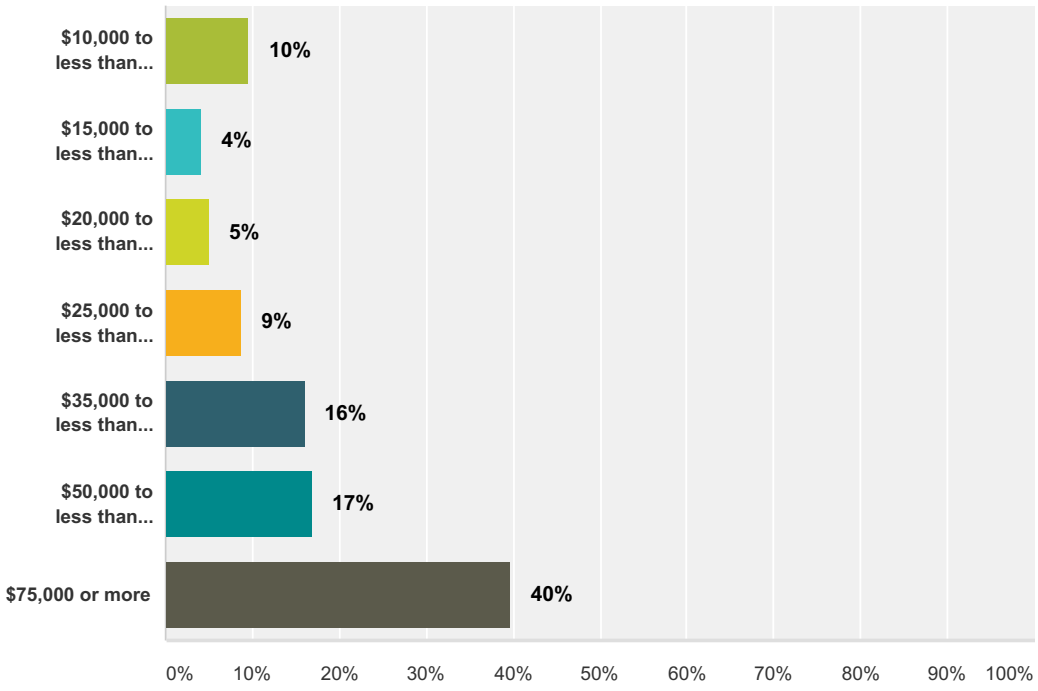
Answered: 973 Skipped: 132



Answer Choices	Responses	
Employed for wages	76%	741
Retired	9%	92
Self-employed	3%	27
Unable to work	3%	27
A Student	3%	25
Other (please specify)	2%	16
Out of work for 1 year or more	2%	15
Out of work for less than 1 year	2%	15
A Homemaker	2%	15
Total		**973**

Q29 Is your annual household income from all sources—

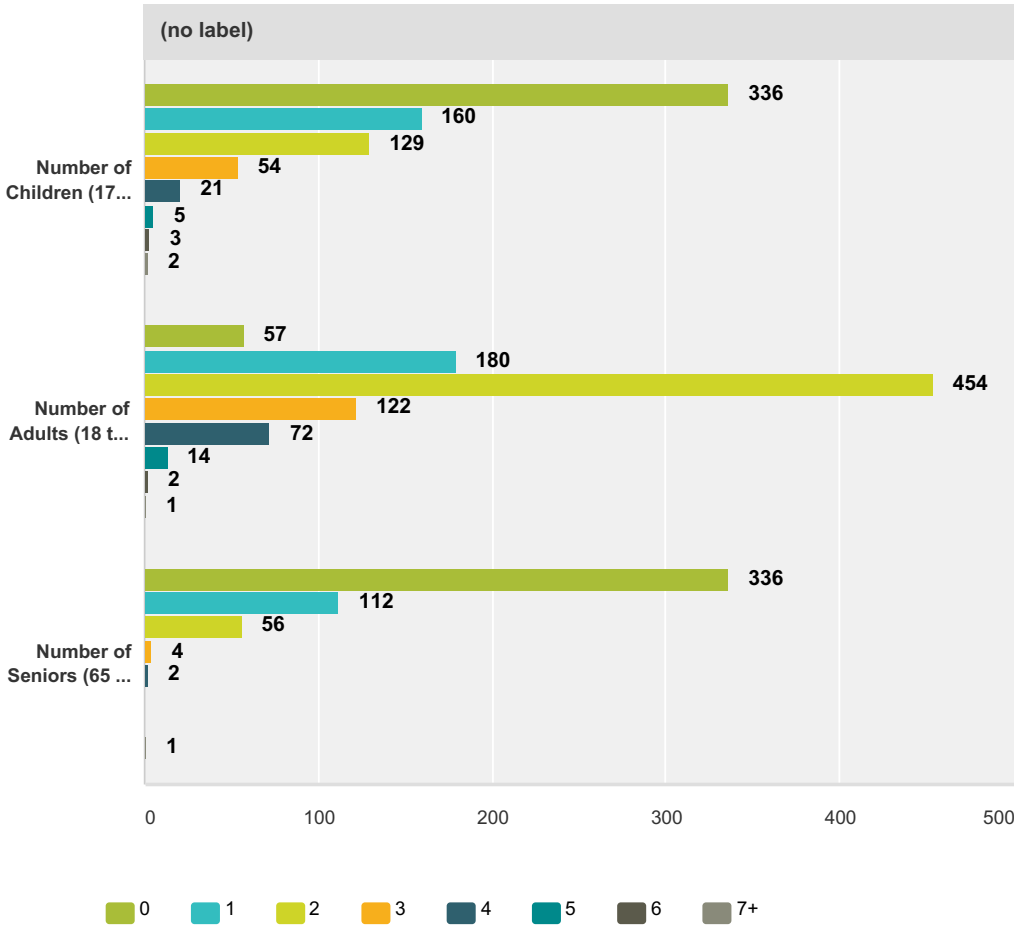
Answered: 926 Skipped: 179



Answer Choices	Responses	
$10,000 to less than $15,000	10%	88
$15,000 to less than $20,000	4%	38
$20,000 to less than $25,000	5%	47
$25,000 to less than $35,000	9%	81
$35,000 to less than $50,000	16%	149
$50,000 to less than $75,000	17%	156
$75,000 or more	40%	367
Total		926

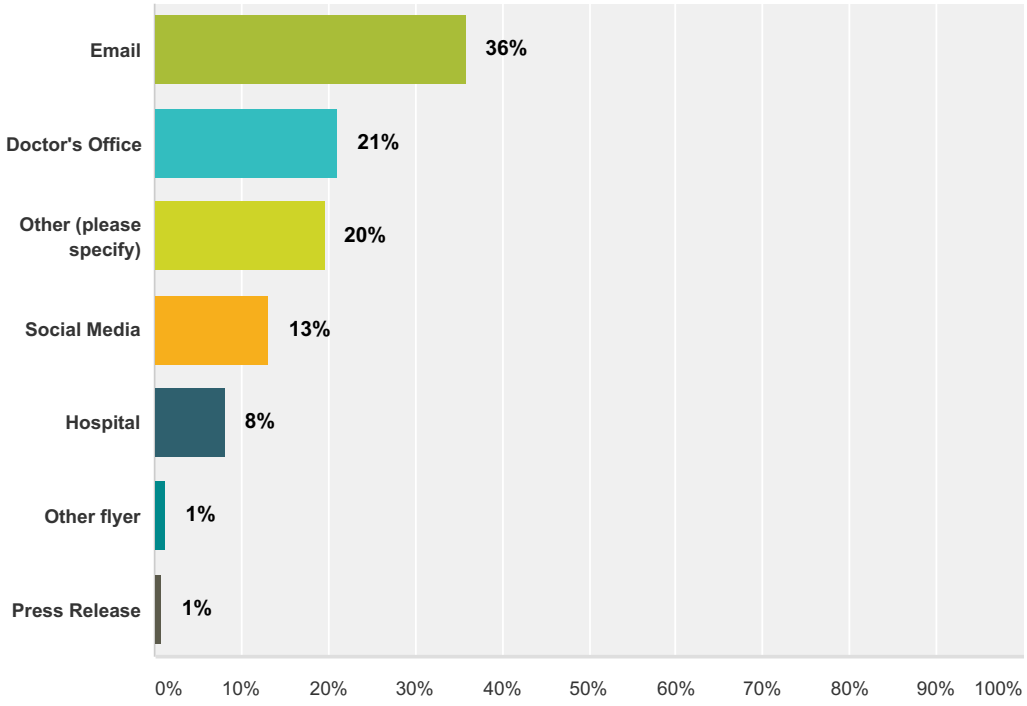
Q30 How many people live in your home, including yourself? Please enter number for each age group.

Answered: 955 Skipped: 150



Q31 Where did you hear about this survey?

Answered: 969 Skipped: 136



CHNA 2013-16

Implementation Tracking

The programs that Mount St. Mary's has put in place to address its priorities involve numerous community groups and organizations. Mount St. Mary's will continue to support several health collaborative groups which include community partners, the Niagara County Health Department, academia, and local schools. These partners will be engaged throughout the years in an evaluation process to determine new areas of need or refine current service offerings.

The Need

Niagara County ranks low in NYS Ratings of Counties for Health Outcomes and Health Factors

- **Health Outcomes Niagara County is 59 of 62**

  Health Outcomes represent the health of the residents of a county

- **Health Factors Niagara County is 45 of 63**

  Health Factors represent what influences the health of the county

Population Health Statistics

Western New York Community Health Needs Assessment (2014)

Delivery System Reform Incentive Payment (DSRIP) Program - VOLUME ONE

On broad composite measures of health status as framed by the New York State "Prevention Agenda" Western New York does relatively poorly. Across sub-categories of chronic disease, health status disparities, creating a healthy and safe environment, preventing HIV, sexually transmitted diseases and other infectious diseases, promoting mental health and preventing substance abuse, and promoting the health of women, infants and children, the region performs generally below par.

The region's poorest ranking comes in the sub-group for HIV and STDs. However, Erie County and to a lesser extent, Niagara County, account for the bulk of the problem. This includes low rankings for HIV prevention, new cases of HIV, and disparities in HIV rates for Black and Hispanic persons, as well as high rates for gonorrhea, chlamydia and syphilis.

The region also has a relatively low composite ranking for the subgroup for chronic diseases with higher incidences of hospitalization for **complications of diabetes**, complications of juvenile diabetes and for heart attacks. Rates for emergency room visits for asthma and by persons 0-4 years old for asthma were also above average compared with the rest of upstate New York.

For chronic diseases and causal behaviors, a few hotspots appear in the data. Orleans and Niagara County have a very high for percentage of adults who smoke. Genesee County ranked at the bottom compared with both WNY and similar counties statewide for hospitalizations for short-term complications from juvenile diabetes.

Niagara County had a similar ranking with regard to adult diabetes. The region also ranked poorly in the sub-group for promoting a healthy and safe environment with measures for **ED visits as a result of falls**, ED visits due to occupational injuries, and ED visits resulting from assault-related injuries. WNY was also at the bottom in terms of the number of jurisdictions approving the Climate Smart Communities pledge and the proportion of workers who use alternative forms of transportation or work from home.

For promoting mental health and preventing substance abuse the region also did poorly but based on a relatively small number of indicators. WNY had low rankings for age-adjusted suicide rate and for binge drinking.

The composite score for promoting the health of women, infants and children was somewhat better than the others. This score, however, might obscure several other troubling individual indicators. These included bottom rankings among upstate regions for percentage of pre-term births, maternal mortality rate, teen pregnancy, unintended pregnancy, percentage of second births within 24 months of previous pregnancy, and percentage of births to Medicaid enrollees.

Priority 1: Chronic Disease (Cardio/Cancer/Stroke/Diabetes)

Mount St. Mary's conducts a series of free community screenings throughout the year to address the priorities of Chronic Diseases:

Cardiology:	Free Lipid Panel Screening *(Attached)*
Cancer:	Free PSA Screening, in cooperation with the Board of Associates Men's Volunteer organization *(Attached)*
Diabetes	Free $HgbA_1C$ Screening
Cancer	Free Digital Mammography Screening in cooperation with the Niagara County Cancer Awareness Program *(Attached)*
Cancer	Smoking Cessation Assistance/Workshops Smoking Prevention Workshops for Teens (HERO) Center for Women: Mommie & Me Tobacco Free

Purpose, Objectives and Audience

- PURPOSE: Decrease Admissions and Re-Admissions
Improve Population Health
Decrease Healthcare Costs
- OBJECTIVE: Awareness, Prevention & Management of Chronic Disease
- ROOT CAUSE: Smoking
Lack of Physical Activity
Poverty/Cost of Quality Food
Environmental Factors
- AUDIENCE: General Population and their Families

Measures to Track Improvements **SEE NEXT PAGE**

- Patient Centered Medical Home Data
    - BP Management
    - ACE/ARB Tracking
- Community Lipid Panel Screenings
- Community PSA Screening
- Reduce illness, disability and death related to tobacco use and secondhand smoke
    - Quarterly Smoking Cessation Education Programs

Priority 1: Chronic Disease (Cardio/Cancer/Stroke/Diabetes)

TRACKING

- BP Management: Tracked for 100% of Primary Care Patients. Goal= <140/90

BLOOD PRESSURE SCREENINGS	2013	2014	YTD2015
Patients/# < 140/90	50%	52%	54%

Efforts by staff include Medication Management, Blood Pressure Followup, and Obesity Education

- ACE/ARB Tracking: Ordered on 100% of Primary Care Patients with Hypertension

ACE/ARB TRACKING	2013	2014	YTD2016
ACE/ARB Tracking	67%	70%	69%

Efforts include Medication Management, Notification of Patient's Primary Care Physician, and Tracking

- Community Lipid Panel Screenings

Conducted for 14 years in the month of February

LIPID PANEL SCREENINGS	2002		2016
Lipid Panel Screening	450		200

Comments show that patients are now getting this test performed routinely through Primary Care. Heart and Diabetes education information now offered as part of screening. The hospital also provides a free heart-healthy breakfast for attendees following the tests since those attending were fasting prior to the test.

- Community PSA Screening

Conducted for 16 years in the month of June (Father's Day Week)

PSA SCREENINGS	2002		2016
PSA Screening	400+		159

Comments show that patients are now getting this test performed routinely through Primary Care.

- Chest Pain Center Accreditation
  - We Track 100% of Acute Myocardial Infarction (AMI) patients for Aspirin on arrival
  - We track 100% of Acute Myocardial Infarction (AMI) patients for Fibrinolytics (TNK) given 30 minutes or less
  - We monitor Door (Arrival) to EKG on chest pain patients to strive for <10 minutes
  - Conduct community education programs in February during Heart Month

AMI: STEMI/TNK	2012	2013	2014	YTD 2015
Total STEMI	25	27	26	22
TNK	21	18	19	15
Door to Needle (TNK) Median Time	27.5 min	25.5 min	21 min	27 min

- Stroke Center Designation
    - We track 100% of all Ischemic, Transient Ischemic Attack & Hemorrhagic stroke patients on all of the required American Heart/Stroke Associations Achievement & Quality Measures. This is also a mandatory requirement to maintain our NYSDOH Stroke Designation status.

Stroke Core Measures based on "Get With The Guidelines"			
Measure	**2013**	**2014**	**2015**
Arrive by 2 hours, treat with tPA by 3 hours	100%	100%	100%
Early antithrombotics	98%	100%	99%
VTE Prophlazis	93%	100%	199%
Antithrombotics @ d/c	99%	99%	98%
Atrial Fibrillation patients d/c on anticoagulanrs	100%	97%	100%
Educated on smoking cessation	100%	100%	100%
d/c on statins	98%	100%	99%
Dysphagia Screening	88%	97%	92%
Stroke Education	94%	97%	99%
Assessed for Rehabilitation Services	100%	98%	100%
NIHSS upon arrival	89%	88%	91%

    - We monitor 100% of the essential TIME TARGETS to be utilized in order to administer the lifesaving drug Alteplase (IV- tPA) in less than 60 minutes from arrival.
    - Conduct community education programs in May as part of Stroke Awareness Month. Includes community presentations.
    - Conduct ongoing education for EMS providers (including volunteer fire company transport crews) to reinforce pre-notification of ER if transporting a potential stroke patients which activates the stroke protocol.

- Reduce illness, disability and death related to tobacco use and secondhand smoke
    - 100% of patients receive a smoking assessment; all patients at all clinics
    - Patients are referred for followup assistance per assessment
    - 100% of patients identified as smokers are provided information on the NYS Quitline and other information sources. The visit summary also includes information.
    - Low-Dose Chest CT Screening offered for long-term smokers

- Quarterly Smoking Cessation Education Programs
    - Programs are advertised in local news media for awareness
    -

Priority 2: Healthy Mothers, Healthy Babies, Healthy Children

Mount St. Mary's conducts a series of community programs throughout the year to address the priorities of Healthy Mothers, Healthy Babies, Healthy Children

Moms Net™ is a network of agencies that provide education services and referrals to women in Niagara County. It is designed to help mothers and mothers-to-be, to learn more about health and wellness during and after their pregnancy. Our mission is to provide the tools and access to education to assist mothers to live healthier lives. The "Moms United Education Group" offers free education designed to help new moms and moms-to-be to learn more about health and wellness during their pregnancies and after the birth of their babies.

Moms Net™ Collaborative Partners include the following:

- Mount St. Mary's Center for Women
- Catholic Health Home Care Services
- Catholic Charities WIC Program
- Family & Children's Services
- Mount St. Mary's Neighborhood Health Center
- Niagara University Department of Nursing
- Help Me Grow Initiative
- CareNet
- Catholic Charities of WNY
- The Northpointe Council, Inc.
- Healthy Families Niagara
- Niagara County Dept of Health
- Trocaire College Dept of Nursing

HERO's Collaborative Partners include the following:

- Niagara University Departments of Nursing and Biology
- Daemen College Department of Physical Therapy Education
- The Northpointe Council, Inc.
- Dr. Shawn Ferguson, Rainbow Pediatrics (Clinical Moderator)
- Catholic Academy of Niagara Falls
- Trocaire College Department of Nursing School
- De Sales Catholic School, Lockport, NY
- St. Peter's Roman Catholic School, Lewiston, NY
- St. Mary's Hospital and Health Center, Departments of:
  - Education and Organizational Development
  - Mission Integration (Sr. Mary Kay Tyrell at HL&S)
  - Rehabilitation and Sports Medicine
  - Community Relations
- The Niagara County Department of Health
- Niagara University College of Education
- Catholic Charities of Western New York
- The Buffalo Diocesan Catholic Schools
- Fidelis Care New York
- The Niagara Charter School
- Niagara Catholic Middle & High Schools
- Lewiston-Porter School District

Purpose, Objectives and Audience

- PURPOSE: Improve Birth Outcomes and Educate the Public
- OBJECTIVE: Screening and Support for Moms and Children
  Provide Referrals to Other Organizations
- ROOT CAUSE: Cycle of Poverty
  Age of Moms
  Cultural and Societal Norms
- AUDIENCE: Women of Child-Bearing Age/Children

Measures to Track Improvements **SEE NEXT PAGE**

- Screenings of Women at Center for Women
- Clinic Vaccination Information
- Total Number of Early Elective Deliveries (≥ 37 & <39 weeks)
- Compliance with HANDS (Handling All Neonatal Deliveries Safely) Program

TRACKING

- Screenings of Women at Center for Women
    - Screenings Offered for Second Hand Smoke

      For 100% of patients, abuse and safe living environment questions, as well as smoking status, are asked and documented on the progress note at the office visit. This now includes second-hand smoke. (Tracked in eCW)

    - Mommies and Babies Program

      The ***BABY & ME – Tobacco Free*** is a smoking cessation program created to reduce the burden of tobacco use on the pregnant and post-partum population. Women who quit smoking are less likely to have premature and low-birth weight babies and reduce the damaging effect of secondhand smoke on their children. The program's design has proved effective in decreasing the number of women who smoke during and after pregnancy.

      Pregnant women are referred by their physician, clinic, or health department or word of mouth to contact their local site and complete an application. The local site arranges for the woman's first appointment during which she receives information about the program and an initial intake session is held. Each participant receives at least four prenatal cessation counseling sessions, support, and carbon monoxide (CO) monitoring, usually during a regular prenatal visit. To verify CO monitor test results, sites may conduct random saliva tests as necessary.

      After the birth of the baby, the mother returns monthly to continue CO monitoring and, if smoke-free, she receives a $25 voucher for diapers for up to 6-12 months postpartum, depending on program funds.

    - Safe Environment/Domestic Violence
        - MSMH screens 100% of patients, including ER, Clinics, and Admissions
        - Patients are referred for assistance when needed
        - Domestic Violence Training provided at Neighborhood Health Center
        - "Feeling Safe" Domestic Violence Training for NHC Social Worker and MSMH ER staff

- Clinic Vaccination Information
    - Provided to 100% of Patients

      Immunizations

IMMUNIZATIONS	2013	2014	YTD 2015
Adult	1,686	1,462	782
Pediatrics	2,561	1,812	985
TOTAL	4,247	3,274	1,767

- Total Number of Early Elective Deliveries (≥ 37 & <39 weeks)
    - TOTAL FOR JAN 2014 0
    - TOTAL FOR JULY 2014 0
    - TOTAL FOR JAN 2015 0
    - TOTAL FOR JULY 2015 0

- Compliance with HANDS (Handling All Neonatal Deliveries Safely) Program
    - COMPLIANCE RATE FOR JAN 2014 100%
    - COMPLIANCE RATE FOR JULY 2014 100%
    - COMPLIANCE RATE FOR JAN 2015 100%
    - COMPLIANCE RATE FOR JULY 2015 100%

- Breastfeeding Participation
    - Community Outreach
        - Mount St. Mary's Hospital made a decision in 2013 to further the quality of its services and care to their maternity patients by hiring a dedicated Board Certified Lactation Manager for Center for Women. Knowing that breastfeeding is a public health priority, recognizing that many recent studies clearly show breast milk has a major impact on human development, and on overall health; our hospital can move ahead to start meeting or exceeding state, and federal standards.

        - One of these goals is the Healthy People 2020 target goal of reaching an 81.9% breastfeeding initiation rate. (MICH-21 Increase the proportion of infants who are breastfed)

        2014
        - Buffalo Breastfeeding Picnic **400+** participants/community members walked by our table.

        - Niagara Falls Breastfeeding Picnic **500** participants/community members walked by our table.

        2015
        - Buffalo Breastfeeding Picnic **450** participants/community members walked by our table

        - Niagara Falls Breastfeeding Picnic **350** participants/community members walked by our table

        (Numbers Calculated from Breastfeeding Coalition & Erie/Niagara County WIC Program)

        - The hospital lactation specialist, hosted **48** women (Jan-July 2015) this year at support group meetings in our education room.

        - **531** women have called, texted, emailed or been called with questions

Priority 3: Concern Physical Activity and Nutrition (Obesity)

CHEERS Program (Choosing Healthy Eating and Exercise RoutineS for healthier life)
Childhood obesity is a health problem reaching epidemic proportions throughout the United States. The Program teaches children a simple healthy eating plan, which they can easily internalize and use throughout their lives. By engaging parents in the Program sessions and homework assignments, their participation in the selection of foods, exercise and other aspects of the curriculum can be encouraged and supported.

CHEERS' Collaborative Partners include the following:

- Mount St. Mary's Hospital Departments of:
  - Education
  - Nutrition Services
  - Diabetic Educators
  - Rehabilitation and Sports Medicine
- Niagara University Faculty & Staff
- Cornell Cooperative Extension
- The Northpointe Council, Inc.
- Lori Caso, Lori & Friends Cooking Television Show/Neighborhood Health Center

Purpose, Objectives and Audience

- PURPOSE: Decrease Co-Morbidities due to Obesity
  Early Intervention for Mild-to-Moderate Obesity
- OBJECTIVE: Educate Public on Risks and Causes of Obesity
  Establish Care Plans
  Educate the Public on Healthy Eating and Activities
- ROOT CAUSE: Cycle of Poverty
  Cultural & Societal Norms
  Move to Technology/Limited Physical Activity
  Knowledge Deficit
- AUDIENCE: General Public

Measures to Track Improvements **SEE NEXT PAGE**

- **Concern Physical Activity and Nutrition (Obesity)**
  - Diabetes Education Data
  - BMI Report
  - Coordination of CardioCraze Community Walk
- **Increase access to high-quality chronic disease preventive care and management in clinical and community settings**
  - Reduce Obesity in Children and Adults
    - CHEERS Program
    - Outreach to Heart, Love & Soul

Priority 3: Concern Physical Activity and Nutrition (Obesity) (Continued)

TRACKING

- **Physical Activity and Nutrition (Obesity)**
    - Diabetes Education Program is Accredited by The American Association of Diabetes Educators
    - Host for monthly Diabetes Support Group
    - Conduct annual screening programs
    - Conduct programming on healthy eating at Neighborhood Health Center
    - Diabetes Education Data

Population	2013	2014	Types of DM	2013	2014	Special Needs	2013	2014
≥ 65 yrs	46	54	T1DM:0-18 yrs	0	0	Visually Impaired	0	0
45-64	79	106	T1DM ≥ 19	0	2	Hearing Impaired	0	0
19-44	16	12	T2DM 0-18	0	0	Low literacy	0	0
<19	0	0	T2DM > 19	127	144	ESL	0	0
Total class	74	70	GDM	9	7	Cognitive	0	0
Total individual	67	102	Pre	4	19			
Gender			**Race/Ethnicity**			**Guests**		
Male	56	82	White	123	161	Follow-ups	32	72
Female	85	90	African American	12	10	Renal/MNT	13	30
			Latino/Hispanic	0		Pre DM class	0	0
			Asian	1	0	Guests- Pre DM	0	0
			Am.Indian/Alaskan	5	1	Medicare	8	7

- BMI Report (100% of Primary Care Patients)
    - >40 = Education, Annual Phone Messages to encourage positive behavior

BMI	2013	2014	YTD 2015
BMI Patients/# >40	3,425	3,428	3,204
BMI >40	81	129	504

    - *Portal Postings for Diabetes information @ Primary Care Clinics*
    - *Patients with BMI over 40 provided education*
- Coordination of CardioCraze Community Walk
    - Community Awareness initiative.
        - Participants in 2011 = 120
        - Participants in 2014 = 180

- **Increase access to high-quality chronic disease preventive care and management in clinical and community settings**
    - Reduce Obesity in Children and Adults
        - CHEERS Programs
            - 8/17-8/21, 8/27, 11/7
                - 8/17 – 13 registered
                - 8/18 – 22 registered
                - 8/19 – 23 registered
                - 8/20 – 19 registered
                - 8/21 – 20 registered
        - Outreach to Heart, Love & Soul Food Kitchen
            - Care Coordination
            - Nutritionist Offered in Care Plans
            - NHC Health Fairs (i.e. BPs at St. John's AME; Doris Jones Ctr

New York State Department of Health
JOINT HOSPITALS/COUNTY PRIORITIES

Priority I –
Reduce Risk of Falls Among Vulnerable Populations

By Dec 2017, Mount St. Mary's will reduce the Rate of Fall-Related ED visits in the 65+ age population by 10%. The baseline MSMH Rate (Nov 2013) is 10.6%. Information will be tracked through Emergency Department Admissions Data in the 65+ Age Group.

This will be accomplished by:

- Staff Education — 100% of Direct Care Givers and Outpatients receive Falls Prevention Education; CFW screens 100% of patients and offers Falls Prevention Education
- Outreach to Senior Centers
- Complete Senior Care (Pace)
- Fall Assessments for patients at our Article 28 clinics include care plans that are reviewed with patients.
  - Review with patients; tracking
  - Report on tracking to staff
  - Full assessment of initiatives for improvement

By July 2014

1) Research and Review hospital specific data related to ED Fall Visits
2) Evaluate current MSMH Fall Assessment Program.
3) Identify community hospital resources for reducing falls

By Jan 2015

1) Evaluate whether tool is suitable for all Article 28 clinics of MSMH
2) Review, Track, and Re-Assess tools
3) Revise as necessary and continue
4) Complete a Falls assessment on 100% of Article 28 Clinic patients age 65+

Outreach

Brochures/Info sent to Primary Care Physicians:	50 offices
MSMH Women's Conference (Nov 2014):	100 women
Lewiston-Porter Health Fair (April 2015):	100 children/adults
Dale Association – Lockport (May 2015):	100 adults
MSMH Women's Conference (Sept 2015):	120 women
PACE Program/Complete Senior Care:	Info packets provided
Lewiston Senior Center – Contacted:	Not Interested at this time
NF Senior Center – Contacted:	Not Interested at this time
Wheatfield Senior Center – Contacted:	Not Interested at this time
"Falls Prevention Week" – Nov/Dec 2015	30 people
Yoga/Falls Prevention Program (Dec 2015)	10 people

Reporting

November 2013 = 10.6% Baseline

July 2013

65 years of age + = 302 Falls over 65 years = 49 Total ED visits = 1,549 49/302 = 16.2%

January 2014

65 years of age + = 215 Falls over 65 years = 44 Total ED visits = 1,236 44/215 = 20.5%

July 2014

65 years of age + = 268 Falls over 65 years = 46 Total ED visits = 1,550 46/268 = 17.2%

February 2015

65 years of age + = 182 Falls over 65 years = 37 Total ED visits = 1,113 37/182 = 20.3%

June 2015

65 years of age + = 252 Falls over 65 years = 49 Total ED visits = 1,540 37/182 = 19.4%

JOINT HOSPITALS/COUNTY PRIORITIES

Priority II –
Increase Access to High Quality Chronic Disease Preventative Care and Management in both Clinical and Community Settings

By Dec 2017, Mount St. Mary's Hospital will promote the use of Evidence-Based Care to Manage Chronic Diseases and increase the percentage of adult patients with chronic disease who receive mental health screening from the current level of approximately 10% up to 50%.

This will be accomplished by:

- Staff Education
- Work with the P2 Collaborative and the Care Coordinators it provides to conduct PHQ2 Screening
- Work with Primary Care Providers
- Track Patient Status following interventions

By Jan 2014

1) Review policies, training and tools to support screening activity — Completed
2) Document baseline of PHQ2 Assessment Completion — Completed Baseline of 18%

By July 2014

1) Review clinical-community linkages that connect patients to follow-up services — Completed
2) Evaluate baseline data (completion of PHQ2 screen) — Completed
3) Track and Monitor and do course correction to build %
4) 100% of patients screened annually — Conducted by Nursing Staff

By July 2015

1) Review clinical-community linkages that connect patients to follow-up services

January 2014 = 18%	January 2015 = 27%
March 2014 = 19%	March 2015 = 54%
May 2014 = 19%	May 2015 = 56%
July 2014 = 20%	July 2015 = 64%
Sept 2014 = 22%	Sept 2015 = 70%
Nov 2014 = 26%	

2) Track and Monitor and do course correction to build %

By July 2016

1) Track and Monitor and do course correction to build %

By July 2017

1) Track and Monitor and do course correction to build %

By Dec 2017

1) Achieve or exceed level of 50% of adult patients with chronic disease who receive
2) screening for mental health

MOUNT ST MARY'S
COMMUNITY HEALTH SURVEY 2016

ATTACHMENT D

January 5, 2016

Catholic Health
Mount St. Mary's Hospital

COMMUNITY HEALTH SURVEY

As a leader in the community we are seeking your personal input and opinion about health problems that exist in the Western Niagara County area.

Mount St. Mary's will compile the results and utilize them as we work with others in developing, implementing, and/or continuing any necessary programs or services to address the overall health needs of the community.

Your opinion is important. PLEASE RETURN BY JANUARY 30

If you have any questions, please contact Fred Caso at Mount St. Mary's at:

Phone: 298-2146

Email: fred.caso@chsbuffalo.org

Mail: Attn: Fred Caso
Director – Public Relations and Community Affairs
Mount St. Mary's Hospital and Health Center
5300 Military Road, Room 735
Lewiston, NY 14092

Catholic Health
Mount St. Mary's Hospital

Community Health Survey
Questionnaire 2016

Please take a few minutes to complete this survey that is designed to gather input and opinions about community health problems in Western Niagara County.

Mount St. Mary's Hospital will be utilizing the results in developing its 2016-2018 Community Service Plan as part of its Community Health Needs Assessment. All responses will be kept in confidence and only released as a compilation of all responses. No individuals or organizations will be specifically identified.

1. **In the following list, what do you think are the <u>three</u> most important factors for a Healthy Community?** ***(Factors which most improve the quality of life in Niagara.)***

   Check only three:

8 Good Place to Raise Children	3 Excellent Race Relations	14 Low Crime/Safe Neighborhoods
0 Low Infant Deaths	0 Low Level of Child Abuse	**22 Good Jobs and Health Economy**
17 Strong Family Life	**20 Good Schools**	5 Healthy Behaviors and Lifestyles
3 Parks and Recreation	2 Clean Environment	10 Religious or Spiritual Values

2. **In the following list, what do you think are the <u>three</u> most important health problems in our Niagara community?** ***(Those problems which have the greatest impact on overall community health.)***

   Check only three:

20 Aging Problems	**30 Heart Disease and Stroke**	0 Rape/Sexual Assault
25 Cancers	1 Homicide	1 Diseases (STDs)
5 Child Abuse/Neglect	2 Infant Death	14 Teenage Pregnancy
9 Dental Problems	**29 Diabetes**	5 High Blood Pressure
3 Domestic Violence	2 Mental Health	**19 Obesity**

3. **In the following list, what do you think are the three most important risky behaviors in our community?** ***(Behaviors which have the greatest impact on overall community health.)***

Check only three:

20 Alcohol Abuse	8 Racism	**22 Being Overweight**
12 Tobacco Use	4 Dropping Out of School	0 Not Using Birth Control
33 Drug Abuse	**29 Poor Eating Habits**	0 Car Safety (Seat Belts/Child Seats)

4. **How would you rate our community as a "Healthy Community?"**

5 Very Unhealthy 12 Unhealthy **20 Somewhat Healthy** 0 Healthy 1 Very Healthy

5. **How would you rate the following in your community:**

Access to Primary Care	18 Very Good	**22** Good	4 Not Good
Access to Specialty Services	6 Very Good	**28** Good	9 Not Good
Education on Health Issues	14 Very Good	**18** Good	10 Not Good

Please answer the following to help us see how different people feel about local health issues.

Sex: 15 Male 18 Female Zip code where you live: **Western Niagara County**

Age: 0 25 or less 5 26 – 39 **19** 40 – 54 5 55 – 64 4 65 or over

Ethnic group you most identify with:

11 African American/Black	1 Asian / Pacific Islander	1 Hispanic/Latino
5 Native American	**15** White / Caucasian	❑ Other _____

Household income

7 Less than $20,000 7 $20,000 to $49,999 **19** Over $50,000

How do you pay for your health care? (check all that apply)

1 Pay cash (no insurance)	**23** Health insurance	2 Medicaid
6 Medicare	1 Veterans' Administration	❑ Other _____

MOUNT ST MARY'S
COMMUNITY HEALTH SURVEY 2016
ORGANIZATIONS SURVEYED

ATTACHMENT E

Survey – Community Input

Blockbusters Block Club
Norma Higgs
MPO Box 2132
Niagara Falls, NY 14302

Bridge Station Block Club
Shirley Hicks
2211 13th Street
Niagara Falls, NY 14305

DeVeaux Beautification
Carmelette Rotella
4026 Carroll Street
Niagara Falls, NY 14305

East Side Block Club
Russ & Pam Vesci
1741 MacKenna Avenue
Niagara Falls, NY 14303

Hyde Park Neighborhood Assn
Adrienne Bedgood
2256 South Avenue
Niagara Falls, NY 14305

LaSalle Avenue Block Club
Vanessa Scott
2406 LaSalle Avenue
Niagara Falls, NY 14301

LaSalle Avenue Block Club
Marie Wilson
1712 11th Street
Niagara Falls, NY 14305

Memorial Park Block Club
Noreen Chatmon
444 Memorial Parkway
Niagara Falls, NY 14303

Niagara Community Action
Laurie Davis
1521 Main Street
Niagara Falls, NY 14301

Ninety Fifth Street Block Club
David David
1264 95th Street
Niagara Falls, NY 14304

Geri Kruse
6658 Errick Road
North Tonawanda, NY 14120

Pierce Avenue Block Club
Justine Munn
2405 Pierce Avenue
Niagara Falls, NY 14305

S.A.F.E. Block Club
Terri Williams
3517 Walnut Avenue
Niagara Falls, NY 14301

South & Cleveland Block Club
John Randolph
2240 South Avenue
Niagara Falls, NY 14305

Tennessee Avenue Block Club
Homer Billips
1708 16th Street
Niagara Falls, NY 14305

Tennessee Avenue Block Club
Mae Nix
2957 21st Street
Niagara Falls, NY 14305

Upper Niagara Street South
Janet Cooper
2713 Falls Street
Niagara Falls, NY 14303

Virginia Avenue Block Club
Mrs. Gray
2026 Virginia Avenue
Niagara Falls, NY 14305

Whirlpool Area Block Club

Michael Wilson

729 Willow Avenue

Niagara Falls, NY 14305

Willow Avenue Block Club

Eric Pawlowski

2715 Willow Avenue

Niagara Falls, NY 14305

Highland Revitalization

Willie Dunn

1750 Tennessee Avenue

Niagara Falls, NY 14305

LaSalle Business Association

Fran Iusi

509 66th Street

Niagara Falls, NY 14304

Niagara Street Business Assocation

Carl DeFranco

481 19th Street

Niagara Falls, NY 14303

American Red Cross			1522 Main Street	Niagara Falls	NY	14305	www.redcross.org/ny/buffalo/
Big Brothers Big Sisters of Niagara			86 Park Avenue	Lockport	NY	14094	www.bbbsniagaracounty.homestead.c
Cancer Services Program of Niagara	Renee Kimble	Outreach Coord	1001 11th Street	Niagara Falls	NY	14301	cheryl.licata@niagaracounty.com
Catholic Charities	Kathleen Hall	Director	256 Third St. Suite 15	Niagara Falls	NY	14303	kathleen.hall@ccwny.org
Catholic Charities WIC	Cheryl Lauth	Counties	237 4th Street	Niagara Falls	NY	14303	cheryl.lauth@ccwny.org
CDPAP of Independent Living of Niag Co.			746 Portage Road	Niagara Falls	NY	14301	
Center for Young Parents	Joan Barrett	Outreach Case Mgr	4455 Porter Road	Niagara Falls	NY	14305	
Community Missions	Robin Krueger		1570 Buffalo Avenue	Niagara Falls	NY	14303	
Cornell Cooperative Extension of Niag County	Kaitlin Smith	Nutrition Team Lead	4487 Lake Avenue	Lockport	NY	14094	kms423@cornell.edu
Destination Life Fellowship	Mark Perkins	Lead Pastor	1609 22nd Street	Niagara Falls	NY	14305	rev.mark.perkins@gmail.com
Erie-Niagara Tobacco Free Coalition	Jenna Brinkworth	Coordinator	Elm & Carolton Street	Buffalo	NY	14263	jenna.brinkworth@roswellpark.org
Everywoman Opportunity Center, Inc.			1905 Pine Avenue	Niagara Falls	NY	14301	www.everywoman.org
Family & Children's Service of Niagara	Connie Ignatowski	Dir Healthy Families	1522 Main Street	Niagara Falls	NY	14305	cignatowski@niagarafamily.org
Family & Childrens PASSAGE Services			826 Chilton Avenue	Niagara Falls	NY	14301	
Girl Scouts of WNY, Inc.			3332 Walden, # 106	Depew	NY	14043	www.gswny.org
Greater Niagara Frontier Council Boy Scouts			2860 Genesee Street	Buffalo	NY	14225	www.wnyscouting.org
GuildCare - Adult Day Health Care Prog	Denise Dipaolo RN	Outreach Worker	4520 Military Road	Niagara Falls	NY	14305	dipaolod@jgb.org
HART Interfaith, Inc.	First Presbyterian Church		PO Box 346	Lewiston	NY	14092	
Health Association of Niagara County			1302 Main Street	Niagara Falls	NY	14301	www.hanci.com
Healthy Neighborhoods Program	Theresa McCabe	Public Health Edu	1001 11th Street Rm 7	Niagara Falls	NY	14301	theresa.mccabe@niagaracounty.com
Heart, Love & Soul, Inc.	Sr. Beth Brosmer	Executive Director	939 Ontario Avenue	Niagara Falls	NY	14305	elizabethb1946@gmail.com
Highland Community Revitalization	Charletta Tyson	Executive Director	2616 Highland Avenue	Niagara Falls	NY	14305	ctyson116@yahoo.com
Independent Living of Niagara County	Sarah K. Lanzo	Director	746 Portage Road	Niagara Falls	NY	14301	slanzo@wnyil.org
Mental Health Assoc. in Niagara Cty., Inc.			36 Pine Street	Lockport	NY	14094	www.mhanc.com
National Grid	Mark Johnson	Consumer Advocate	1720 New Road	Niagara Falls	NY	14304	mark.johnson@nationalgrid.com
Native American Community Services	Pete Hill	Director	1005 Grant Street	Buffalo	NY	14207	phill@nacswny.org
Empower	Jeffrey Patterson	Executive Director	9812 Lockport Road	Niagara Falls	NY	14304	mmorreale@niagaracp.org
Niagara Community Action Program, Inc.	Suzanne Shears	Director	1521 Main Street	Niagara Falls	NY	14305	niagaracap@prodigy.net
Niagara County AIDS Task Force	Jimmy Rowe	Director	1302 Main Street	Niagara Falls	NY	14301	jimmyrowe@notmail.com
Niagara County Home Energy Assistance	Janene Hiscock	Senior SSW	301 10th Street	Niagara Falls	NY	14303	janene.hiscock@niagara County.com
Niagara County Legal Aid Society	Mary Ann Oliver	Managing Attorney	225 Old Falls Street	Niagara Falls	NY	14303	maoliver@wnylc.com
Niagara County Office of the Aging			111 Main Street	Lockport	NY	14094	
Neighborhood Legal Services			225 Old Falls St.	Niagara Falls	NY	14302	
Niagara Falls Boys and Girls Club, Inc.			725 17th Street	Niagara Falls	NY	14301	www.nfbgc.org
Niagara Falls Housing Authority	Howard Patton	Site Supervisor	3001 9th Street	Niagara Falls	NY	14305	howard.patton@nfha.attain.suny.edu.
Niagara Falls Neighborhood Housing Serv	Danielle Rice	Housing Counselor	479 16th Street	Niagara Falls	NY	14303	drice@roadrunner.com
Niagara Falls Police Department Substation	Alan P Booker	Liaison/Director	1667 Linwood Avenue	Niagara Falls	NY	14305	allen.booker@niagarafallsny.gov
Niagara WorkSourceOne	Marilyn Patterson	Coordinator	1001 11th Street	Niagara Falls	NY	14305	marilyn.patterson@nigaracounty.com
Northpointe Council, Inc.	Cheri Kelly	Specialist	800 Main Street	Niagara Falls	NY	14301	ckelly@northpointecouncil.org
NYSDOH - Hunger Prev & Nutrition Prog	John Ingram	Public Health Rep.	584 Delaware Ave.	Buffalo	NY	14202	jai01@health.state.ny.us
Opportunities Unlimited of Niagara			1555 Fact Outlet Blvd	Niagara Falls	NY	14304	www.opportunitiesunlimited.org
Orleans Niagara BOCES	Irene Kalls	Coordinator	1001 11th Street	Niagara Falls	NY	14301	mtopor@onboces.org
Ray of Hope Inc.	Joyce Scott	Director	PO Box 4045	Niagara Falls	NY	14304	scott.joyce43@yahoo.com
Senior Companion Program			1302 Main Street	Niagara Falls	NY	14301	
St. Vincent dePaul Society	Margaret Horey	Agency Coordinator	2437 Niagara Street	Niagara Falls	NY	14303	mlrteach715@aol.com
Tuscarora Nation Community Health Prog	Ann Printup	Program Supervisor	5226 Walmore Road	Lewiston	NY	14092	ann.printup@nfmmc.org
United Way of Niagara	Connie Brown		6420 Inducon Dr.	Sanborn	NY	14132	
GuildCare			1319 Pine Avenue	Niagara Falls	NY	14301	
Venture Forthe, Inc.			3900 Packard Road	Niagara Falls	NY	14303	
YWCA of Niagara			32 Cottage St	Lockport	NY	14092	www.ywcaniagara.org

COMMUNITY DEMOGRAPHICS

COUNTY HEALTH RANKINGS AND ROADMAPS

ATTACHMENT F

Demographics – County Health Rankings & Roadmaps

	Niagara County	Top US	New York	Rank (of 62)
Health Outcomes				**55**
Length of Life				**58**
Quality of Life				**45**
Poor or fair health**	13%	12%	17%	
Poor physical health days**	3.4	2.9	3.6	
Poor mental health days**	3.5	2.8	3.7	
Low birthweight	8%	6%	8%	
Infant mortality	6	5	5	
Frequent physical distress	10%	9%	11%	
Frequent mental distress	11%	9%	12%	
Diabetes prevalence	9%	9%	10%	
HIV prevalence	100	41	782	
Health Factors				**45**

	Niagara County	Top US	New York	Rank (of 62)
Health Behaviors				**44**
Adult smoking**	16%	14%	14%	
Adult obesity	30%	25%	24%	
Food environment index	7.6	8.3	7.9	
Physical inactivity	22%	20%	24%	
Access to exercise opportunities	88%	91%	91%	
Excessive drinking**	19%	12%	17%	
Alcohol-impaired driving deaths	25%	14%	23%	
Sexually transmitted infections	386.8	134.1	489.5	
Teen births	26	19	23	
Food insecurity	13%	11%	14%	
Limited access to healthy foods	5%	2%	2%	
Drug overdose deaths	17	8	11	
Drug overdose deaths -	8.1-10	6.1-8.0	11.3	

	Niagara County	Top US	New York	Rank (of 62)
Clinical Care				**51**
Uninsured	10%	11%	12%	
Primary care physicians	2,300:1	1,040:1	1,200:1	
Dentists	1,910:1	1,340:1	1,280:1	
Mental health providers	1,010:1	370:1	420:1	
Diabetic monitoring	87%	90%	86%	
Mammography screening	60%	71%	62%	
Uninsured adults	12%	13%	15%	
Uninsured children	4%	5%	4%	
Health care costs	$8,711		$9,443	
Other primary care providers	2,321:1	866:1	1,159:1	

	Niagara County		Top US	New York	Rank (of 62)
Social & Economic Factors					**38**
High school graduation	83%		93%	77%	
Some college	66%	63-68%	72%	66%	
Unemployment	6.9%		3.5%	6.3%	
Children in poverty	18%	14-22%	13%	23%	
Income inequality	4.7	4.5-4.9	3.7	5.6	
Children in single-parent households	38%	36-40%	21%	35%	
Social associations	10.4		22.1	7.9	
Violent crime	378		59	400	
Injury deaths	57	53-62	51	42	
Additional Social & Economic Factors (not included in overall ranking) +					
Median household income	$49,300	$46,200-52,300	$61,700	$58,800	
Children eligible for free lunch	35%		25%	41%	
Residential segregation - black/white	64		23	76	
Residential segregation - non-white/white	52		15	63	

WNY DSRIP
SUMMARY OF COMMUNITY HEALTH

ATTACHMENT G

VIII(B) Summary of CNA Findings

CNA #	CNA Title	Brief Description	Supporting Data
CNA 1	Need for delivery system integration across the spectrum of care	Excess bed capacity. Lack of interoperable HIE between health care settings. Primary care gaps. Lack of Behavioral health integration with primary care. Behavioral health gaps. Care management inadequate across settings (Hospital/ED to PCP, to BH, to community supports)	1,240 Inpatient Beds not in use region wide. 499 excess SNF beds. More than 40% community level consent with RHIO. Large portions of inner city and rural areas are Primary Care HPSAs. Only 21% of the 512 primary care locations are NCQA PCMH recognized. Structural barriers between medical system and behavioral health system. WNY have half the number of psychiatrists and psychologists per beneficiary as does the state. Care management crossing settings not functional.
CNA 2	Need for accessible primary care as an alternative to emergency department	Emergency Department is currently the preferred source of care for the uninsured and the Medicaid beneficiaries without access to primary care.	35,053 PPV preventable ED visits per year; current rate is 37.6/100; goal rate for 25% reduction would be 28.2/100. Most EDs have no triage function for dealing with non-emergent care needs. Most have little follow-up with PCP to prevent repeat ED visits.
CNA 3	High Readmission rates due to poor transitions between settings	Currently many patients with chronic conditions are readmitted within 30 days because there was no support to assist their transition to community, to home, to their primary or to hospice.	2,042 PPR potentially avoidable readmissions per year; current rate is 5.8/100; goal rate for 25% reduction would be 4.4/100. Lack of care coordination during transitions, low health literacy, language issues, and lack of engagement with the community health care system have been identified as important factors.
CNA 4	High hospital transfer rates from SNF	Many SNF patients are transferred to hospitals for conditions that could have been identified early and preempted before emerging to acute problems.	Over half of the counties in WNY have SNF to hospital admission rates higher than the state's 14.81/1,000 SNF beneficiaries.
CNA 5	High Readmission rates due to poor collaboration with home care & PCMH	Currently many patients with chronic conditions are readmitted within 30 days because home care was not evaluated & arranged under supervision of the PCP.	2,042 PPR potentially avoidable readmissions per year; current rate is 5.8/100; goal rate for 25% reduction would be 4.4/100. Lack of care coordination during transitions, low health literacy, language issues, and lack of engagement with the community health care system have been identified as important factors. Transition supports such as home care services not well deployed.

CNA #	CNA Title	Brief Description	Supporting Data
CNA 6	High avoidable chronic disease admissions in underserved areas low access areas	Many complex patients in underserved areas often do not go to a PCP in their county and do not have nearby access to specialist.	Region lacks a robust public transportation system, vehicle ownership is fundamental for adequate access to care. Overall, in WNY, 12% of households do not own a vehicle. Remote patient care supports such as telemedicine is not well deployed. Some specialist such as Psychiatrists are missing in rural areas and the state has twice as many per beneficiary as are in WNY.
CNA 7	Need for patient activation & engagement to integrate uninsured & non-utilizers into community care	Currently, the only contact the uninsured have with the health system is through the ED. Engaging this population and connecting them to community care can improve health and reduce inappropriate ED use.	The rural counties have high uninsured rates. Cattaraugus County has the highest proportion of uninsured in WNY (11.8%), slightly higher than the state average. While WNY Medicaid patients are slightly less likely to be non utilizers of OP, IP, and ED facilities than the state in general, despite their poor health they are less likely to see a PCP (35% compared to NYS 31%). Little integrated functionality in crisis intervention community settings geared to activate and connect the UI and NU population to the health care delivery system.
CNA 8	Need for greater integration of primary care and behavioral health services	Currently primary care settings have few providers trained in BH and their integration with BH is fragmented. Patients with BH needs often view care as inaccessible, stigmatizing, and often feel marginalized by the health care system.	Structural barriers between medical system and behavioral health systems hamper integration. WNY have half the number of psychiatrists and psychologists per beneficiary as does the state. Care management crossing settings is not functional. Health Homes just started, and are not yet a meaningful part of the integrated infrastructure with primary care, especially in rural counties.
CNA 9	Need for behavioral health community crisis stabilization services	Currently many patients with BH problems end up in acute care for extended periods of time because they lack support and assistance in the community at times of crisis.	Limited integration in crisis intervention community settings that is geared to activate and connect the uninsured and non-utilizing high need population to the health care delivery system. Most crisis services have limited coordination across the region and there is virtually no interoperability with the RHIO.
CNA 10	High cardiovascular disease prevalence & leading cause of death	Currently many patients with cardiovascular conditions or risks do not consistently receive evidenced base care in primary care settings.	CVD/ heart related conditions are the (a) leading cause of death, (b) leading cause of premature death, (c) leading cause of hospitalization, (d) and leading cause of preventable hospitalization for the general population and more so for African Americans.

CNA #	CNA Title	Brief Description	Supporting Data
CNA 11	Poor Perinatal indicators for low income population	Many women on Medicaid and their children do not consistently receive adequate prenatal or well child care.	The % of preterm birth is 12.1%, above the NYS Prevention Agenda goal of 10.2. The Maternal mortality rate is 26.8/100,000 births, above the Prevention Agenda goal of 21/100,000. The 69.5% of children who have had the recommended number of well child visits in government sponsored programs is below the State goal of 76.9%. Medicaid Well Care Visits in 1st 15 months are done 87.4% of the time. Medicaid Low Weight Births (<2,500 grams) happens 9.6% of the time. Inadequate Prenatal Care for Medicaid women occurs 22.2% of the time. High Risk Pregnancies occur for Medicaid mothers 10.9% of the time. The % of unintended pregnancy among live births is 33.2%, well above the Prevention Agenda goal of 23.8%.
CNA 12	Palliative care shared decision making not occurring when most appropriate	Often times patents and families have not been engaged in palliative care options prior to reaching end stage ICU care that is not informed by quality of life wishes.	"Community Conversations" Focus Groups key findings called for integration of hospice and expansion of palliative care shared decision making in more settings.
CNA 13	Mental, emotional, & behavioral well-being not addressed for the general population	Promotion of community well-being is fragmented at the local level and is not orchestrated at the regional level.	% of adults with poor mental health in the general population is 11.7%, above the NYS Prevention Agenda goal of 10.1%. % of adult binge drinking in the general population is 18.9%, above Prevention Agenda goal of 18.4%. Suicide death rate in the general population is 11.4/100,000, far above the Prevention Agenda goal 5.9/100,000.
CNA 14	Tobacco use tied to leading causes of premature death and preventable hospitalizations	Currently patients who use tobacco are not consistently presented with offers of cessation assistance in primary care settings.	The % of cigarette smoking among adults is 20.8%, above the NYS Prevention Agenda goal of 15%. Smoking related conditions are top five causes of death and premature death in every county (heart followed by lung). The same is true for African Americans.
CNA 15	Poor Premature Birth indicators for the general population	Premature birth rates in the general population is tied to inadequate prenatal care, risk reduction, and management of high risk pregnancy.	The % of preterm birth is 12.1%, above the NYS Prevention Agenda goal of 10.2. Medicaid Low Weight Births (<2,500 grams) happens 9.6% of the time. Inadequate Prenatal Care for Medicaid women occurs 22.2% of the time. High Risk Pregnancies occur for Medicaid mothers 10.9% of the time. The % of unintended pregnancy among live births is 33.2%, well above the Prevention Agenda goal of 23.8%

III. Community Resources Supporting Joint Approach by Two PPSs

(A) Available community resources

Community Resources Infrastructure		Central Region			North Region		South Region			WNY Total
		Erie	Genesee	Wyoming	Niagara	Orleans	Allegany	Cattaraugus	Chautauqua	
Community Based Organizations	Food Basic Needs Services	252	18	12	41	16	9	38	51	437
	Housing/Shelter Basic Needs Services	181	21	6	67	14	5	27	49	370
	Material Goods Basic Needs Services	103	11	6	23	7	3	17	29	199
	Transportation Basic Needs Services	44	5	7	12	4	2	7	10	91
	Utilities Basic Needs Services	17	6	5	5	8	3	13	4	61
	Perinatal Support Services	46	4	2	16	2	1	2	6	79
	Crisis Intervention Services	14	2	7	5	1	1	9	3	42
	Smoking Cessation Services	11	3	2	3	1	1	2	3	26
	Mutual/Peer Support Services	212	16	7	34	13	2	35	47	366
All Other	Public Assistance Programs	74	16	11	19	7	6	19	32	184
	Individual & Family Support Services	17	2	2	4	2	1	4	0	32
	Community Outreach Resources	85	2	3	13	2	2	3	10	120
	Education & Literacy Support Services	60	2	5	5	4	2	5	13	96
	Criminal Justice & Legal Services	93	15	5	17	13	4	12	14	173
	Information & Referral Resources	46	7	11	20	5	1	17	21	128

(B) Community Resources Gaps and Integration Needs

Western New York has a broad array of community resources spanning all counties. With 437 food banks, including food pantries and soup kitchens, as well as community gardens and farmers markets. There are 370 shelter programs, including agencies that provide housing services to special populations, such as: victims of domestic violence, people living with HIV/AIDS, people with mental illness, and homeless veterans. There are 199 basic needs programs that provide clothing and furniture.

There are 184 local government agencies such as food stamp programs and Medicaid offices located in each county. There are 317 employment support services such as job centers, located predominantly in counties with urban areas. There are 121 youth development programs, including those designed to keep at-risk youths away from gun violence and substance abuse. There are 487 education programs, including schools, colleges, and community-based organizations providing educational services. Some of these organizations focus on special populations such as children with emotional disturbances, at-risk youth, immigrants, and refugees. There are approximately 16 programs that offer alternatives to incarceration services located in Erie and Niagara Counties.

Appendix I - WNY DSRIP CHNA – Summary of Community Resources

A significant asset that ties these resources together is an online 211 Information referral system that is well developed. However many medical providers are not aware of these resources and not geared to assess patients for social determinants of health and to actively assist patients in accessing these resources. Connected chronic disease patients to community supports is one of the most neglected components of the Chronic Care Model to improve and sustain self-management skills.

In the region there are 42 organization involved with crisis intervention services. They typically do not have effective protocols to deescalate behavioral health crisis situations and to activate and connect beneficiaries with the health care system. Most crisis services are local with limited coordination across the region and there is virtually no interoperability with the RHIO.

There are 91 transportation service programs, including those providing transportation needs to seniors and the disabled. However, transportation is a pervasive problem in ensuring access to health care for the poor and nearly poor. Many low-income households lack access to a vehicle, public transit services in the region are weak or non-existent outside the metropolitan area, and use of Medicaid funded services requires significant advance notice for pick-up and drop off. These challenges contribute to problems with no- shows to primary care appointments.