



Community Health Needs Assessment &
Community Service Plan
2016 ASSESSMENT



MERCY HOSPITAL OF BUFFALO • KENMORE MERCY HOSPITAL • SISTERS OF CHARITY HOSPITAL • SISTERS OF CHARITY/ST. JOSEPH CAMPUS

ERIE COUNTY

December 2016



Joseph D. McDonald
President & CEO
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, Erie 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.

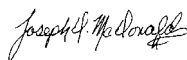


Bart Rodrigues
SVP & Chief Mission
Officer
Catholic Health

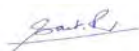
The completed assessment provides the framework for our implementation plans which address the identified and prioritized community needs. One of the areas emphasized in our assessment and plan is the need to address health disparities in our community by improving access to care, especially for the 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.

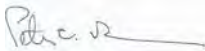
We look forward to working together with you and our community partners to improve the health and quality of life for the residents of Erie County. We welcome you to learn more about Catholic Health by visiting www.chsbuffalo.org or calling HealthConnection at 716-447-6205.



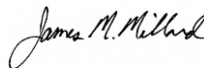
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1. Executive Summary

Background and Overview of Process

Catholic Health (CH) is an integrated healthcare delivery system that operates acute care operations in both Erie and Niagara counties. A single Community Health Needs Assessment (CHNA) was jointly conducted in 2016 for Catholic Health's Erie County based acute care operations including Kenmore Mercy Hospital, Mercy Hospital of Buffalo, Sisters of Charity Hospital, and Sisters of Charity Hospital - St. Joseph Campus. The assessment was comprehensive and included input from a broad range of healthcare and community service providers as well as individuals of varying socioeconomic backgrounds.

It should be noted that Mount St. Mary's Hospital in Niagara County became a full member of CH in 2015. Accordingly, a separate CHNA was also conducted in 2016 for Niagara County which serves as the basis for the Mount St. Mary's three year Implementation Strategy report (not part of this report; refer to www.chsbuffalo.org/msmh).

The 2016 Erie County Community Health Needs Assessment began by first re-evaluating the needs prioritized in the previous cycle (2013) and the impact of the projects corresponding to those needs that were selected for implementation. Catholic Health's understanding of the communities it serves was then updated by soliciting new input from the public and several community organizations as outlined in the Process and Methods section of this report. This assessment represents a collaborative effort across Catholic Health's facilities as well as with external organizations to identify the health needs of the community and to develop a strategy for addressing them. The systematic process used helped identify significant health needs across Catholic Health's Erie County service area including vulnerable and under-represented populations.

As part of this coordinated initiative, CH developed an updated three-year (2016-2018) Community Health Improvement Strategy (CHIS) to continue the collaboration in our community to improve patient care, preventive services, overall health, and quality of life.

The CHNA and CHIS 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 – [Appendix G](#)).

Significant Community Health Needs Themes

The community outreach and research conducted in 2016 revealed the following themes with regard to the significant health care needs and disparities in Erie County which will be targeted by Catholic Health as part of its Community Health Implementation Strategy.

- 1) Improve screening and identification of persons with mental health and substance abuse
- 2) Ensure better coordination of mental health and substance abuse services across the care continuum with an emphasis on coordination with primary care providers
- 3) Address the growing opioid epidemic through education and prevention as well as improving access to treatment options
- 4) Improve access to primary care services in federally designated health professional shortage areas in Erie County
- 5) Educate and train the health care community workforce to optimize their capabilities and better direct their efforts to meet the health care needs of marginalized populations including the LGBTQ community, minorities, and the poor
- 6) Recognize and address the special barriers and challenges (language, transportation, etc.) of Buffalo's growing immigrant population that limit access to basic health care
- 7) Improve access to nutrition and physical activity programs and options to reduce the prevalence of obesity and its effects on health
- 8) Increase the proportion of NYS babies who are breastfed; Erie County DOH Community Collaboration priority
- 9) Chronic Disease Prevention with focus on Cardiac disease; Erie County DOH Community Collaboration priority
- 10) Prevent and better manage impact of opioid addiction in Erie County; Erie County DOH Community Collaboration priority

Community Health Implementation Strategy

Catholic Health is committed to addressing the significant health needs of its community which is reflected in the System's updated three-year (2016-2018) Community Health Improvement Strategy (CHIS). The plan began with a structured internal prioritization of the significant health needs identified in CH's CHNA. Catholic Health then considered the health needs identified and prioritized in the:

- New York State Prevention Agenda
- Erie County Department of Health 2016 community health needs assessment ([Appendix D](#))
- CHNA jointly sponsored and conducted in 2015 by the Participating Provider Systems (PPS) in WNY tied to the NYS Medicaid waiver Delivery System Reform Incentive Payment (DSRIP) program to improve care to the Medicaid and underinsured population.

Then, and most importantly, Catholic Health assessed its capabilities and resources along with the potential to partner with others in the community to select projects that had the greatest opportunity to reduce the health disparities and meet the needs of the Erie County community. The progress of Catholic Health's CHIS will be measured and reported annually to the community on Catholic Health's website in addition to paper copies which are available at each of its acute care locations. 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.

Websites for each of Catholic Health's Erie County acute care operations are as follows:

Kenmore Mercy Hospital,	www.chsbuffalo.org/kenmoremercy
Mercy Hospital of Buffalo,	www.chsbuffalo.org/mercy
Sisters of Charity Hospital,	www.chsbuffalo.org/sisters

Other Needs NOT Addressed in CH's 2016 CHIS

Other needs were identified as part of the Community Health Needs Assessments conducted by Erie County Department of Health, the local DSRIP PPS organizations, and Catholic Health. However, a number of those needs were not incorporated into CH's individual 2016-2018 Community Health Implementation Plans for each of its acute care operations for one or more of the following reasons:

- ✓ was not deemed as impactful on the overall health of the community as compare to other identified needs
- ✓ is being targeted or addressed by other entities within the community
- ✓ Requires resources that CH does not currently have available without compromising other important initiatives. But, should community circumstances change or additional resources become available, CH will consider incorporating other initiatives into its plan.

Among those additional needs not addressed in the 2016-2018 CHIP are:

- Need for greater integration of primary care and behavioral health services (being addressed by local PPS organizations via NYS DSRIP *)
- Need to address childhood obesity through improved nutrition especially in urban "food deserts" and increased exercise programming for children
- Continued need to improve access to smoking cessation programs (Roswell Park Cancer Institute leading efforts of local PPS organizations as part of the NYS DSRIP program)
- Need to improve educational services to parents in urban areas with regard to asthma management and dangers of lead poisoning
- Slowing the rate of HIV infection especially within minority communities (NYS Prep program with local support from Evergreen)

Process and Methods

Satisfying the requirements of the IRS and DOH, Catholic Health followed the process described below in completing its Community Health Needs Assessment and Community Health Implementation Strategy.

Establish the Assessment Infrastructure

An Internal Steering Committee (ISC) was established that included the Chief Operating Officers from each of Catholic Health's acute care operations (Kenmore Mercy Hospital, Mercy Hospital of Buffalo, Sisters of Charity Hospital, Sisters of Charity Hospital - St. Joseph Campus), representation from Catholic Medical Partners (CH's independent practice association), each of CH's clinical service line Vice Presidents, Mission Integration leaders from each site, Planning and Finance. The Internal Steering Committee reviewed IRS & DOH requirements and established the project timeline and work plan.

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 Catholic Health in focusing its assessment efforts and in defining its service area as Erie County. It also helped to identify the most important health issues in the community, set priorities and align work with community partners.

Collect and Analyze Data

Catholic Health relied on both quantitative and qualitative methods to assess community need which are summarized as follows.

The primary data collection efforts included:

- a) Conducted 2 focus groups including representation from a broad range of health care and social service organizations in Erie County to gather their unique perspectives with regard to the needs in our community, the significance of each, and where improvement efforts should be directed. A summary of those community discussions appears in [Appendix B](#).

- b) CH conducted 50 patient interviews (verbal survey) targeting individuals utilizing services at Catholic Health clinics operating within federally designated Health Professional Shortage Areas (HPSA). A summary of those interviews appears in [Appendix C](#).

- c) Disseminating and promoting the completion of a fifty-seven question survey developed by the Erie County Department of Health to the community at large including Catholic Health's own staff. The County's survey results appear in [Appendix D](#).
- d) Western New York Community Health Needs Assessment (December 2014) jointly sponsored by the two Performing Provider Systems in the region linked the Delivery System Reform Incentive Program (DSRIP). Refer to [Appendix H](#) for a summary of identified needs.

Other information was compiled using multiple local, New York State and nationally recognized secondary sources to further assess the health needs of the community. The main secondary sources used include: Truven Health Analytics, The Nielsen Company for demographics, County Health Rankings, Behavioral Risk Factor Surveillance System, New York State Vital Statistics, and Center for Disease Control (CDC). See [Appendices A & E](#) for key indicators and respective data sources.

Identify Resources/Community Collaboration

The Catholic Health CHNA Internal Steering Committee reached out to a cross section of the System'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 the Erie County community. Catholic Health, including its three hospitals, worked collaboratively with Catholic Medical Partners, Erie County Department of Health, Kaleida Health, University of Buffalo, and multiple other local organizations throughout the process.

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

To further guide prioritization of the identified community health needs, the ISC committee adopted its own criteria. Each potential project was evaluated against those criteria. A wide range of clinical and administrative representatives from Catholic Health and Catholic Medical Partners participated in the evaluation process utilizing the following six criteria:

- A. Existing leadership structure can support effort
- B. Current data collection effort confirms need and its significance in the community

- C. Meaningful opportunity exists to collaborate with external partners and make a meaningful impact
- D. Related initiative aligns with and will not compromise the Ministry's Mission and goals
- E. Other resources required are realistic and within the organizations capacity/budget
- F. The likelihood that substantial or meaningful impact can be made in our stated service area

Again, the Internal Steering Committee considered the feedback received from the general community (Erie County Department of Health survey and community meetings) and from leaders within the healthcare community (CH focus groups) to develop a preliminary list of potential initiatives. Finally, the ISC evaluated the various potential projects against the aforementioned criteria to arrive at its final list of prioritized initiatives.

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.

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

Board Approval and Public Availability of the CHNA/IS Plan

The Mission Committee of the Catholic Health Ministry Services Board was engaged throughout the CHNA process by reviewing progress, providing feedback and endorsing the resulting work product. The final CHNA was approved by both the Mission Committee and the Catholic Health Ministry Services Board.

The Erie County needs assessment served as input for the development of Implementation Strategies and Plans for each of the three hospitals. The CH Hospital Boards 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 website (*see web addresses on page 4*) with hard copies available upon request at each hospital.

2. Community Health Needs Assessment

3.A. Overview of Catholic Health

Formed in 1998 under four religious sponsors, Catholic Health (The System) is a not-for-profit integrated healthcare delivery system that operates acute care operations in both Erie and Niagara counties. Catholic Health's Erie County based acute care operations include Kenmore Mercy Hospital, Mercy Hospital of Buffalo, Sisters of Charity Hospital, and Sisters of Charity Hospital - St. Joseph Campus. Mount St. Mary's Hospital in Niagara County became a full member of The System in 2015. Catholic Health brings together the strengths and talents of more than 9,000 full and part-time associates and 1,500 physicians under one healthcare ministry.

Catholic Health's network also includes primary care centers, diagnostic and treatment centers, home care agencies, long-term care facilities and other programs serving the community, either directly or in partnership with other organizations. The role of Catholic Health's Sponsors is to ensure that all of the organization's associates and physicians live the mission in the way they care for their patients, clients and residents and in the way they work with and treat each other.

Catholic Medical Partners (CMP), Catholic Health's physician partners, is a physician-led independent practice association with a network of over 1000 physicians of which one-third are primary care providers. Catholic Health's hospitals are non-physician members of CMP. CMP is driven to improve care delivery in the community through its member physicians. Refer to [Appendix L](#) for a more detailed description of the health system's network of sites and services.

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 Erie County and the surrounding communities. Integral to this effort is caring for the needs of those who are poor and disadvantaged. The services provided by Catholic Health organizations are provided in response to identified community needs and reflect the System's emphasis on caring for the underserved.

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. 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 at least \$99 million in Community Benefit to the residents in Western New York.

3. B. Catholic Health Mission

Catholic Health's mission – We are called to reveal the healing love of Jesus to those in need.

Catholic Health 2020 Vision

Inspired by faith and committed to excellence, we will lead the transformation of healthcare in our communities.

Catholic Health Values

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.

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.

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.

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.

3.C. Community Served

Catholic Health is a not-for-profit integrated healthcare delivery system that operates four acute care operations in Erie County and one in Niagara County. For all intents and purposes, the primary service area for Catholic Health’s Erie County based acute care operations is Erie County. In fact, Erie County residents account for 88% of all inpatient volume, 85% of ambulatory surgery cases and 96% of emergency room visits. Utilizing various secondary sources, a demographic profile of the Erie County community is summarized below in tabular form.

Community Served 2.c. Demographics, socioeconomics, community health status and healthcare utilization in the market		
	2010 Population	917,845
	2016 Total Population # & % Male: # & % Female:	923,060 • 445,419, 48.3% • 477, 641, 51.7%
	2021 Total Projection # & % Male: # & % Female:	933,577 • 450, 904, 48.3% • 482, 673, 51.7%
	% Change 2016-2021	1.1%
	Avg. Household Income	\$70,110
Population <ul style="list-style-type: none"> The total population of Erie County has increased (by 0.57%) between 2010 and 2016, from 917,845 to 923,060. The overall population size is expected to increase by 1.1% between 2016 and 2021. The population of individuals aged 65 or greater is expected to increase from 160,916 individuals in 2016 to 184,667 individuals in 2021 (a 14.76% increase). The median household income in Erie County rose 12.5% from 2010 to 2016. 		
Race / Ethnicity <ul style="list-style-type: none"> The population of Erie County is predominantly white, representing 76.3% or 704,294 individuals. The Black or African American race represents 13% or 119,723 of the population. The next largest population segment is Hispanic representing 5.3%, or 48,709 individuals. A small portion, 3.1% or 28,536 individuals identifies as Asian & Pacific Island, Non-Hispanic. All others equal 2.4% or 21,798 individuals. 		

Socio-economic/Unemployment

- In 2014 approximately 15.2% or 136,047 individuals from Erie County lived below the poverty level.
- Among those living in poverty, 23.5% of children in the County are under the age of 18.
- 41.7% of families in poverty are identified as female householder with children under the age of 18, no husband present.
- There is a strong correlation with poverty & poor health outcomes.

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

For families/households with more than 8 persons, add \$4,160 for each additional person.

Health Insurance Coverage

- Approximately 94.8% of the Erie County population has some form of health insurance coverage, leaving the remaining 5.2% (47,676 individuals) uninsured.
- Only 2.3% or 4,353 of children under 18 are uninsured, lower than the New York State rate of 3.3%.
- Erie County's 7.5% of adults aged 18 to 64 who are without health insurance coverage is less than the State rate of 12.3%.

Employment/Unemployment

- Currently there is a 4.4% unemployment rate among the population in the labor force in Erie County. This rate was lower than both the New York State unemployment rate of 4.7% and national unemployment rate of 4.9%.
- The largest occupational category representing nearly 39% of the work force as defined by the government census categories is "Management, business, science, and arts occupations". The next largest occupational category, for the County, is Sales and office occupations representing 25%.

Education

- Approximately 63% of individuals over the age of 25 have a degree beyond a high school diploma.
- 27.9% of the population has no education beyond a high school diploma.
- 9.07% of the population has never graduated from high school.

Sources: Truven Health Analytics, The Nielsen Co., NYS Dept. of Labor 2014, ASPE.hhs.gov/2015-poverty-guidelines

3.D. Community Health Need Status

A review of various secondary data sources regarding the health outcomes and behaviors in Erie County was conducted. This assisted in identifying areas where important potential gaps or disparities in health services might exist. This secondary information guided our primary data collection efforts and assisted in developing a list of prioritized health needs.

The data sources referenced included: County Health Rankings & Roadmaps 2016, County Health Rankings.org 2015, Health Indicators.gov 2012-2014, NYS Health Indicators by Race/Ethnicity 2011-2013, NYS Vital Statistics 2016 (2014 data), the NYS Prevention Agenda 2013-2018, and the Erie County Medical Examiner’s Office. Refer to related appendices for details.

Health Status/Outcomes
<p>County Health Rankings</p> <ul style="list-style-type: none"> • Under the Health Outcomes category, which reflects morbidity and Mortality, Erie County is ranked 57 out of 62 counties in New York making it one of the worst counties in the state. • In terms of health factors, Erie County is ranked 32 of 62. The health factors of today are an indicator of health outcomes of the future.
<p>Health Status</p> <ul style="list-style-type: none"> • The residents of Erie County report more physical unhealthy days in 2015 than their state and national counterparts, which indicates a greater burden of chronic diseases in the community. • The reported mentally unhealthy days for Erie County residents is slightly lower than the state, but greater than the national comparison, indicating a greater need for mental health services in this community.
<p>Life Expectancy and Preventable Deaths</p> <ul style="list-style-type: none"> • Compared to the state and national benchmark, Erie Co. has a greater rate of potential life lost before age 75. • Within Erie Co., White and Black populations have a greater rate of potential life lost before age 75 than the Hispanic population. The Asian and Pacific Islander population has the best opportunity to reach life expectancy.
<p>Leading Causes of Death in Erie County</p> <ul style="list-style-type: none"> • Heart Disease, Cancer, Stroke, Chronic Lower Respiratory Disease (CLRD)
Health Behaviors
<p>Tobacco, Alcohol and Obesity</p> <ul style="list-style-type: none"> • Erie County adult residents report a higher percentage of smoking, heavy drinking and obesity than NYS and the national benchmark.
<p>Substance Abuse</p> <ul style="list-style-type: none"> • Fatal Opioid Overdoses in Erie Co. have been projected to more than double from 2014 to 2015. • The Suburbs of Erie County has the largest percentage of fatal overdose in 2014 being 44.5%, Buffalo had 39%. • The average age of overdose victim was 37.8 years old with the youngest being 17 years and the oldest being 83 years old.

3.E. Community Resources – Systems and Access to Care

The Erie County health care system is supported by two major integrated health delivery systems; Catholic Health System and the Great Lakes Health System. Another important provider is Roswell Park Cancer Institute, a national cancer center.

Catholic Health

CH operates four acute care campuses in Erie County with a total of 946 beds. Two of its facilities are located within the City of Buffalo (639 beds) and two are in the first-ring suburban communities of Kenmore and Cheektowaga (307 beds). The System is positioning itself to become a high performing health system, aligning services across its ministries and supporting its service line structure. The System has developed an integrated health network that includes primary care, outpatient rehabilitation services, inpatient medical rehabilitation, skilled nursing care, home care, and outpatient lab and imaging services.

Great Lakes Health

Great Lakes Health System is a network comprised of the four Kaleida Health hospitals, three of which are based in Erie County and one in Niagara County. The other partners comprising the Great Lakes Health network are Erie County Medical Center and the University at Buffalo.

Kaleida Health operates two acute care facilities one in the City of Buffalo (457 beds) and one in the suburban community of Amherst (265 beds) with a total of 722 beds. It also operates a 200 bed women's and children's hospital within the City of Buffalo and another acute care general hospital in southern Niagara County (66 beds).

ECMC is a 602 inpatient facility within the City of Buffalo and serves as the regional center for trauma, burn care, behavioral health, transplantation, and medical rehabilitation. ECMC is also major teaching facility for the University at Buffalo. ECMC also provides on and off campus primary care and family health centers and maintains a 390-bed long-term care facility in the City of Buffalo.

Other Community Providers

Important health care provider organizations in Erie County include two Federally Qualified Health Centers, one in Buffalo and one in Kenmore and two New York State Health Homes, both in the City of Buffalo. 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 which is summarized in [Exhibit I](#).

4. Evaluation of 2014-2016 Implementation Strategy Impact

A. Erie County DOH Collaborative Priorities

In collaboration with the Erie County Department of Health and other community partners, a 2013 Community Health Needs Assessment was conducted which was used to help form Erie County's implementation strategy. That strategy included three specific implementation priorities around which the community was asked to collaborate. Each is indicated below in *blue font* and an assessment of the 2013-2016 community collaborative effort can be found in Exhibit X. *County report at the time of publishing was not available.*

B. Catholic Health Identified Priorities

In addition to the 3 county wide collaborations, Catholic Health elected to include 16 other projects in each of its facilities 2013 implementation plans. Many of the project goals were achieved in the 2013-2016 time period with positive effect. While some of these initiatives have concluded, other will continue as part of CH's normal course of operations given that positive influence. We solicited input from the community regarding the 2013 CHNA report and received no comments or input regarding the 2013 report. Refer to [Exhibit K](#) for more detail regarding 2013 implementation impact.

CH 2013 Implementation Strategy Project List:

Improve Health Status and Reduce Health Disparities

1. Physician Recruitment
2. Charity Care / Medicaid
3. Community Health Workers
4. Faith Community Nursing
5. Access to Care in Medically Underserved Areas Community Outreach
6. Community Outreach Prevent Care
7. Preventable Hospitalizations

Prevent Chronic Disease

8. Cardiovascular Health – Congestive Heart Failure
9. Stroke – Cerebrovascular Disease – *Erie County Community Collaboration Project*
10. Diabetes Mellitus
11. Peripheral Arterial Disease
12. Colorectal Cancer – Collaboration – *Erie County Community Collaboration Project*

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

13. Seasonal Influenza Vaccination
14. House-Wide Central Line-Associated Bloodstream Infections
15. HIV

Promote Healthy Women, Infants and Children

16. Breastfed Babies – *Erie County Community Collaboration Project*

Promote Mental Health and Prevent Substance Abuse

17. Collaborate with Community Mental Health Providers
18. Health Home
19. Integrate Mental Health and Physical Health

5. 2016 – 2018 Community Health Implementation Strategy

As previously described in the Process and Methods section of this report, Catholic Health selected initiatives addressing health care disparities that it believes it can positively and meaningfully affect over the 2016 – 2018 timeframe as a collaboration across its own acute care operations and in cooperation with Erie County and other community partners. A brief summary of those initiatives appears below. For further detail please reference the individual hospital CHIP reports as provided on the websites previously provided in this report.

1. Reduce healthcare disparities in vulnerable population through “Trauma-Informed” care practices	
<p>NYS Prevention Agenda Improve health status and reduce health disparities</p> <p>Note: Also ties to CPWNY DSRIP cultural and structural competency initiatives</p>	<p>Identified Need and Project Description CH focus group conversations with various non-profits 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.</p> <p>Target Population: Vulnerable communities include, but are 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.</p>
2. Mental Health First Aid Training	
<p>NYS Prevention Agenda Promote mental health, prevent substance abuse and other mental emotional behavioral disorders</p> <p>Note: Also ties to CPWNY DSRIP promote mental, emotional, and behavioral (MEB) well-being in communities</p>	<p>Identified Need and Project Description CH focus group conversations with various non-profits highlighted the importance of 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.</p> <p>Target Population: CH physicians, nurses, and other front line staff interacting with patients, key community stakeholders (fire fighters, EMS, Catholic Charities, community centers, etc.) and the general community.</p>

3. Stroke Prevention	
<p>NYS Prevention Agenda Improve health status and reduce health disparities</p>	<p>Identified Need and Project Description Conducting health screenings in under-served communities and provide education on increasing awareness of stroke signs and symptoms thereby reducing the number of strokes and the debilitating effects if a stroke does occur. Target Population: under-served communities in Erie County, NY.</p>
4. Stroke Support Programming	
<p>NYS Prevention Agenda Improve health status and reduce health disparities</p>	<p>Identified Need and Project Description The need for stroke support to provide psych-social emotional support for care givers, patients, families was identified by the patients and families across CH and the local Stroke Association. Target Population: Patients and/or their families who have suffered a stroke and seek support from other people in similar situations.</p>
5. Donor Breast Milk for Newborns who Fail to Thrive and are in ICU	
<p>NYS Prevention Agenda Improve health status and reduce health disparities and increase proportion of infants who are fed breast milk.</p> <p><i>Erie County Community Collaboration Project</i></p>	<p>Identified Need and Project Description CH’s maternity hospitals will become licensed depots for donor human milk. Breast-feeding 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 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. Target Population: Mothers in Erie County, NY who are producing excess breast milk. Mothers who cannot produce breast milk or who choose not to breast feed, and newborns who fail to thrive, are in the NICU, or have other needs.</p>

6. Helping High Risk Moms to Prevent Prematurity and Address Opioid Dependence	
<p>NYS Prevention Agenda Improve health status and reduce health disparities 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.</p>	<p>Identified Need and Project Description 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 a shortage of PMDs and OB-GYNs able to prescribe buprenorphine and naloxone (Suboxone®). Connect pregnant women to support options. Target Population: Pregnant women, OB-GYNs, PMDs in Erie County, NY.</p>
7. Opiate Prevention In Erie County	
<p>NYS Prevention Agenda Promote mental health and prevent substance abuse</p> <p><i>Erie County Community Collaboration Project</i></p>	<p>Identified Need and Project Description Opiate crisis in community and lack of viable treatment options have made it difficult for patients to receive treatment/care. Waiting list at both STAR (counseling) and Pathways (suboxone/methadone) have demonstrated need for enhanced services. Target Population: Opiate addicts in Western NY, primarily in Erie County.</p>
8. Primary Care Recruitment To Underserved Communities	
<p>NYS Prevention Agenda Prevent chronic diseases</p>	<p>Identified Need and Project Description The identified community need is the lack of primary care provider’s at all four Catholic Health mission-based clinics which are St. Vincent’s Health Center, Mercy Comprehensive Care Center, Our Lady of Victory Family Care Center, and Ken-Ton Family Care Center. All of CH mission-based clinics (excluding Ken-Ton Family Care Center) are located in areas designated by the Health Resources & Services Administration (HPSA) and Medically Underserved Area (MUA). Consequently, the shortage of primary care providers limits access to primary care service to the uninsured and Medicaid population in Erie County, NY. Target Population: Uninsured and Medicaid population in Erie County, NY.</p>

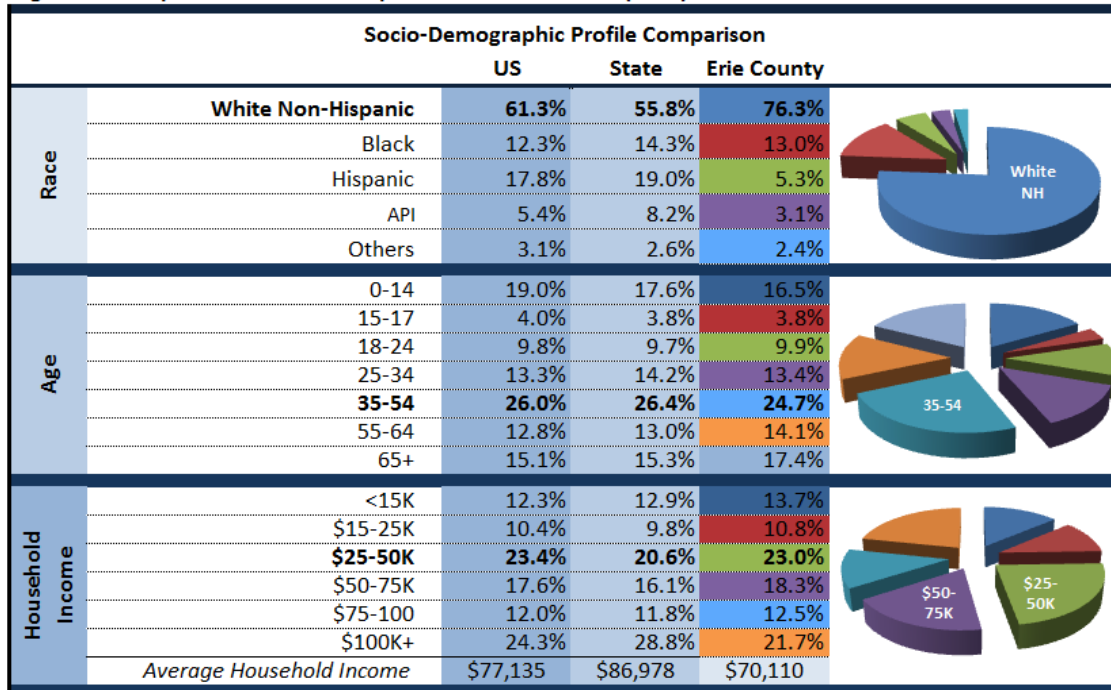
APPENDICES

APPENDIX A: Area Demographics

Community Served - Details

Catholic Health serves the eight counties of Western New York. The System’s primary service area is Erie County which accounts for 88 percent of its inpatient admissions, 96 percent of emergency room visits and 85 percent of ambulatory care visits. Erie County consists of a mix of urban, suburban and rural populations. It includes the City of Buffalo, New York State’s second largest city, surrounded by a ring of older suburbs, which is followed by a ring of more newly developed suburbs, and then rural communities. The current population of Erie County is 923,060, with about one-third living in Buffalo. A demographic comparison of Erie County with New York State and the country is shown in Figure 1.

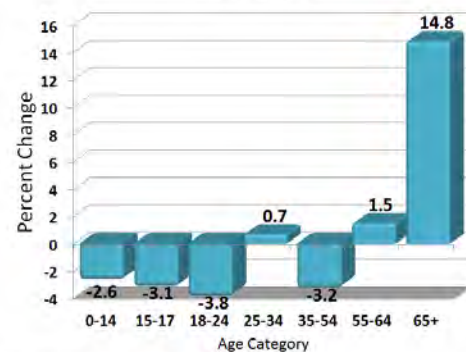
Figure 1 - Comparison of Current Population Characteristics (2016)



Source: Truven Health Analytics & The Nielsen Company

Erie County has an average income significantly lower than the New York State average household income. The population in Erie County has a greater percentage of persons over the age of 55, in comparison to New York State and the United States. Erie County’s population is projected to gradually increase between now and 2021, with the greatest increase expected in those ages 65 and older. Slight decreases in population can be seen in age groups 0-14, 15-17, 18-24 and 35-54. See Figure 2.

Figure 2 Erie County Projected Population Change by Age Category 2016-2021



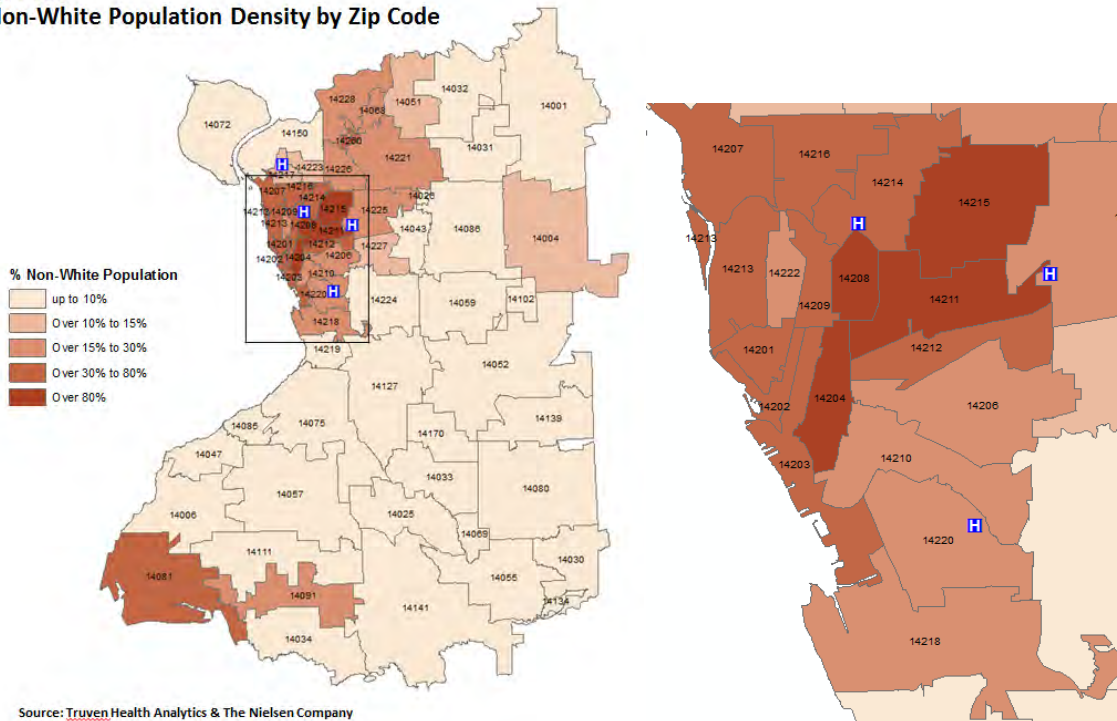
Source: Truven Health Analytics & The Nielsen Company

As noted in Figure 1, Erie County is less racially and ethnically diverse than areas outside of Western New York or the rest of the country. The Non-White populations are concentrated in

and immediately around the City of Buffalo. The 11 zip codes that comprise the City of Buffalo are densely populated with a Non-White population of 50 percent or more. (See Figures 3 and 4).

Figures 3 & 4

Non-White Population Density by Zip Code



Source: Truven Health Analytics & The Nielsen Company

Economy

Today the largest economic sectors in Erie County are health care, professional and business services, and education.¹

The 10 largest private sector employers (in alpha order) as of March 2014 are as follows: General Motors, Kaleida Health, M & T Bank, Mercy Hospital, Moog Inc., People Inc., Sisters of Charity Hospital, Tops Markets, Walmart and Wegman’s Food Markets.²

According to the New York State Department of Labor, between July 2006 and July 2016, employment has increased by 0.2 percent in the Buffalo-Niagara Falls Metro Area.

Education

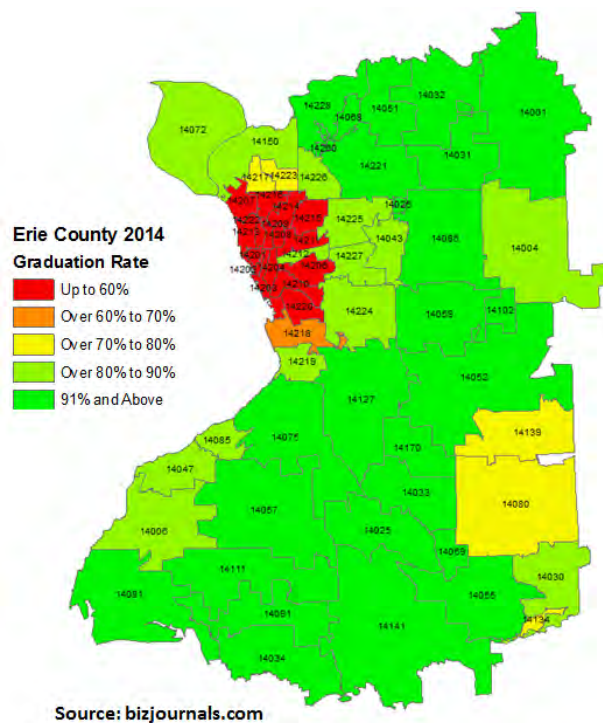
According to the National Poverty Center³, there is a clear association between education and health. In general, better educated persons tend to have fewer incidences of disease. This is due to a variety of reasons: health choices, access to proper healthcare, as well as, having the means to provide themselves a healthier lifestyle.

¹ NYS Dept. Labor/Quarterly Census of Employment and Wages

² IBID

³ National Poverty Center, Policy Brief #9, March 2007; http://www.npc.umich.edu/publications/policy_briefs/brief9/.

Figure 5



As shown in Figure 5, students in the City of Buffalo School District achieve a diploma within four years at a rate significantly lower than in the surrounding districts. The graduation rate statewide for June 2014 was 76.4 percent. Across Erie County, the overall grad rate was 79 percent (same as 2013). The most currently reported four-year graduation rates for students in the graduating class of 2014 in the City of Buffalo School District is 53 percent.⁴ Low graduation rates are solely concentrated within the City of Buffalo.

Income

An individual's health is affected by his or her income level. According to a Commonwealth Fund report there is a strong correlation between low income and poor health and "the U.S. stands out for income-based disparities in patient experiences, with below-average-income U.S. adults reporting the worst experiences."⁵ In the U.S., there is a health care gap between lower-income and higher-income Americans leading to income based disparities in access to care.⁶ Within Erie County, the areas of lower median household income are concentrated in the City of Buffalo (See Figure 6 & 7).

⁴ <http://www.bizjournals.com/buffalo/new/2014/12/18/new-york-state-releases-high-school-grad-rates-for.html>

⁵ <http://www.commonwealthfund.org/Publications/Fund-Reports/2006/Apr/The-U-S--Health-Care-Divide--Disparities-in-Primary-Care-Experiences-by-Income.aspx>.

⁶ Ibid.

Figure 6

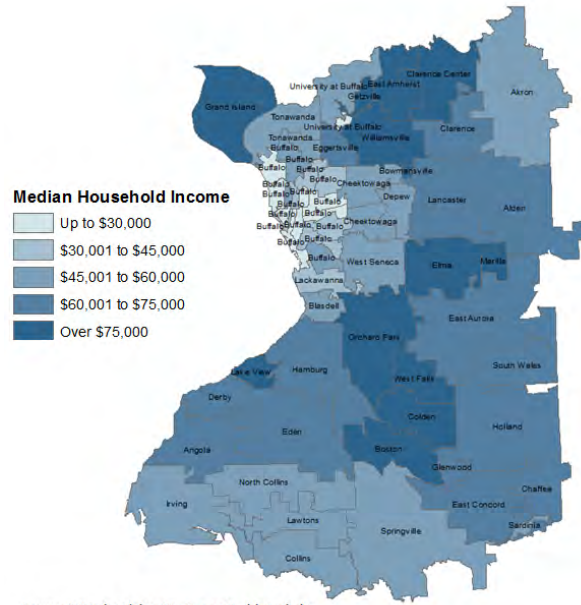
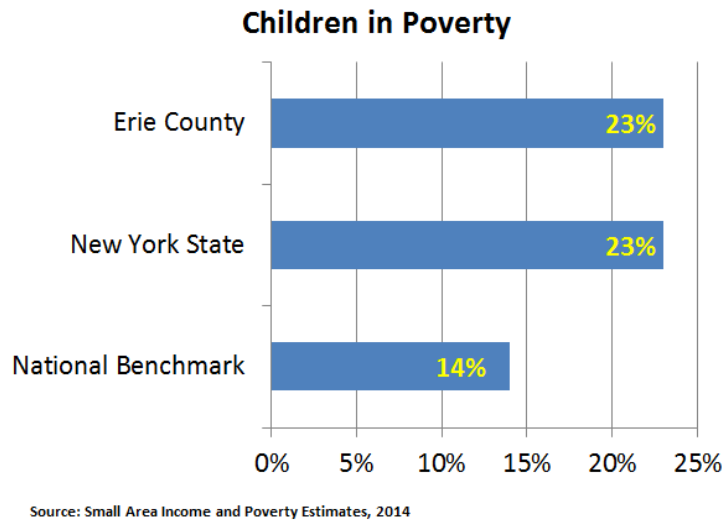
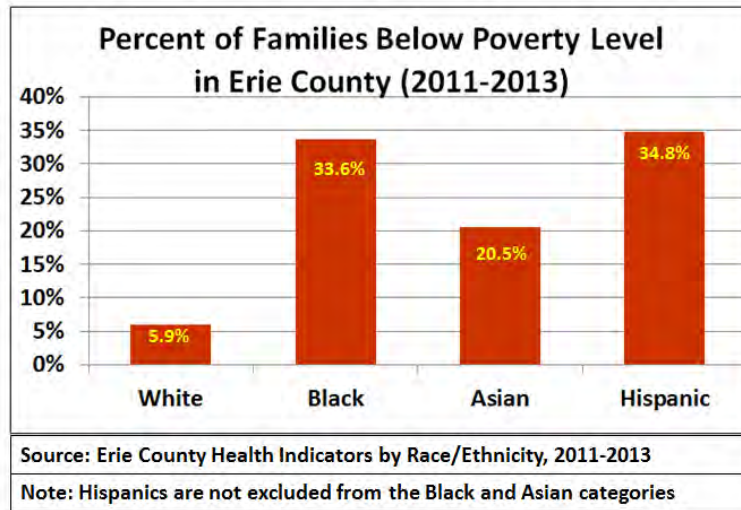


Figure 7



Within Erie County, poverty is disproportionate across race and ethnicity. The percent of Black and Hispanic families in Erie County with income below the poverty level is far greater than that of their White and Asian counterparts. See Figure 8. At the same time, Black and Hispanic populations of Erie County reside primarily in the City of Buffalo.

Figure 8



Socioeconomic Factors

Understanding the demographics of Erie County is important to gaining an understanding of the community's health needs because many issues that compromise health status disproportionately impact different socio-economic groups, as can be seen from the data presented in the following sections. The poor, the undereducated, racial minorities and the aged tend to experience greater health status disparities and determinants compared to other parts of the population.

Challenges due to socioeconomic factors and access to care were discussed during the Catholic Health group interviews with community and public health experts. Participants recognized City of Buffalo neighborhoods are challenged with high rates of poverty, illiteracy, crime and poor access to primary care, compared to suburban neighborhoods. At the same time, the rural areas throughout Erie County present health care delivery challenges for the low-income families living there. Lack of access to close care and lack of transportation are deterrents to good health. Public transportation services are concentrated in and immediately around the City of Buffalo and are not readily available to those living in the outer suburbs and rural areas of the county.

Uninsured and Medicaid Recipients

In addition to Buffalo representing the area of Erie County with the greatest race, ethnicity, income and education disparities compared to the county as a whole, it is also where the county's uninsured and Medicaid populations are concentrated. (See Figures 9 and 10).

Figure 9

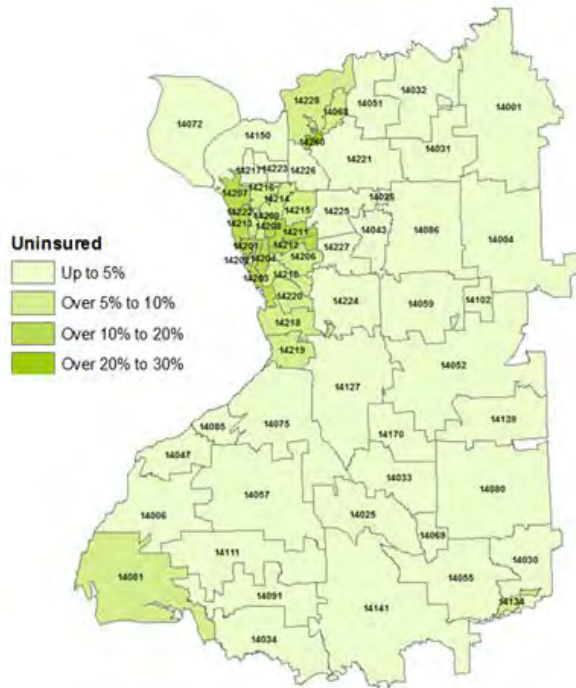
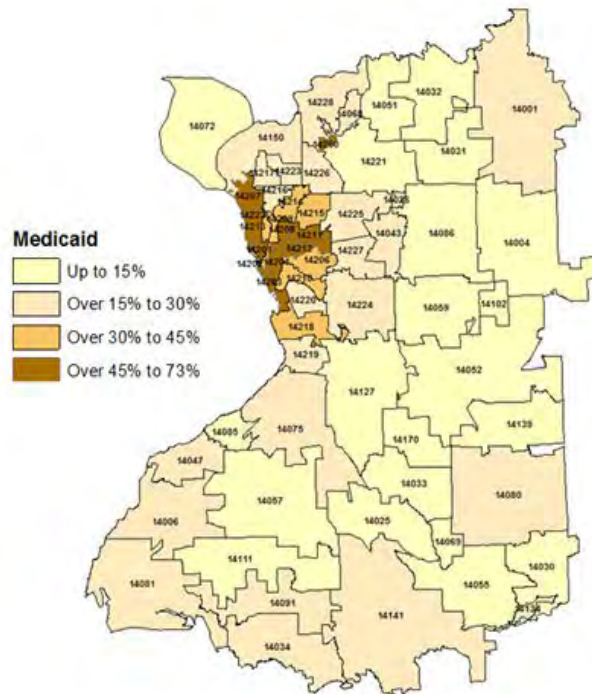


Figure 10



Source: [Truven Health Analytics & The Nielsen Company](#)

Unemployment

The June 2016 unemployment rate of 4.4 percent in Erie County is lower than the national unemployment level of 5.1 percent.⁷ The map in Figure 11 illustrates that there are concentrations of unemployment in the City of Buffalo and the rural areas of Erie County compared to the suburban areas.

Unemployment can leave people without the ability to pay for their medical care. Moving forward, with the advent of health insurance exchanges, access to insurance should not be tied as much to employment status.

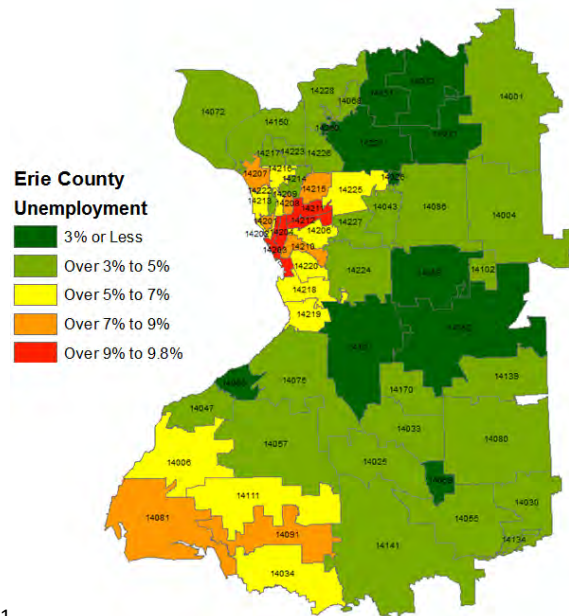


Figure 11

Source: 2016 Truven Health Analytics & the Nielsen Company

⁷ <http://www.bls.gov/>. Access 8/23/16.

APPENDIX B: Catholic Health Community Organization Focus Groups

Community Participation

Focus group participants represent a broad range of organizations serving various populations including those with HIV/AIDS, mental health disorders, drug addiction, and the poor and underserved in general.

May 19, 2016, 4:30 PM - 6:30 PM, CH Administrative Center, Conference Rm 1B

Ms. Briana Petersdorf, Cazenovia Recovery Systems, Community Residence Program Director
Mr. Joseph Heary, Friends of Night People, Executive Director and Kristen Yansick, Intern
Ms. Ann Brittain, Director, Catholic Charities, Immigration & Refugee Assistance Program
Lt. Richard Hanes-Stetter, Buffalo Fire Department, EMS Officer
Ms. Hillary Kirk, Northwest Community Center, Director of Quality
Ms. Elizabeth Mauro, Mid Erie Counseling and Treatment Center, Chief Executive Officer

May 23, 2016, 11:00 AM - 12:30 PM, CH Administrative Center, Conference Rm 1E

Ms. Jesse Ladoue, American Heart Association
Ms. Chris Procknal, Meals on Wheels
Ms. Karen Hall, P² Collaborative of Western New York
Mr. Andrew Mattle, Evergreen Services
Mr. Damian Mordecai, Pride Center of Western New York
Ms. Tisha Tanyi, Brylin Hospitals
Ms. Suzanne Challen, United Way

Summary of Key Findings

The purpose of the focus groups was to listen to the knowledge of leaders that work with specific populations that we may have difficulty engaging.

- Please identify the gaps in care for the populations that your organization serves.
- What factors should we consider when removing barriers to care services? If there are particular initiatives that should be included, then how can Catholic Health potentially support them?
- Let's engage in a discussion see how we can potential help underserved communities.

Session #1 – May 19, 2016

Limited Access to Behavioral Health and Substance Abuse Treatment: Several stakeholders identified the need for improved access to Behavioral Health and Substance Abuse treatment, robust wrap-around services and revision of policies for inpatient treatment. Behavioral health organizations have a shortage of therapeutic practitioners that can prescribe medication; therefore, limiting the availability of care. In addition, many substance abuse treatment centers have long waiting lists, which limit new patients to only receiving outpatient care. These gaps in services have prohibited patients from receiving adequate care. A stakeholder indicated that a policy revision is needed for referring patients for inpatient treatment. The tool used to measure a patient's need for inpatient treatment is the Level of Care for Alcohol and Drug Treatment Referrals (LOCADTR). Unfortunately, opioid addiction is the only Community Health Needs Assessment & Community Service Plan 2016 Assessment

addiction that generates a referral; addictions to marijuana and/or alcohol do not meet the criteria. The opioid epidemic in Erie County, New York has prompted professionals outside of healthcare such as firefighters to respond to the epidemic by administering Narcan to individuals that have overdosed. A stakeholder identified that opioid tasks forces must focus on prevention education in order to minimize the opioid epidemic. The premise is that education will minimize stigma, limit drug use and encourage patients to receive treatment. Another stakeholder indicated that robust wrap-around services (e.g. housing, income and employment) are instrumental for ensuring a patient's sobriety during and after treatment.

Trauma of Poverty: Trauma-informed care is an organizational structure and treatment framework that involves understanding, recognizing and responding to the effects of all types of trauma (SAMHSA, 2016). The University of Buffalo's School of Social Work has trained health professionals on how to implement this framework, when working with patients that live in poverty and/or have a substance abuse addiction. A stakeholder identified how important it is to, "meet the patient, where they are", which translates into actively listening to the patient and building trust to further assist the patient in obtaining holistic wellness. It is imperative for health professionals to have an aptitude in this area in order to discover underlying stressors that may cause health problems. A stakeholder indicated that some patients have health conditions that have been exacerbated by childhood trauma. This framework indirectly demonstrates the need for co-locating or combining primary care and behavioral health services.

Access Barriers for people with limited resources: Many stakeholders indicated that targeted populations that include racial and ethnic minorities, refugees, Medicaid recipients and/or uninsured individuals have difficulty accessing health and social services. A few identified health determinants and disparities that affect an individual's health outcomes are low socioeconomic status, lack of transportation, language barriers, and cultural norms and behaviors. All four of the identified health determinants and disparities shape how this population utilizes health and social services, which could greatly affect their quality of life and health outcomes. A few stakeholders agreed that communities that are heavily populated with the identified targeted populations should have health and social service organizations located within those communities. Easier access to health and social services would assist with minimizing health determinants and disparities. The integration of Community Health Workers (CHWs) was also identified as a method to minimize health disparities and determinants for people in medically underserved communities.

Obesity and Lack of Exercise: A few stakeholders indicated that the prevalence of obesity for both adults and children is increasing due to the lack of opportunities for exercise and poor access to healthy foods. One stakeholder revealed that the Buffalo City Schools eliminated recess from the school day, which only leaves gym class as an opportunity for children to be physically active. In addition, many families have limited physical activity at home due to living in unsafe neighborhoods. The Northwest Community Center has provided solutions for this chronic condition through providing education on nutrition and dietary care management.

Session #2 – May 23, 2016

Clinical gaps in Behavioral Health and Substance Abuse Treatment: One stakeholder identified a few clinical gaps in behavioral health and substance abuse treatment that include lack of standardization in care, shortage of clinical practitioners and long-waiting lists for inpatient care. Only a few behavioral health and substance abuse organizations use the harm reduction approach; whereas, other organizations use alternative clinical approaches coupled with strict attendance policies, which can result in early termination of treatment for many patients. The shortage of clinical practitioners, long-waiting lists for inpatient care and poor reimbursement for opiate treatment drugs are barriers for patients to receive care. Therefore, government policy is being reviewed to improve clinical care delivery within this area. A stakeholder indicated that the Governor of New York has considered allowing Psych Nurse Practitioners to treat opiate addiction. In addition, there is a possibility that legislation may be passed that will allow providers to treat up to 200 patients for opiate addictions. In light of these improvements, one setback is poor reimbursement for a new opiate treatment drug called Vivtrol, which has a co-pay of \$100. Therefore, in order to improve care to patients receiving behavioral health and substance abuse treatment there is a need for standardization of care, revision of policy and improvement of reimbursement structures for new medications.

Recognizing Sexual Identity and Addressing Rising Rates of HIV and Hepatitis C (HCV): A stakeholder identified a gap in patient engagement when engaging with Lesbian, Gay, Bisexual, and Transgender (LGBT) patients and their families. There is a need for clinical practitioners, administration, managers, and support staff to be culturally competent when engaging with LGBT patients and their families. The Pride Center of Western New York has partnered with the University of Buffalo's Medical School to conduct cultural competency trainings. This training has assisted with prompting paradigm shifts within many health organizations that prioritize being respectful and inclusive of all patients. One stakeholder's organization has begun to be inclusive of LGBT patients by altering their intake forms to indicate if the patient is transgender and acceptable pronouns that can be used to address the patient. Another stakeholder indicated that the rates of HIV and Hepatitis C (HCV) are still increasing. The incidence rates of HIV has increased among Young Men who have Sex with Men (MSM) of Color and the incidence rates of HCV has increased among the general older population.

Target Organizations that Focus on Asthma and Lead Poisoning: Some stakeholders indicated a need for education on asthma management and lead poisoning. A few stakeholders confirmed high incidence rates of asthma on the Westside of Buffalo. Asthma that is not well managed can lead to hospitalizations and high rates of absenteeism for both adults and children. Education on asthma can assist with improving the quality of life and health status of individuals with this chronic condition. Another opportunity for community education is on lead poisoning. Many children ages 0-5 that lived in older homes had the opportunity of being exposed to paint that contains lead. Consequently, the exposure to lead paint can cause developmental difficulties and learning disabilities. Education would raise awareness for parents and guardians; therefore, assisting them with making informed decisions that will protect their families.

APPENDIX C: Catholic Health Mission Clinic Patient In-depth Interviews

Introduction

The purpose of the Community Health Needs Assessment is to identify the needs of the community through various methods. One method used to collect data is through surveying individuals in a specific community. This survey was specifically distributed to Medicaid and uninsured patients receiving care at Catholic Health System's Mission-based Clinics. The three identified locations were St. Vincent's Health Center, Ken-Ton Family Care Center and Mercy Comprehensive Care Center. Data collection took place on May 11, 12, 13 and 14, 2016. There was a population size of 50 patients (n=50) that completed the survey.

Demographics:

The following statements indicate the demographics of individuals that completed the survey:

- The average age of the survey respondent is 45 years old.
- Twenty-two women and twenty-five men indicated their gender and three respondents did not indicate their gender.
- The average income bracket was \$25,000-\$35,000.
- The average household size was 4 individuals.
- **Race and Ethnicity Distribution:**
 - Thirteen respondents were White;
 - Two were White-Hispanics;
 - Twenty-nine were African American, none Hispanics;
 - And, three respondents did not indicate their race and/or ethnicity.

This survey also collected data on patient utilization of services at Catholic Health System's Mission-based Clinics. One objective of this survey was to assess how severe a patient's symptoms must be in order to prompt the patient to seek primary care services. Approximately, 74 percent of the respondents indicated they only seek primary care services, when their symptoms become severe or urgent. This indicates that respondents are not completely engaged in primary care services and are not utilizing preventative services. The two identified methods for receiving urgent care is to see a Primary Care Provider or go to the Emergency Room. Twenty-seven respondents indicated that they only see a Primary Care Practitioner and fifteen respondents revealed they only use the Emergency Room to utilize urgent and primary care services.

Two metrics that were measured in this survey were patient engagement and health disparities and determinants. Our patient engagement question evaluated the patient's perception of their physician's aptitude to effectively communicate. About 85 percent of respondents indicated that their physicians effectively communicated with them concerning their health status, behaviors and treatment plans. According to the data, patient engagement and care are in great standing; however, patients are unable to completely engage and utilize health services due to lack of transportation. The improvement of transportation for Medicaid and uninsured individuals may improve health outcomes.

APPENDIX D: Erie County New York State Department Health Needs Assessment

NYS DOH – Leading Causes of Death by County

Source: Vital Statistics Data as of March 2016

Erie	Heart Disease 2,281 176 per 100,000	Cancer 2,207 181 per 100,000	Stroke 472 36 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 461 36 per 100,000	Unintentional Injury 362 34 per 100,000
Total: 9,646					
New York State	Heart Disease 42,408 175 per 100,000	Cancer 34,790 149 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 6,694 29 per 100,000	Stroke 6,035 25 per 100,000	Unintentional Injury 5,561 26 per 100,000
Total: 147,440					

2016 Community Health Needs Assessment

The Erie County Department of Health report summarizing its 2016 CHNA efforts and resulting community priorities has not yet been released. These results will be included when received.

Erie County Substance Abuse Epidemic Statistics

FATAL OPIOID OVERDOSES 2012 - 2015

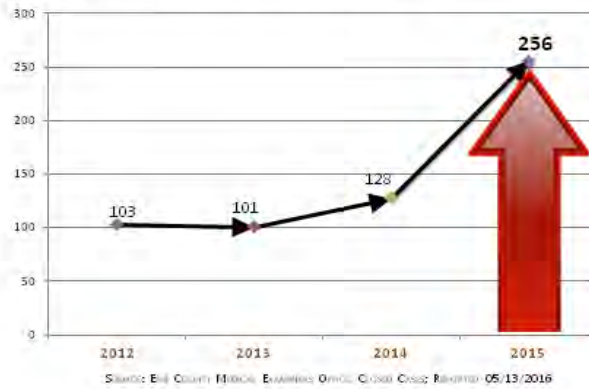


Figure 12

2015 ERIE COUNTY OPIOID OVERDOSE DEATHS BY RESIDENCE

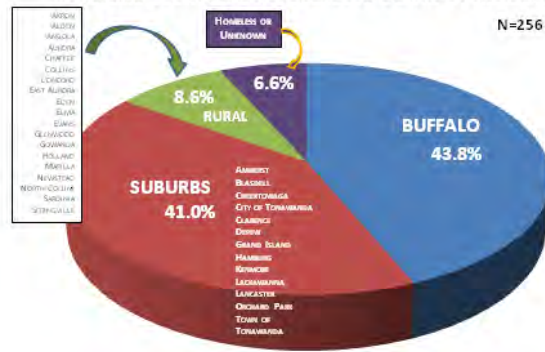


Figure 13

2015 ERIE COUNTY OPIOID OVERDOSE DEATHS BY RACE & GENDER

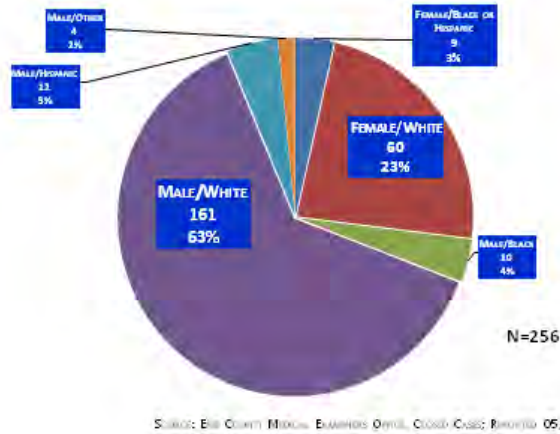


Figure 14

APPENDIX E: Key Health Indicators and Secondary Data Sources

1. Health Status/Outcomes

County Health Rankings

The *County Health Rankings & Roadmaps*⁸ (County Health Rankings) program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute that measures the health of counties across the nation and ranks them within each state. High ranks (e.g., 1 or 2) are estimated to be the healthiest areas.

The *County Health Rankings* recognizes that so much of what contributes to the health outcomes of individuals, and communities, happens outside the traditional influence of the physician’s office; in schools, workplaces and neighborhoods. The Health Outcomes and Health Factors are measured and ranked for each county which allows for comparisons between counties.

Under the Health Outcomes category, which reflects morbidity and mortality, Erie County is ranked 57 out of 62 counties in New York making it one of the worst counties in the state. In terms of Health Factors, which includes health behaviors, access to and quality of care, and socioeconomic factors, Erie County is ranked 32 of 62. See Figure 15. The health factors of today are an indicator of health outcomes of the future. Therefore, a better ranking in health factors may lead to an expectation of improvement in future health outcomes.

	County	Health Outcomes Rank	Health Factors Rank
Western New York	Nassau	2	1
	Wyoming	8	24
	Livingston	12	23
	Genesee	27	22
	Orleans	44	55
	Allegany	48	44
	Niagara	55	45
	Erie	57	32
	Chautauqua	58	51
	Cattaraugus	60	54
	Bronx	62	62

Source: County Health Rankings & Roadmaps, 2016

Figure 15

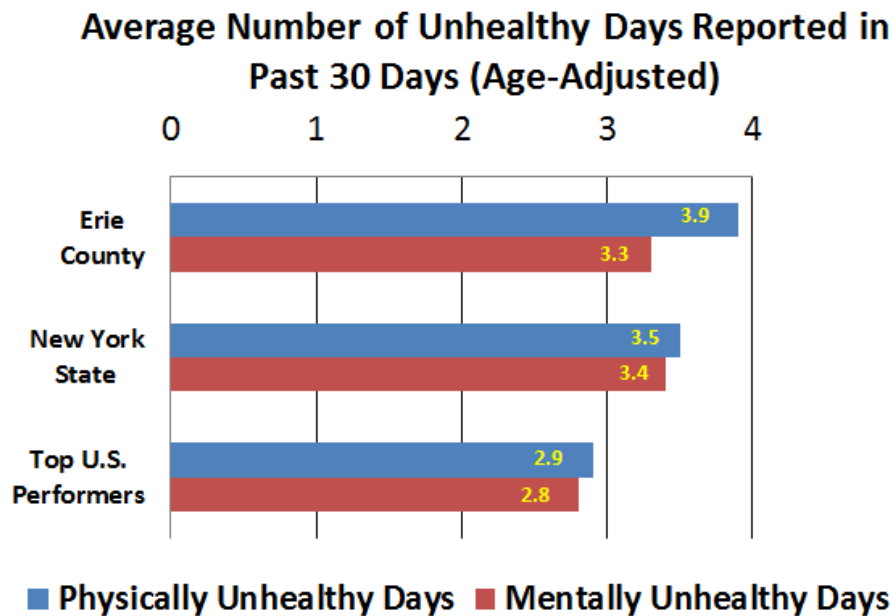
⁸ County Health Rankings & Roadmaps, 2016.

Health Status

An individual's health depends on both physical and mental well-being. Measuring the number of days people report that their health was not good is an important indicator of quality of life and a factor that drives the demand for health care services.⁹

The residents of Erie County report more physically unhealthy days than their state and national counterparts, which indicates a greater burden of chronic diseases in this community.¹⁰ The reported mentally unhealthy days for Erie County residents is near the same as the state, but greater than the national comparison, indicating a greater need for mental health services in this community. See Figure 16.

Figure 16



Source: www.cdc.gov/community Health/Profile 2015

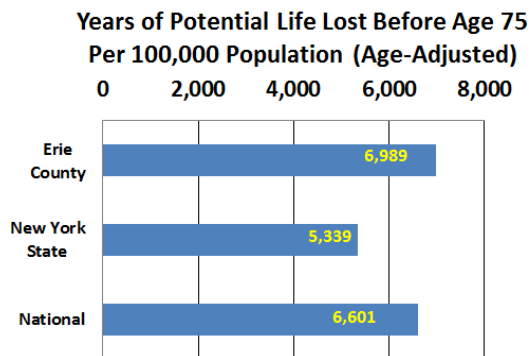
⁹ *ibid.*

¹⁰ *ibid.*

Life Expectancy and Preventable Deaths

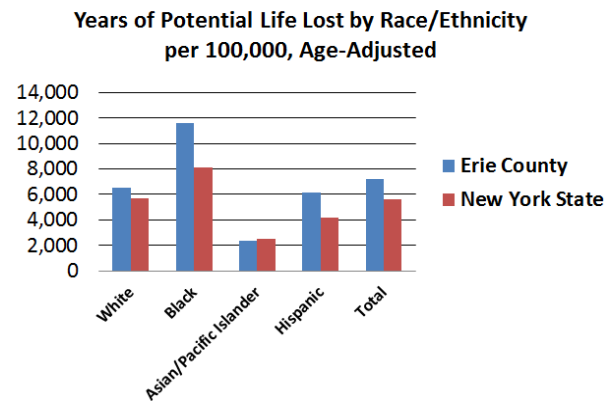
Years of potential life lost before age 75 is a measure of premature death that focuses on deaths that could have been prevented.¹¹ Each death occurring before the age of 75 contributes to the total number of years of potential life lost. Further study may result in better knowledge of the underlying causes of premature death allowing for targeting prevention and education resources toward specifically identified needs of the population.

Figure 17



Source: www.healthindicators.gov 2012-2014

Figure 18



Source: NYS Health Indicators by Race/Ethnicity, 2011-2013

Compared to the state and national numbers, Erie County has a greater rate of potential life lost before age 75, as shown in Figure 17. Erie County ranks poorly on this measure at 57 out of 62 counties in New York State.¹² Within Erie County, Black and White populations have a greater rate of potential life lost before age 75 than the Hispanic population. The Asian and Pacific Islander population has the best opportunity to reach life expectancy, but represents a very small percentage of the Erie County population. See Figure 18.

Leading Causes of Death

Erie County and New York State have the same four leading causes of death including, heart disease, cancer, chronic lower respiratory disease, and stroke. While stroke is the fourth highest cause of death for New York State, it is the third highest for Erie County. The top two causes of death, heart disease and cancer, are more frequently the cause of death for men than women. See figure 19.

According to a research study from Harvard School of Public Health, the leading causes of death can be attributed to preventable causes including smoking, high blood pressure, obesity, physical inactivity, and poor nutrition.¹³

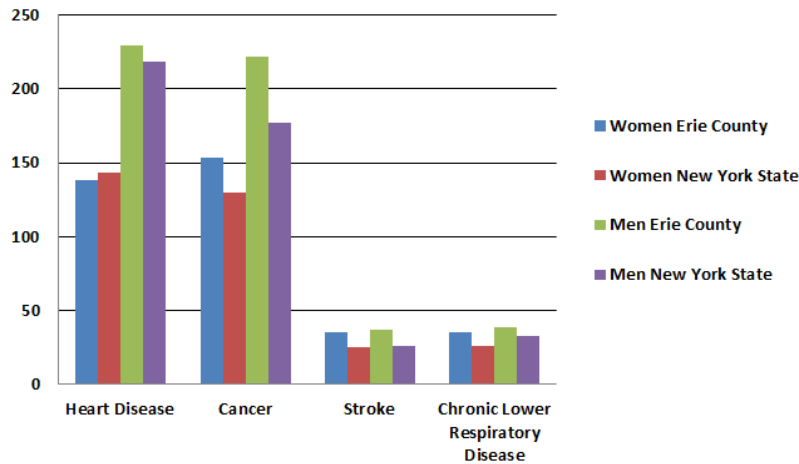
¹¹ *ibid.*

¹² *ibid.*

¹³ <http://www.hsph.harvard.edu/news/press-releases/smoking-high-blood-pressure-overweight-preventable-causes-death-us/>. Accessed 8/18/16.

Figure 19

Leading Cause of Death by Gender, Rate per 100,000



Source: NYS Vital Statistics 2016 (2014 data)

2. Health Behaviors

Chronic diseases have preventable risk factors¹⁴ including:

Smoking - Related to disease conditions such as cardiovascular disease, various cancers, and respiratory conditions

Alcohol Abuse -Related to adverse health outcomes such as hypertension, alcohol poisoning, suicide, violence, and automobile accidents.

Inactivity -Related to disease conditions such as cardiovascular disease, cancer, stroke, type 2 diabetes, and hypertension

Obesity - Related to adverse health outcomes such as cardiovascular disease, cancer, stroke, type 2 diabetes, hypertension, and respiratory conditions

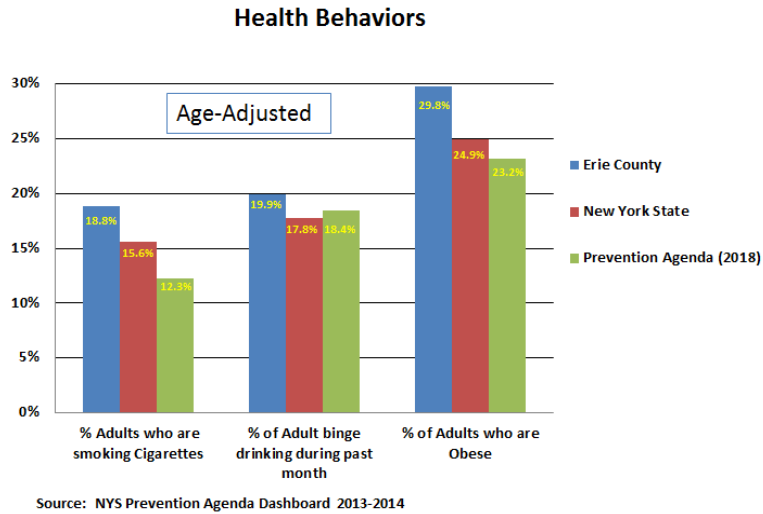
Poor Nutrition - There is a correlation to obesity and premature mortality

According to the Harvard School of Public Health research study, in *PLoS Medicine*, linking health behaviors to premature death, “these findings indicate that smoking and high blood pressure are responsible for the largest number of preventable deaths in the US, but that several other modifiable risk factors also cause many deaths . . . these findings suggest that targeting a handful of risk factors could greatly reduce premature mortality in the US.”¹⁵

¹⁴ County Health Rankings & Roadmaps. <http://www.countyhealthrankings.org/app/#/new-york/2013/rankings/outcomes/overall/by-rank>.

¹⁵ <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000058>.

Figure 20



A significantly higher percentage of Erie County residents report heavy drinking and smoking behaviors compared to the national benchmark. Erie County residents also report the percent of adults who are obese at a higher percentage than the national benchmark. See Figure 20. This suggests that in Erie County there is an opportunity to improve the health of the community by addressing unhealthy behaviors.

APPENDIX F: Overview of Local Health Systems Resources and Access to Care

The community experts consulted for this assessment voiced the opinion that lack of, or limited, access to care is a significant barrier to receiving needed healthcare for much of the underserved population. Access to care encompasses all the reasons a person is not able to obtain, or chooses not to obtain, the medical care they require. Some important questions, the answers to which help define access to care, include:

- Are there enough providers in an area?
- Do the providers accept a patient's insurance?
- Can patients afford to go to the provider?
- Is public or private transportation available to get patients to providers?
- Are physician's office hours amenable to patient's work or school schedules?
- Are companions available to take those who are unable to go to appointments alone?
- Are there language or cultural barriers for a patient?

Having to find a provider who accepts Medicaid or other specific insurance products can reduce the likelihood of a patient receiving the coordinated preventive care they may need. The City of Buffalo, with a rate of 30.9%, is home to the largest percentage of the population of people living in poverty, compared to 15.2% in Erie County and 15.9% in New York State.¹⁶

Another common issue associated with access to care and poverty is reliance on public transportation which can limit a patient's choice of caregivers in an area that already has a shortage of Primary Healthcare Providers. Reducing these barriers to access will require community initiatives that involve partnerships among public and private stakeholders in government, healthcare, and community service organizations.

Health Professional Shortage Area

Attracting physicians to work in underserved areas of poverty has been challenging enough that the federal government provides incentives to physicians through Health Resources and Services Administration (HRSA), Health Profession Shortage Area (HPSA) program.¹⁷ The government uses specific criteria to determine if an area is a HPSA and an area can be a HPSA for Primary Medical Care, Dental Care, or Mental Health. In Erie County, much of the City of Buffalo has been designated as HPSA for all three provider types.¹⁸

¹⁶ <http://quickfacts.census.gov/qfd/states/36/36029.html>. Accessed 8/17/16.

¹⁷ <http://www.hrsa.gov/shortage/>. Accessed 8/17/16.

¹⁸ <http://hpsafind.hrsa.gov/>. Accessed 8/17/16.

Primary Care

As shown by the data in the Health Resources and Services Administration Area Resource File, 2013 (Figure 22), the ratio of population of Erie County to primary care providers in Erie County is slightly higher than that for New York State and significantly higher than the U.S. top Performers.¹⁹ This means there are fewer primary care providers to treat residents in Erie County compared to other regions across the state and country, which highlights a lack of access to primary care in the community. The HPSA primary care map shows the Erie County primary care shortage is concentrated in the City of Buffalo. See Figure 21.

Figure 21

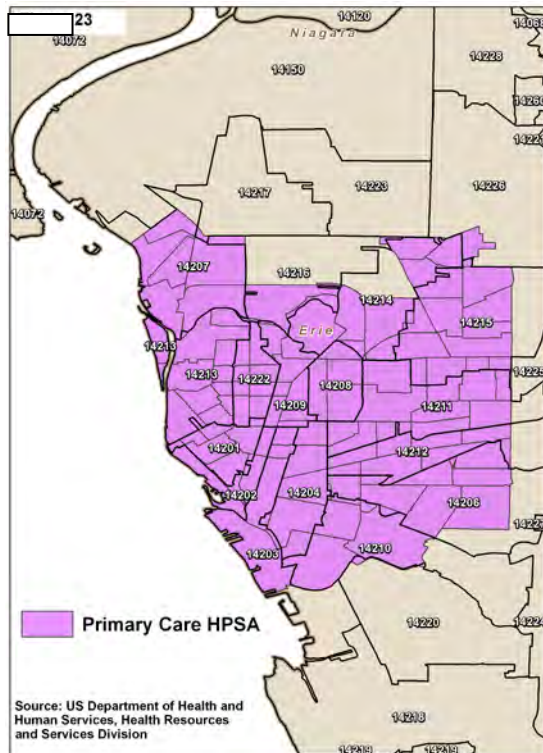
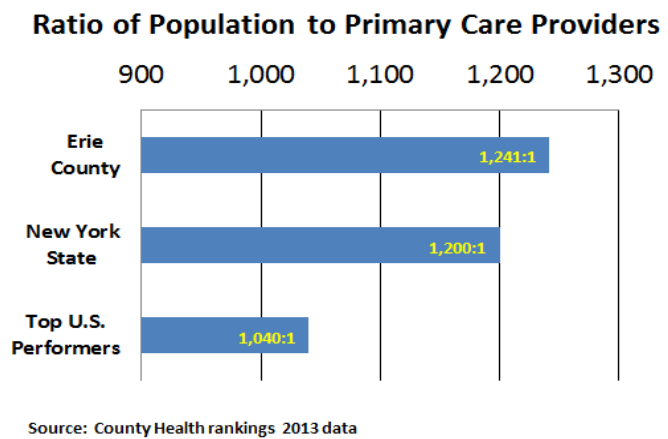


Figure 22



¹⁹ <http://www.countyhealthrankings.org/app#/new-york/2013/measure/factors/4/datasource>. Accessed 8/17/16. Community Health Needs Assessment & Community Service Plan 2016 Assessment

Mental Health

Based on input from the community experts, removing mental health stigma and integrating mental and behavioral health care with primary care is integral to improving the health of our community. Collaboration between organizations is necessary to making progress toward integrated care.

As shown in Figure 24, the ratio of population in Erie County to mental health providers for the county is higher than the ratio for New York State and significantly higher than the U.S. top performers, indicating a significant mental health provider shortage in our community. In addition to the shortage of mental health providers in the urban zip codes shown on the mental health HPSA map (Figure 23).

Figure 23

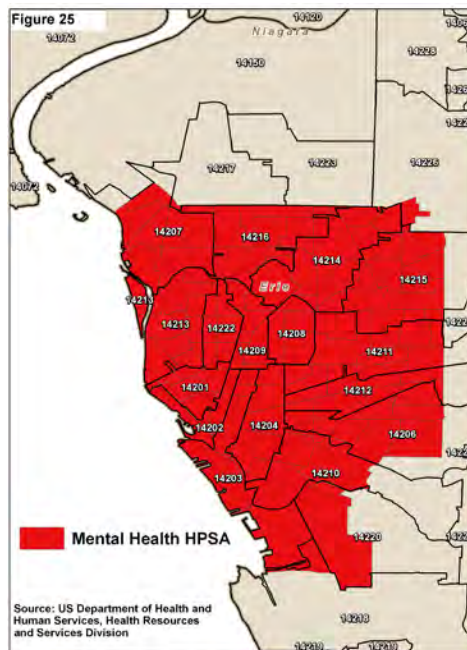
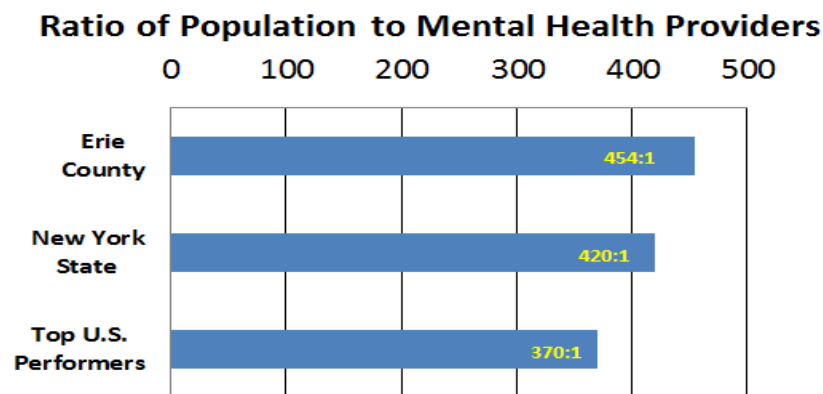


Figure 24



Source: County Health rankings 2015 data

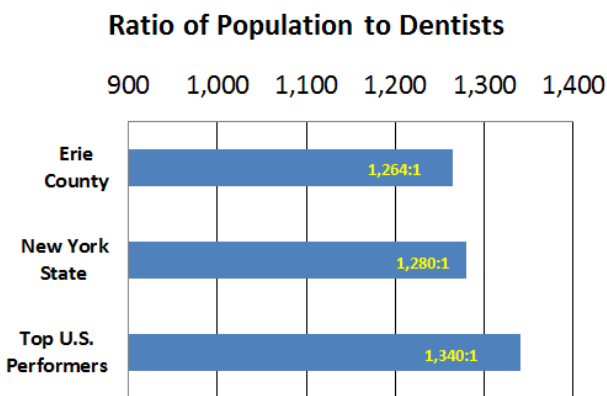
Dental

According to the New York State Department of Health, “Oral health is integral to overall health. Diseases and conditions of the mouth have a direct impact on the health of the entire body.”²⁰ According to Healthy People 2020, there is a growing body of evidence that links oral health to chronic disease including cardiovascular disease, stroke and diabetes.²¹

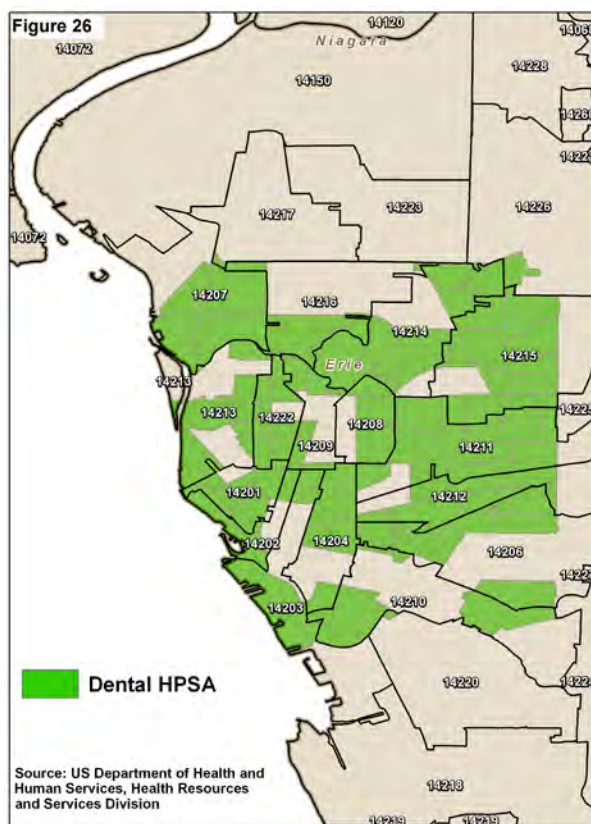
The dental HPSA map shows the dental shortage concentration in Erie County and, like the HPSA areas for primary care and mental health, it is concentrated in the City of Buffalo. See Figure 25.

As shown in Figure 26, the ratio of population in Erie County to Dental health providers for the county is lower than the ratio for New York State and the U.S. top performers.

Figure 25



Source: County Health rankings 2014 data



²⁰ <http://www.health.ny.gov/prevention/dental>.

²¹ <http://www.healthypeople.gov/2020/LHI/oralHealth.aspx>.

Community Need Index

The Community Needs Index (CNI) identifies the severity of health disparity for every zip code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations.²² The CNI gathers data about the community's socio-economy to determine the severity of the barriers to health care. These barriers include those related to income, culture/language, education, insurance, and housing:

Income Barriers – Percentage of elderly, children, and single parents living in poverty

Cultural/Language Barriers – Percentage Caucasian/non-Caucasian and percentage of adults over the age of 25 with limited English proficiency

Educational Barriers – Percentage without a high school diploma

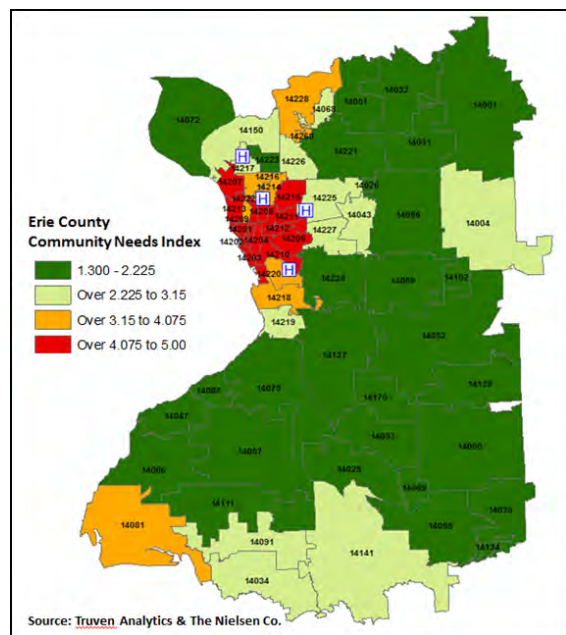
Insurance Barriers – Percentage uninsured and percentage unemployed

Housing Barriers – Percentage renting houses

The index gives each zip code a score of one to five for each barrier condition, with one representing a lower socio-economic barrier or less community need, and five representing a higher socio-economic barrier or more community need. The scores are then aggregated and averaged for a final CNI score, with equal weight for each barrier in the average.

A review of the Erie County zip codes shows the overall health disparity in the City of Buffalo is significantly worse than that found in most of the rest of the county. See Figure 27. In addition to having a higher CNI index, this same area has the added challenge of being in designated primary care, mental and dental provider HPSAs in Erie County.

Figure 27



²²http://www.dignityhealth.org/stellent/groups/public/@xinternet_con_sys/documents/webcontent/231921.pdf.
Community Health Needs Assessment & Community Service Plan 2016 Assessment

Quality and Effectiveness of Care

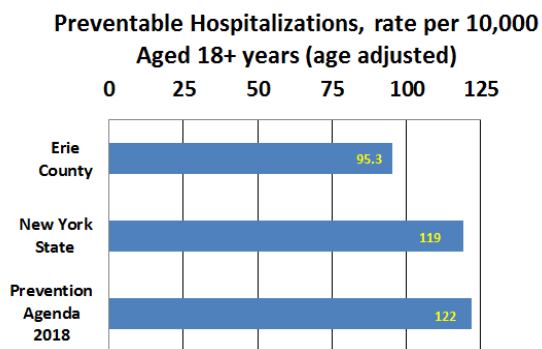
Ambulatory Sensitive Conditions

An assessment and review of hospital utilization for Ambulatory Sensitive Conditions (ASC) reflects community issues of access to and quality of ambulatory care in a given geographic area. ASC, or primary care treatable conditions are those for which good patient education, self-management, outpatient care, and monitoring can potentially prevent the need for hospitalization. Timely and early intervention with access to high quality primary outpatient care which utilizes evidenced based treatment recommendations may slow disease progression. This approach ultimately allows people to stay healthier longer.

The Erie County rate of hospitalizations for ambulatory sensitive conditions is lower than the rate across New York State, and also the Prevention Agenda goal, See Figure 28.

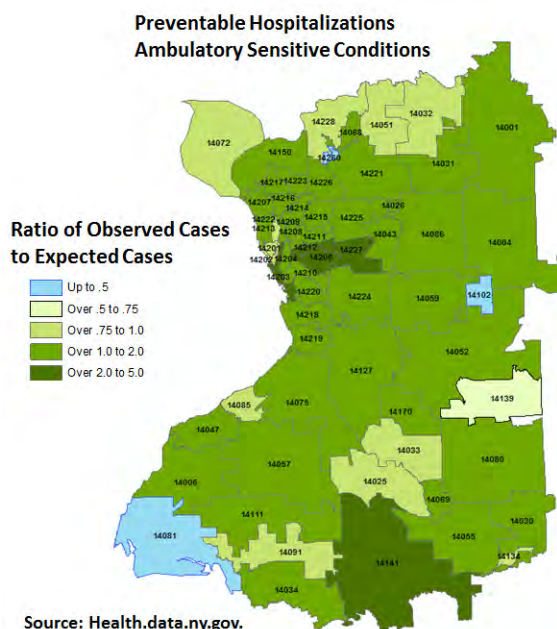
This means that Erie County sees fewer hospitalizations for conditions that could be treated more appropriately in less acute settings, when compared to New York State.

Figure 28



Source: Prevention Agenda 2011-2018, data is year 2013

Figure 29



A review of the map in Figure 29 shows that the Erie County zip codes in which reducing preventable hospitalizations could result in the greatest impact are primarily in the City of Buffalo, with some in the outermost rural areas of the county. Access to appropriate quality care in a timely fashion for these populations is likely to reduce preventable hospitalizations and improve health outcomes.

Hospital Readmissions

Patients discharged from U.S. hospitals are too often readmitted within very short time periods. Almost one in five elderly patients released from a hospital is back within 30 days, and more

than one in three are back within 90 days.²³ Although some readmissions are part of a patient's treatment plan, many are avoidable. Many factors contribute to readmissions including not well understood discharge plans which lead to confusion about how to care for oneself at home, lack of a support system, not getting the necessary follow-up care and other breakdowns within the continuum of care. For the measurement period of 7/1/15 – 6/1/15 Buffalo Mercy Hospital = 14.3%, Kenmore Mercy Hospital = 14.8%, Sisters of Charity Hospital = 14.7% which are all under the National rate of 15.6%. These rates are all risk adjusted, all cause readmissions, Medicare population only.²⁴ In comparison the measurement for New York State from 7/1/2013 – 6/30/2014 is 16.25%.²⁵

Emergency Department (ED) Utilization

There were over 6.4 million visits to NYS emergency departments by NYS residents in 2013 at a rate of 328.07 ER visits per 1,000 population. The most common conditions seen in the ER included 'Superficial injury; contusion', 'other upper respiratory infections', and 'Sprains and strains' while the most commonly performed procedures were blood tests and X-Rays. Individuals who visited the ER more than five times in 2013 represented 1.92% of patients but 11.75% of all visits. The high number of ER visits coupled with nearly 72% of these visits being classified by 3M grouper logic as potentially preventable indicates that the ER is a usual source of care for the population, often for clinical conditions that could have been treated or prevented through access to high quality primary care settings.²⁶

As shown in prior sections of this assessment, the City of Buffalo is an area with a greater percentage of its population at lower socioeconomic levels and a greater proportion of its population covered by Medicaid. The fact that patients in lower socioeconomic levels tend to use the ED over primary care presents an opportunity to further study and address utilization patterns with the goal of improving access, health outcomes and cost-effectiveness of health care.²⁷ The ED use rate for WNY 2012-2014 was 35.1%, 33.8%, 34.8%, for Erie County 33.1%, 32.5%, 33.5%. Catholic Health System percentage of Erie County ED volume was 46.3%, 46.5%, and 47.9% for the three years.

²³ Jencks SF, Williams MV and Coleman EA. "Re-hospitalizations among Patients in the Medicare Fee-for Service Program." *New England journal of Medicine*, 360(14):1418-1428,2009

²⁴ www.medicare.gov/hospitalcompare

²⁵ NYS DOH, NYS Health Profiles, profiles.health.ny.gov/measures/all/state/16284, <http://www.health.ny.gov/statistics/sparcs/sparcs/sb/docs/sb8.pdf>

²⁶ IBID

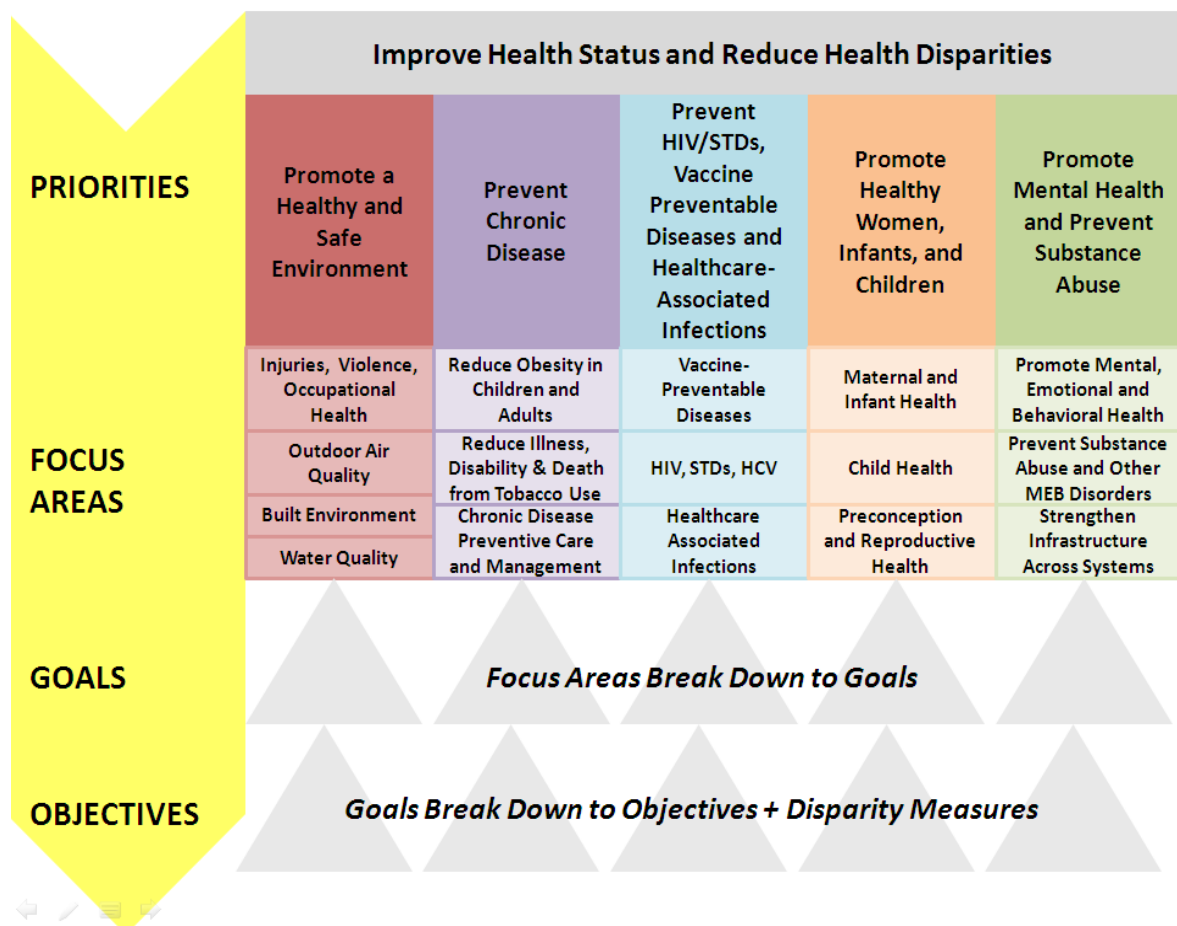
²⁷ <http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/07/understanding-why-patients-of-low-socioeconomic-status-prefer-ho.html>.

APPENDIX G: New York State Department of Health Prevention Agenda

The Prevention Agenda 2013-2018 is New York State’s five-year health improvement plan that is designed in collaboration with organizations across the state to demonstrate how communities can work together to improve the health and quality of life for all New Yorkers. The Prevention Agenda vision is New York as the Healthiest State in the Nation. The Agenda has five priority areas and an over-arching goal to Improve Health Status and Reduce Health Disparities. The five priority areas are:

- A. Promote a healthy and safe environment
- B. Prevent chronic disease
- C. Prevent HIV/STDs, vaccine-preventable diseases and healthcare-associated infections
- D. Promote healthy women, infants, and children
- E. Promote mental health and prevent substance abuse

New York State Department of Health Prevention Agenda



A. Promote a Healthy and Safe Environment

Promoting a healthy and safe environment focuses on the quality of water we drink, the air we breathe, and the physical environment where we live and work.

Air Quality Index (AQI)

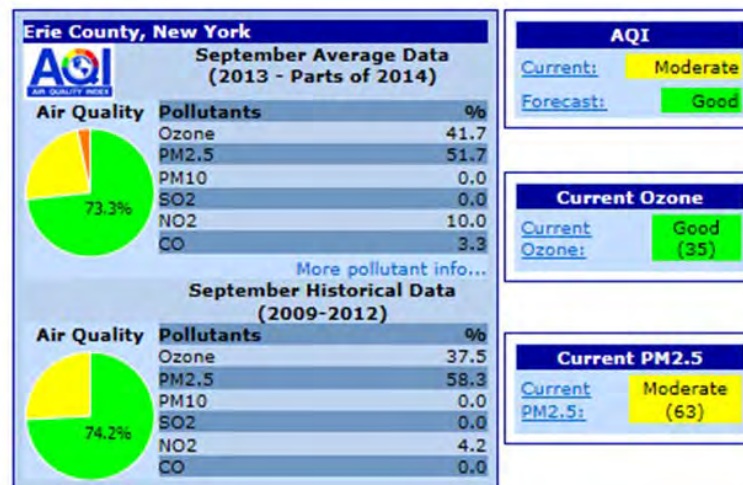
Environmental Protection Agency (EPA) calculates the AQI for five major air pollutants regulated by the Clean Air Act: ground-level ozone, particle pollution (also known as particulate matter), carbon monoxide, sulfur dioxide, and nitrogen dioxide. For each of these pollutants, EPA has established national air quality standards to protect public health. Ground-level ozone and airborne particles are the two pollutants that pose the greatest threat to human health in this country.²⁸

An AQI value of 100 generally corresponds to the national air quality standard for the pollutant, which is the level EPA has set to protect public health. AQI values below 100 are generally thought of as satisfactory. When AQI values are above 100, air quality is considered to be unhealthy-at first for certain sensitive groups of people, then for everyone as AQI values get higher.²⁹

Figure 30

Air Quality Index

The AQI is an index for reporting daily air quality. It tells you how clean or polluted your air is, and what associated health effects might be a concern for you. The AQI focuses on health effects you may experience within a few hours or days after breathing polluted air.



Source: epa.gov

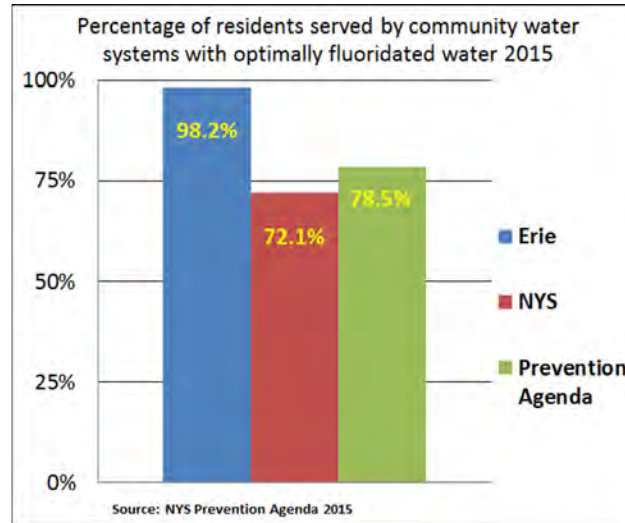
²⁸ Epa.gov

²⁹ IBID

Access to a Quality Water Supply

In 2015, 98.2 percent of residents in Erie County, New York have access to clean water through community water systems. See Figure 31. This benchmark outperforms New York State and the benchmark identified in the New York State Prevention agenda. Access to a clean water source assists to prevent illness and birth defects.

Figure 31



B. Prevent Chronic Disease

Chronic diseases are among the leading causes of death, disability and rising health care costs in New York State. The burden of chronic disease may be preventable with access to high-quality chronic disease preventive care and management.³⁰

Cancer Health

Prevalence for Major Sites of Cancer

The prevalence rates of Cancer in Erie County are higher for nearly all of the major cancers compared to state and national statistics. Cancer mortality rates in Erie County are high and have not met Healthy People 2020 targets. Males are diagnosed with, and die from, cancer at a greater rate than females. See Figure 32.

Top Ten Cancer Sites - 2013	Females			Males		
	U.S.	NYS	Erie	U.S.	NYS	Erie
Female Breast	123.7	130.3	144.6			
Lung and Bronchus	51.5	53.8	68.5	69.8	67.6	87.8
Colon and Rectum	33.6	34.4	37.1	44.2	45.6	47.5
Corpus and Uterus, NOS	25.9	32.2	30.8			
Thyroid	21.6	29.8	25.9			8.9
Melanomas of the Skin	16.3	15.5	22.1	26.6	24.2	32.2
Non-Hodgkin Lymphoma	15.4	17.5	18.4	22.4	26.1	26.7
Kidney and Renal Pelvis	11.2		12.0	21.7	22.7	24.1
Ovary	11.2	12.7	12.8			
Pancreas	10.9	12.2	12.1	14.1	15.7	16.9
Prostate				101.6	125.6	172.3
Urinary Bladder			14.6	34.9	41.0	52.1
Oral Cavity and Pharynx			6.7	17.4	16.0	18.1
Leukemias		12.5	12.4	16.9	20.5	22.1

↑ signifies that Erie County rate is higher than National Rate

Figure

32

Source: U.S. Cancer Statistics Working Group. United States Cancer Statistics: 1999-2013 incidence and Mortality Web-based Report.
www.health.ny.gov/statistics/cancer/registry

³⁰ http://www.health.ny.gov/prevention/prevention_agenda/2013-2018/plan/chronic_diseases/focus_area_3.htm.

Colorectal Cancer Screening

Colorectal cancer can often be cured when detected early. Regular screening is available through a yearly take-home multiple sample fecal test (FOBT – fecal occult blood test or FIT – fecal immunochemical test), a flexible sigmoidoscopy every 5 years or a colonoscopy every 10 years.

Throughout New York State, White non-Hispanic and Hispanic residents receive colon cancer screening more often than Black and other non-Hispanic residents. See Figure 33. The percentage of adults between the ages of 50 to 75 that received a colorectal screening is 71.7%. This is higher than the New York benchmark but 8.3 percent lower than meeting the goal identified in the Prevention Agenda. See Figure 34.

Figure 33

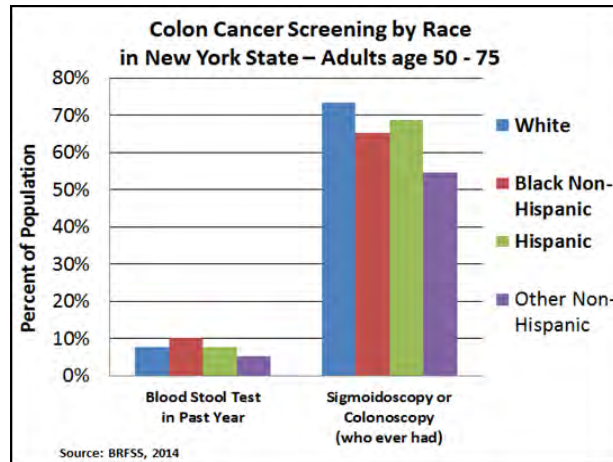
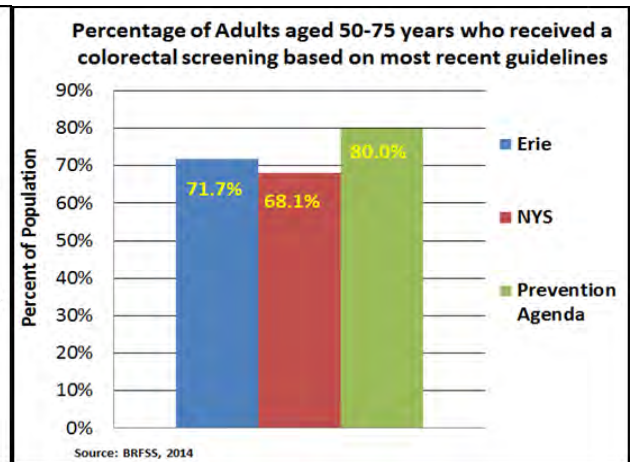


Figure 34

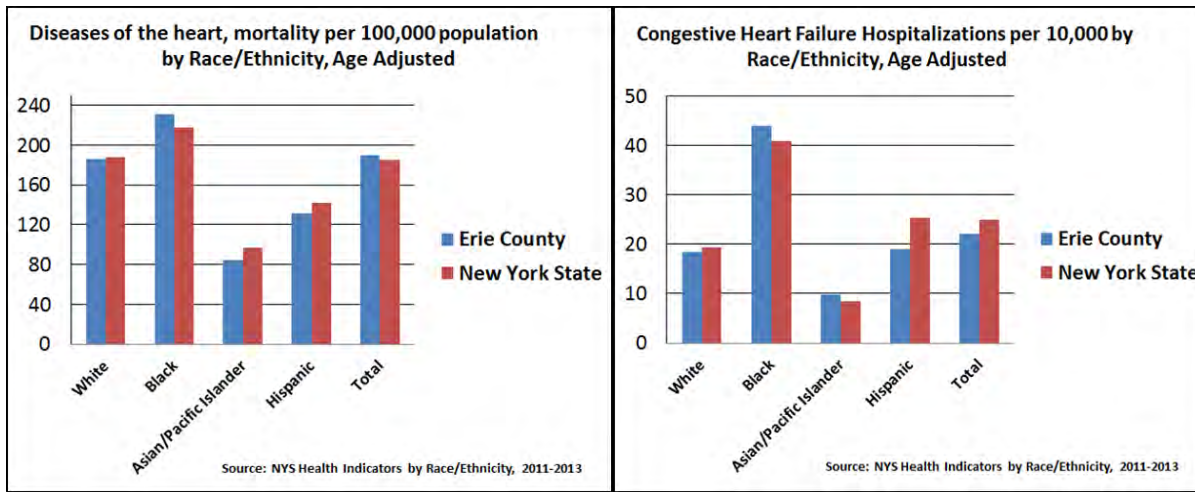


Cardiovascular Health

Cardiovascular Disease is the leading cause of death among residents of Erie County and New York State. Residents of Erie County report having diseases of the heart at a higher rate than those in New York State and the nation. See Figure 35. Diseases of the heart include angina, heart attack, arrhythmia, and heart valve problems. Heart disease is often preventable through reducing risk factors such as obesity, high blood pressure and inactivity.

Figure 35

Figure 36



Erie County has a lower rate of congestive heart failure hospitalizations than New York State. The Black and Hispanic populations are admitted to the hospital at a higher rate than their counterparts for both Erie County and New York State. See Figure 36. Hospital admission of Black patients in Erie County for congestive heart failure is 25.6% higher than admission of White patients.

Cerebrovascular (Stroke) Health

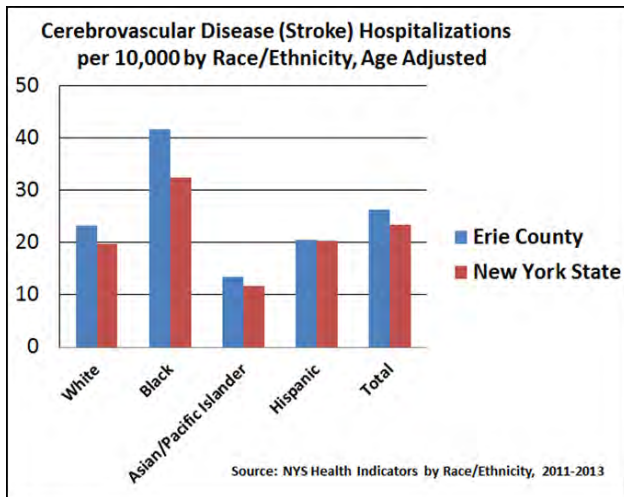
Stroke is the third leading cause of death in Erie County compared to the fourth leading cause of death in New York State. According to the Centers for Disease Control and Prevention, stroke is a leading cause of disability and contributes to the cost of health care, medication and missed days of work.³¹

The risk of stroke varies with race and ethnicity. The risk of having a first stroke for Blacks is twice that of Whites, with Hispanics' risk between that of Blacks and Whites.³² Erie County has a higher rate of stroke hospitalizations than New York State. The Black and Hispanic populations also are admitted to the hospital at a higher rate than their counterparts across New York State. See Figure 37. Hospital admission of Black patients in Erie County for stroke is at a rate that is 18.4% higher than admission of White patients.

³¹ <http://www.cdc.gov/stroke/facts.htm>.

³² *ibid.*

Figure 37



Chronic Lower Respiratory Disease

Chronic lower respiratory disease is the fourth leading cause of death in Erie County. Chronic lower respiratory disease includes emphysema, chronic bronchitis and asthma. Major risk factors include tobacco smoke, indoor and outdoor air pollutants, allergens, and occupational agents.³³

The death rate in Erie County from chronic lower respiratory disease is higher than that of New York State, but lower than the rate for the United States. See Figure 38. The hospitalization rate for chronic lower respiratory disease in Erie County is lower than the rate for New York State across all race/ethnicities. See Figure 39.

Figure 38

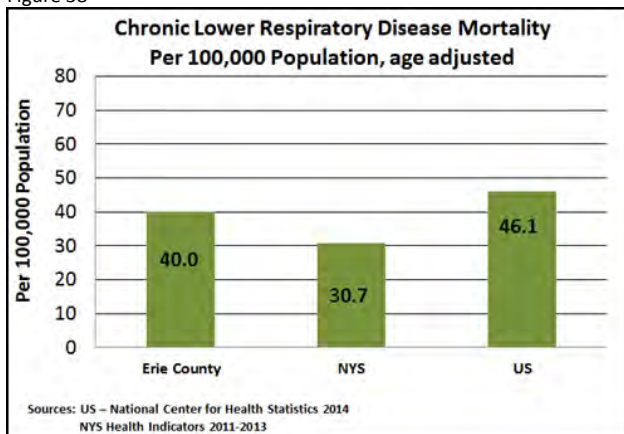
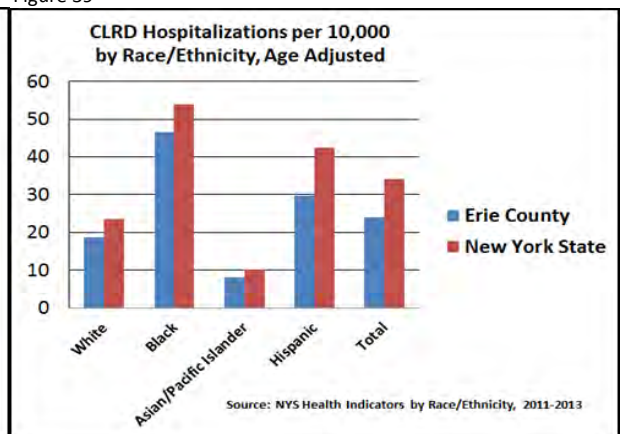


Figure 39



Diabetes Health

The self-reported diabetes rate in Erie County is higher than the rate across New York State, but 0.8 percent lower than the country, as shown in Figure 40. The actual hospitalization rate for Black and Hispanic residents in Erie County is higher than the respective rates across New York State. Within Erie County, the diabetes hospitalization rate for the Hispanic population is more

³³ <http://www.who.int/gard/publications/Risk%20factors.pdf>.

than double the rate for the White population, while the diabetes hospitalization rate for the Black population is more than triple the rate for the White population. See Figure 41.

Figure 40

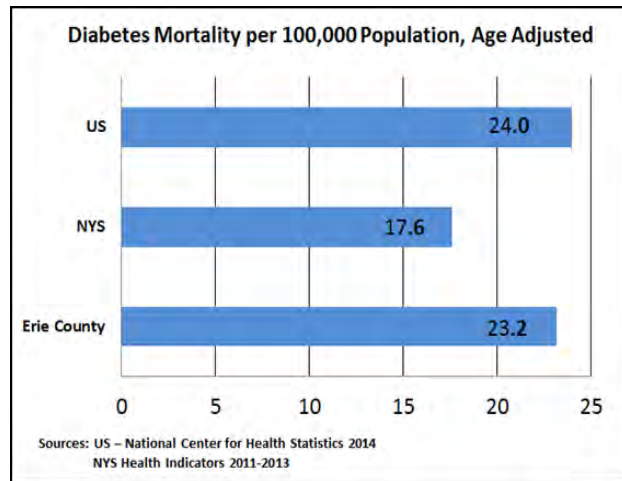
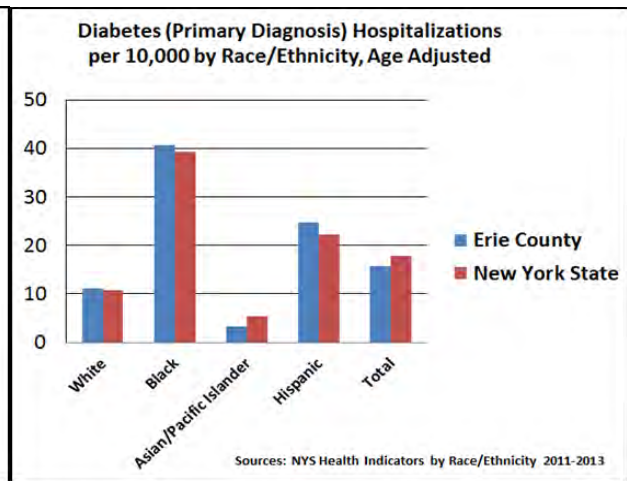


Figure 41



C. Preventable Diseases and Healthcare-Associated Infections

There are many preventable diseases that impact the health status of the community. Community-driven prevention efforts are available and must be maintained to avoid these preventable diseases.³⁴ Those of significance locally include:

- ✓ HIV/AIDS, sexually transmitted diseases and hepatitis C (HCV) are significant public health concerns. Counseling, education and clinical, as well as, protective interventions are critical to increasing early access to care and decreasing disparity and morbidity. The prevalence of HIV and AIDS is lower in Erie County than across New York State and the USA. See Figure 42
- ✓ Flu Immunization is a successful and safe public health strategy for preventing disease
- ✓ Many healthcare-associated infections are preventable and represent significant opportunity to improve the patient experience, reduce mortality rates and the total cost of care. The Buffalo area hospital infection rate per 100 procedures for Central Line All Bloodstream Infections (CLABSI) in critical care units is higher than the state baseline average of 1.00. See Figure 43

Figure 42

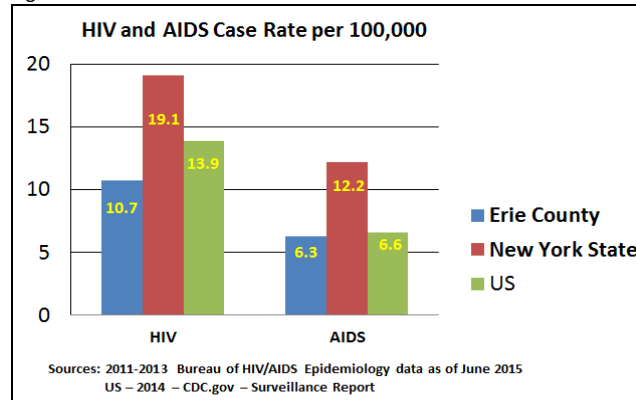
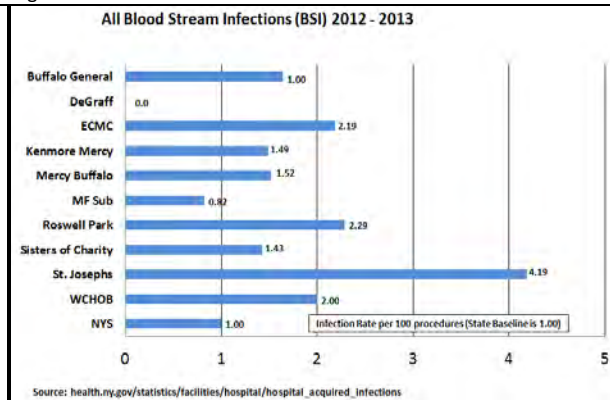


Figure 43



³⁴ http://www.health.ny.gov/prevention/prevention_agenda/2013-2018/plan/stds/index.htm.

D. Promote Healthy Women, Infants, and Children

Promoting healthy women, infants and children is a priority for the New York State Prevention Agenda, as well as, a public health goal of the United States Healthy People 2020. It is fundamental to overall population health, promoting health and preventing disease throughout life.³⁵

Maternal and Infant Health

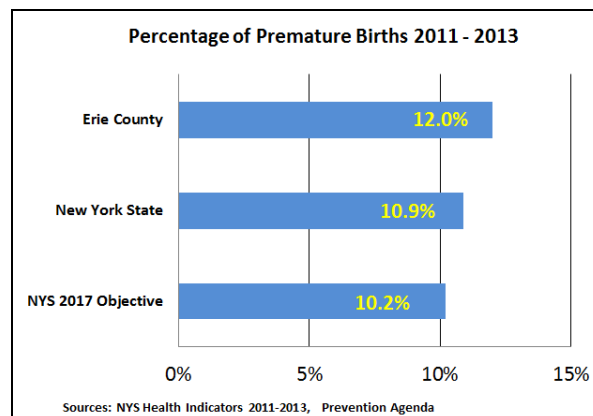
Health begins early, even before birth. Adequate prenatal care, pre-pregnancy weight and age of the mother, and breastfeeding are all components to providing the best outcomes for baby.

Preterm Birth and Prenatal Care

The leading cause of death for infants is preterm birth, which is birth before 37 weeks of gestation. Babies born prematurely, or at a low birth weight, are more likely to have, or develop, significant health problems such as respiratory, gastrointestinal, immune system, central nervous system, behavioral and social-emotional concerns. Preventable risk factors include, but are not limited to, late or no prenatal care, smoking, obesity, alcohol and drug abuse, stress, high blood pressure, and diabetes.³⁶

The Erie County preterm birth rate is 12 percent, which is 1.1 percent higher than the New York State rate and will need to be reduced over the duration of the state health improvement plan to reach the 2018 New York State objective of 10.2%. See Figure 44.

Figure 44

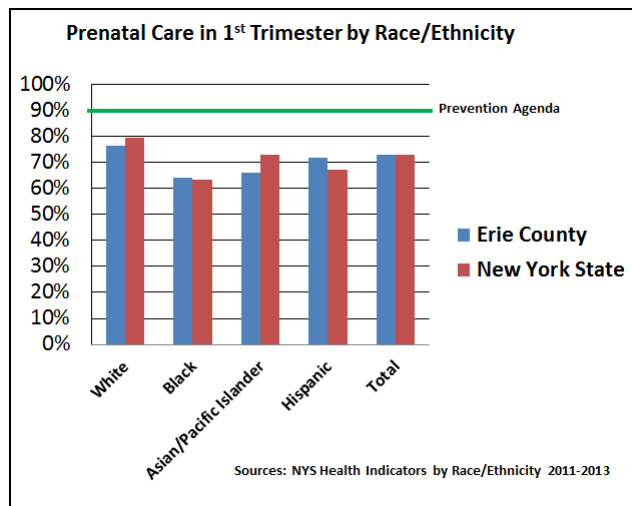


The percentage of pregnant women receiving prenatal care in their first trimester is below the 90 percent benchmark identified in the Prevention Agenda. Blacks have the lowest percentage of pregnant women receiving prenatal care within their first trimester. Community engagement and education is needed in order to improve the percentage of pregnant women receiving prenatal care across all races and ethnicities within Erie County. Figure 45 illustrates this disparity that exists across New York State.

³⁵ http://www.health.ny.gov/prevention/prevention_agenda/2013-2018/plan/wic/read_more.htm.

³⁶ http://www.health.ny.gov/prevention/prevention_agenda/2013-2018/plan/wic/focus_area_1.htm.

Figure 45



Breastfeeding

Breastmilk is an optimal food for infants and increasing the number of mothers who choose the option of breastfeeding is a straightforward way to increase the health of children from the start.³⁷ The American Academy of Pediatrics recommends exclusive breastfeeding to support optimal growth and development for approximately the first six months of life, and continued breastfeeding for at least the first year of life or beyond, for as long as mutually desired by mother and child.³⁸

As noted on the New York State Department of Health website, “breastfed infants are less likely to develop medical problems such as childhood obesity, respiratory and gastrointestinal infections and are at lower risk for childhood cancers, asthma and Sudden Infant Death Syndrome (SIDS).”³⁹ In addition, “breastfeeding benefits mothers by decreasing risks of breast and ovarian cancers, osteoporosis and postpartum depression, and by increasing the likelihood of returning to pre-pregnancy weight.”⁴⁰

³⁷ http://www.health.ny.gov/prevention/prevention_agenda/2013-2018/plan/wic/focus_area_1.htm.

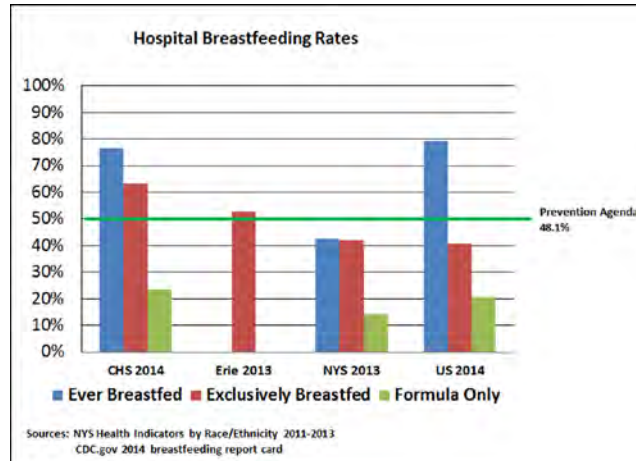
³⁸ <http://pediatrics.aappublications.org/content/115/2/496.full#sec-12>.

³⁹ http://www.health.ny.gov/prevention/prevention_agenda/2013-2018/plan/wic/focus_area_1.htm.

⁴⁰ *ibid.*

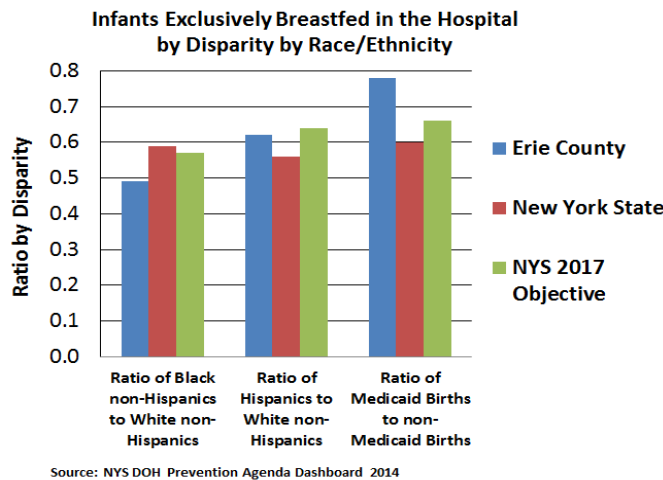
There is a greater percentage of infants exclusively breastfed in hospitals in Erie County than in the New York State. In addition, the Erie County exclusively breastfed rate surpasses the New York State 2018 objective of 48.1%. See Figure 46.

Figure 46



In Erie County, for infants exclusively breastfed, the ratio of Black and Hispanic women to White women is higher than it is in New York State and higher than the New York State 2018 objective. See Figure 47.

Figure 47



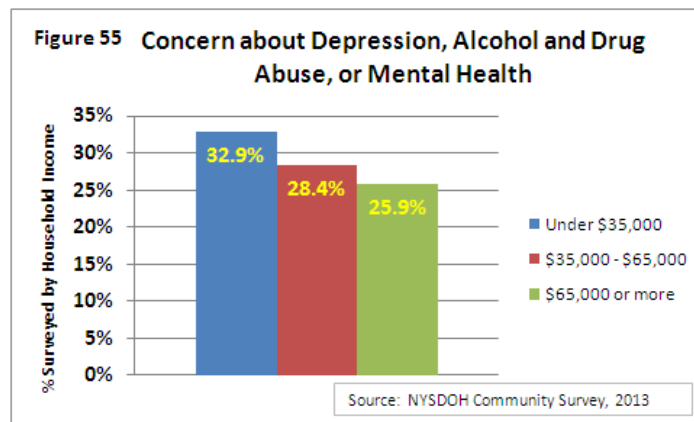
E. Promote Mental Health and Prevent Substance Abuse

Mental and emotional well being is integral to the health of the community. Mental and emotional disorders interfere with people’s ability to establish relationships, succeed in school

and work, and remain functional throughout life.⁴¹ Integration of mental health care with physical health care was reported as being critical to population health during the Catholic Health group interviews and the community forum.

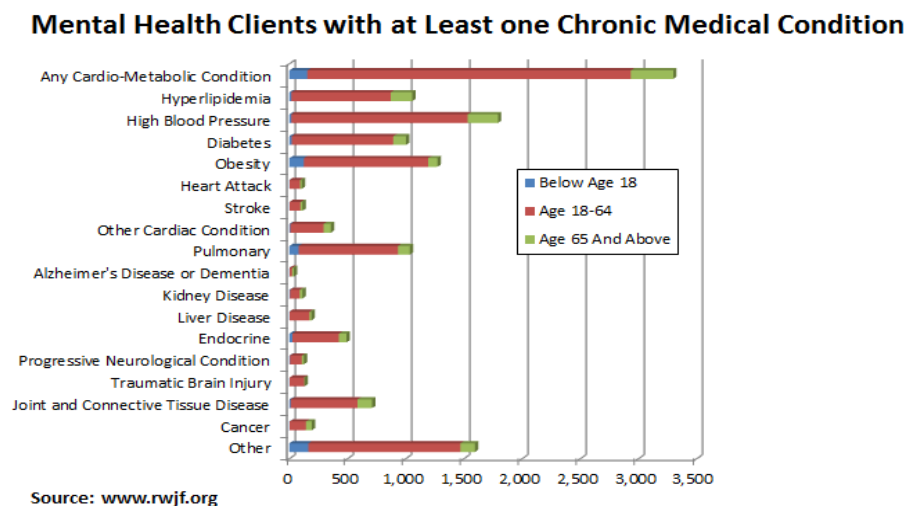
The Erie County Department of Health Community Survey results show that 8% of Erie County residents are unhappy or depressed and 28.6% of the survey respondents have concern regarding depression, alcohol or drug abuse, or mental health. A higher percentage of residents in lower income ranges responded that they have these concerns. See Figure 48.

Figure 48



The New York State Office of Mental Health Patient Characteristic Survey shows that approximately half of Erie County mental health patients also have at least one chronic medical condition, which indicates that a person’s physical health may be interrelated with mental and emotional health.⁴² Shown in Figure 49, cardiovascular disease is the most prevalent chronic disease among Erie County residents that are mental health consumers.

Figure 49



⁴¹ http://www.health.ny.gov/prevention/prevention_agenda/2013-2018/plan/mhsa/mhsa_introduction.htm.

The Patient Characteristics Survey (PCS) is conducted every two years, and collects demographic, clinical, and service-related information for each person who receives a public mental health service during a specified one-week period (2011). The PCS receives data from approximately 5,000 mental health programs serving 175,000 people during the survey week. All programs licensed or funded by the NYS Office of Mental Health (OMH) are required to complete the survey. The PCS is the only OMH data source that describes all the public mental health programs in New York State.⁴³

According to CMS, “the health home service delivery model is an important option for providing a cost-effective, longitudinal ‘home’ to facilitate access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions.” The health home model is a holistic approach to care which provides care management where all the individual’s caregivers communicate in order to address the patient’s needs comprehensively. Health Homes have been established as part of the New York State Medicaid program for Medicaid enrollees with chronic conditions.

⁴³ <http://bi.omh.ny.gov/pcs/index>.

Appendix H: WNY DSRIP CHNA – Summary of Community Health Needs

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 patients 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%.

Appendix I: WNY DSRIP CHNA – Summary of Community Resources

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.

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.

Appendix J: Prioritization of Health Needs

The Catholic Health Internal Steering Committee met on June 24th, 2016 to evaluate the relative priority of the various needs in the community. The ISC first agreed that the following criteria are the most relevant to narrowing the list of projects where the greatest impact could be realized within the resources available.

Need Prioritization Criteria

1. A natural leader or champion for the initiative exists within the existing organizational structure.
2. The need was specifically identified as being significant in one of the recent community outreach data collection efforts (focus groups, survey) AND is indicated in other secondary data sources and key indicators
3. Meaningful opportunity to collaborate with external partners exists
4. Addressing this health need aligns with the Ministry/Service Line and will not compromise other Ministry outreach.
5. The related effort to address the need is feasible from a funding perspective
6. Impact: What is the potential effectiveness of addressing this issue in your service area?

Appendix K - CH Detailed Progress Assessment of 2013 CHIS

Catholic Health Assessment of 2014 CHIP - Detailed Summary

1. Prevention Agenda Priority - Improve Health Status and Reduce Health Disparities

1.1 Physician Recruitment

Need: Erie County has a community need for primary care physicians and for many specialty care physicians to adequately service the medical needs of the residents of Erie County.

Impact: *Recruitment efforts continued to increase the number of new PCPs and specialty care physicians to Erie County from outside the region and to increase the number of mid-level providers added to Catholic Medical Partners' practices. Targets were mostly met with only the PCP target at Mercy Hospital of Buffalo and the specialist target at Sisters Hospital falling short. This project will continue as part of the focused improvement efforts as outlined in each of CH's acute care operations 2016 CHIP reports.*

1.2 Charity Care / Medicaid

Need: Assistance for individuals and families in the Catholic health service area in need of health care services that are without or have limited health insurance coverage.

Impact: *Access to care for the poor and vulnerable and the broader community was the overarching goal, with the objective to reduce the uninsured patient population and increase the patient enrollment in insurance programs. Catholic Health's policy is to provide Charity Care to 100% of all patients who qualify for Charity Care. Additionally, Catholic Health achieved the goal to increase the number of patients that were provided assistance in applying for Medicaid at the acute care hospitals, nursing homes and primary care centers by over 20% from 2013 through 2015. This is an ongoing commitment of each of CH's acute care operations.*

1.3 Community Health Workers

Need: Access to health care for specific high-risk populations.

Impact: *Target achieved and implementation began in 2015 through our DSRIP program. Hired 2 community health workers.*

1.4 Faith Community Nursing

Need: To identify "at risk" populations and broaden the available services to the parishioners of faith based institutions.

Impact: *The Faith Community Nurse Program is well embraced by the community. The initiative provided a systematic way of data collection, through the use of the Parish Nurse Electronic Documentation System and increased level of community involvement for at-risk population like homeless and homebound. The program has expanded to several faith communities. The program assisted in the national goals to reduce ER visits and barriers to health care by referring individuals to MD's (for those without) and other community services, detection of problems early within the FCN Ministry by the FCN being available for individual BP screening and one on one consultation. The good work being done was evidenced by the grants received from agencies like ACOR (\$15,000), HWRI Grant with PNMNY, Inc. (\$15,000 used). The program is embedded now as part of our mission outreach.*

1.5 Access to Care in Medically Underserved Areas

Need: Urban areas of Buffalo have higher incidence of many chronic diseases as well as higher utilization of emergency services for urgent and primary care.

Impact: *The primary care mission sites provide care in medically underserved areas and increase access for the communities to primary care services and prevention. The new patient and increased visit targets*

at Mercy Comprehensive Care Center were met in 2015 while the new patient and visit targets at St. Vincent Health Center were not met due to the loss of two full time providers and closure of the OB/GYN practice. Because of primary physician shortages, these measures will be difficult to maintain without improved recruitment. Refer to 1.1 above.

1.6 Community Outreach

Need: Access to preventive care, primarily for those who are underserved.

Impact: The System worked with the community to offer programs and health screening outreach, performing nearly 9,500 free health screenings with over 65% being Erie County underserved and over 8,700 community guests attending programs, classes and workshops. Outreach is an ongoing commitment for each of CH's acute care operations.

1.7 Preventable Hospitalizations

Need: Better management of pneumonia and urinary tract infections to prevent unnecessary hospitalizations.

Impact: Preventable urinary tract infection inpatient admissions were reduced beyond the 5% annual target at all hospitals. Preventable community acquired pneumonia inpatient admissions were reduced beyond the 5% annual target at Kenmore Mercy Hospital and Mercy Hospital of Buffalo; the preventable admissions were reduced for Sisters Hospital, but not to the extent of the target.

2. Prevention Agenda Priority - Prevent Chronic Disease

2.1 Cardiovascular Health – Congestive Heart Failure

Need: Significant opportunities continue to exist to educate, treat, and support CHF patients, especially in urban communities, where patients are less compliant with directed medical therapies, and therefore have worse outcomes in key metrics such as mortality and readmission rates.

Impact: The System continued coordination of patient care for congestive heart failure patients, scheduling follow up PCP/cardiologist visits prior to the patient leaving the hospital 76%-86% of the time, depending on the hospital, and reducing readmission rates at Sisters Hospital, but not reaching the reduction target at Kenmore Mercy and Mercy Hospital of Buffalo.

2.2 Stroke – Cerebrovascular Disease

Need: Stroke is the primary cause of long-term disability. Stroke survivors and their caregivers face a new set of challenges during the survivor's recovery.

Impact: Two stroke support groups for survivors and caregivers, one in the Erie Count "Southtowns" region and one in the "Northtowns", continued to meet throughout 2015 to provide education and locate resources. Stroke Prevention and Stroke Support Programming will be included as specific initiatives in the 2016 Implementation Strategy.

2.3 Diabetes Mellitus

Need: Diabetes is a chronic disease with many high cost complications. The great need is to promote healthy lifestyles, compliance with clinical practice guidelines and improve access to health care services in order to prevent diabetes and delay its progressions once diagnosed.

Impact: Promotion of educational opportunities for people with or at risk for diabetes and programs for providers in conjunction with care management and collaboration with our partners supports prevention and management of this chronic disease. The professional educational programs held in 2015 (31) surpassed the originally planned (23) programs. Thirty-two life skills classes, including classes at inner-city locations, were planned and held. In the Saint Vincent Health Center, Mercy Comprehensive Care Center and OLV Family Care Center primary care sites, there has been an increase in patients with HbA1c measured in 2015, but targets for HbA1c level and blood pressure control were not met, which could be a result of improved data.

2.4 Peripheral Arterial Disease

Need: Peripheral Arterial Disease is prevalent in Western New York, which is substantiated by the average rate of 30% abnormal ABI's at our vascular screening events.

Impact: This was a pilot program that offered at all Catholic Health rehab sites where physicians refer patients into the program. The program originated in response to the increase in diagnosed peripheral arterial disease in our patient population. This is an additional option to medically manage patients and their quality of life. Patients with PAD suffer from claudication. This program is a supervised walking program that will assist patients to increase their circulatory response and improving their quality of life. Patients complete a questionnaire prior to starting their program and their comfortable walking distance is documented. When the patients complete the program, an exit survey is completed and their comfortable walking distance is again assessed. Almost all patients that have completed the program have had improved quality of life with improved walking distance. Catholic Health's rehab facilities offer this program which is intended to continue.

2.5 Colorectal Cancer

Need: Colorectal Cancer is the 4th in the United States in terms of new diagnosis and is also one of the most preventable, and when caught in early stages, most "curable."

Impact: *The System is committed to increasing colorectal screening rates at Catholic health Primary Care Centers providing healthcare to lower income patient populations – St. Vincent health Center (SVHC), Mercy Comprehensive Care Center (MCCC) and OLV Family Care Center (OLV). Since 2013, through increased awareness, along with provider and patient engagement, colorectal screening rates have successfully increased for the patient populations at SVHC (from 8% to 29%), MCCC (from 23% to 32%) and OLV (from 37% to 49%).*

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

a. Seasonal Influenza Vaccination

Need: In compliance with the New York State Department of Health (DOH) new regulation requiring personnel in regulated settings to receive an influenza vaccination and those who have not to wear a surgical or procedure mask in areas where patients may be present.

Impact: *Promotion of flu vaccine for healthcare workers has significantly increased the compliance rate from below 50% during the baseline year 2012-2013 to over 80% in 2013-2014 and 2014-2015. This is an ongoing commitment of the CH organization and each of its operations.*

b. House-Wide Central Line-Associated Bloodstream Infections

Need: Central line-associated bloodstream infections (CLABSIs) result in thousands of deaths each year and billions of dollars in added costs to the U.S. health care system, yet these infections are preventable.

Impact: *The System utilizes CDC-recommended infection control steps and process improvements to maintain or reduce house-wide central line-associated bloodstream infections with Kenmore Mercy maintaining their low infection count, Sisters of Charity Hospital reducing their infection count, but not reaching the target and Mercy Hospital of Buffalo not reducing their infection count.*

c. HIV

Need: In 2010, the NYS Legislature passed the Amended HIV Testing Law and in 2011, the NYS Department of Health promulgated regulation to address HIV-positive New Yorkers that are unaware that they are living with HIV and learning about their diagnosis late in disease progression.

Impact: *An HIV test is offered and provided to all consenting individuals between the ages of 13 and 64 when a patient is in the emergency room, admitted as an inpatient or seen in a primary care clinic associated with the hospital.*

3. Prevention Agenda Priority - Promote Healthy Women, Infants and Children

3.1 Breastfed Babies

Need: Increase ability for women in WNY to be supported while breastfeeding, including actually breastfeeding baby as well as expressing breast milk as needed.

Impact: *The System is dedicated to increasing the proportion of NYS babies who are breastfed and reducing the disparity of breastfed babies exclusively in the hospital through strategies that include lactation consultation, employee education, a formula-free environment and providing space for breastfeeding. The percent of babies ever breastfed in the hospital exceeded the 75% target rate set in 2013 for both Mercy Hospital of Buffalo (78%) and Sisters of Charity Hospital (76%).*

4. Prevention Agenda Priority - Promote Mental Health and Prevent Substance Abuse

4.1 Collaborate with Community Mental Health Providers

Need: Lack of physical health care integration with mental health care.

Impact: *Due to continued federal issue with co-location of Article 31 Mental Health Providers in Article 28 clinic space, we have been unable to integrate mental health services in our clinics (MCCC, CVHC, and Ken-Ton). However, as part of our DSRIP efforts, we are piloting a mental health counselor in our OLV Family Care Center free of charge. If successful, we will provide a free mental health counselor at MCCC as well in late 2016, early 2017.*

4.2 Health Home

Need: Medicaid patients with complex medical, behavioral, and long-term care needs tend to be high utilizers of high cost services. Helping them appropriately access and manage these services, through improved care coordination and service integration, is essential to controlling future health care costs and improving health outcomes for this Medicaid population.

Impact: *The Health Home supports Medicaid patients with complex medical, behavioral, and long-term care needs through improved care coordination and service integration. Health Home new clients (510) greatly surpassed the 2015 target (150) and all clients have been screened for depression. The goal to reduce preventable hospitalization and emergency department visits will be measured New York State Department of Health analytics tool is accessible. Efforts in this area will continue as the normal course of operations.*

4.3 Integrate Mental Health and Physical Health

Need: Lack of physical health care integration with mental health care.

Impact: *Due to continued federal issues with co-location of Article 31 Mental Health providers in Article 28 space, we have been unable to integrate mental health services in our Emergency Departments. We have worked with the NYSDOH and they have requested a waiver of this co-location issue to CMS. We are still awaiting a response from CMS.*

Appendix L – Catholic Health Sites and Services

CH operates four acute care campuses in Erie County. Two of its facilities are located within the City of Buffalo and the other two are in the first-ring suburban communities of Kenmore and Cheektowaga. The System is positioning itself to become a high performing health system, aligning services across its ministries and supporting its service line structure. The System has developed an integrated health network that includes primary care, outpatient rehabilitation services, inpatient medical rehabilitation, skilled nursing care, home care, and outpatient lab and imaging services. This network of services ensures patients receive the right care, in the right place, at the right time, and positions the System for future success as the nation moves toward Accountable Care, where integration and efficiency are critical to controlling health care costs, while simultaneously enhancing quality.

Network Overview

Primary Care Centers – Intermediate Care

The System operates eight primary care centers recording more than 112,000 patient visits annually and employing 30 primary care physicians and 19 mid-level providers.

Rehabilitation Services

The System offers the largest outpatient rehabilitation network through various locations across the region offering acute care, medical rehabilitation, sub-acute care, home care, long-term care and outpatient care rehabilitative services. The System offers two outpatient rehabilitation centers, along with off-site athletic training services at over 20 area high schools and three colleges.

Medical Rehabilitation Units (MRU)

The System's Medical Rehabilitation Units at Mercy Hospital in the south and Kenmore Mercy Hospital in the north, provide more intensive rehabilitation services (physical, occupational and speech therapy) for patients recovering from strokes, hip fractures, amputations and other neurological conditions.

Skilled Nursing Homes

The System is developing new delivery models to meet the changing health needs of area seniors including connection to the System's service lines. The System's skilled nursing facilities provide comprehensive nursing, rehabilitation, and support services in a safe, caring and comfortable environment. The homes also offer social and recreational activities to foster a sense of community and help residents live active, dignified lives. Three of the four skilled nursing facilities are hospital-based, and consequently included in the Obligated Group. These include St. Catherine Labourè, a department of Sisters of Charity Hospital – Main St. Campus, the Mercy Skilled Nursing Facility, a department of Mercy, and the McAuley Residence, a department of Kenmore, and therefore included in the Obligated Group. Two of the nursing homes of the System offer short-term sub-acute care to help patients with complex medical conditions make the transition from hospital to home. These include the McAuley Residence,

part of the Obligated Group, and Father Baker Manor. The System's commitment to quality and best practices is reflected in its optimal clinical outcomes and clinician-to-patient staffing levels above national standards. Sub-acute services help to reduce hospital admissions by diverting patients in the System's emergency departments directly to sub-acute services, reducing the cost of care.

Our Lady of Victory Senior Neighborhood

The neighborhood includes 74 low and moderate-income senior apartments and the 84-bed "household model" Mercy Hospital Skilled Nursing Facility. The neighborhood also houses the Program of All-inclusive Care for the Elderly (PACE). This unique program allows the frail elderly to remain in their own homes while accessing the necessary support and medical assistance required maintaining their quality of life.

Home Care

The System's complement of home care services includes skilled nursing care, rehabilitation services, private duty nurses, home healthcare aides, spiritual care, medical equipment services, a personal emergency response system, telemedicine services for management of chronic illness, and in-home infusion therapy services. The Home Care Division directly supports the System's service lines, offering maternal and child home services to the Women's Service Line and cardiac home services to patients of the Cardiac Service Line. Working in cooperation with the area's health plans, Home Care's Transitions Program improves the coordination of care as patients make the transition from hospital to home, ensuring patients get the care they need to continue their recovery and reduce re-admissions to the hospital.

Laboratory and Imaging Services

Catholic Health has a centralized laboratory, as a result of which the System is less reliant on independent laboratories and maintains this service as an additional source of revenue. Through Urgent Response Labs at each hospital and 24 Laboratory Service Centers located throughout Western New York, the System processes over 4.1 million laboratory tests annually. With a commitment to offer the most advanced diagnostic technology, the System provides digital mammography, digital x-ray, ultrasound, MRI, CT, nuclear medicine and interventional radiology, along with other imaging modalities. The System performed 328,477 imaging procedures in 2014.

Physician Integration

Physician integration and care management are key components of high performing health systems and are viewed by the system as critical to the long-term success of the System. The System enjoys a unique, strategically aligned relationship with an independent practice association (IPA), Catholic Medical Partners. Catholic Medical Partners ("CMP") represents nearly 1,000 physicians throughout the region. Both the physicians and CHS are members of CMP, with no ownership interest.

Like the System, CMP provides the organizational structure to lead key transformational initiatives among the physicians in the community. This includes the use of health information

technology. As of December 2014, 100% of CMP physicians used an electronic health record (EHR), compared to 78% nationally as found by two studies published by the HHS Office of the National Coordinator for Health Information Technology (ONC) and published in Health Affairs.

The IPA also provides the framework for advanced clinical integration and disease management programs. Enabled by technology, physician practices are managing their patients using disease management programs and office-based “care coordinators.” Currently, 265 care coordinators work with high risk patients to facilitate timely, cost-effective care.

In April 2012, CMP was one of just 27 organizations nationally, and the only one in New York State, to be chosen to participate in the federal Shared Savings Accountable Care Organization (ACO) program. CMP was selected based on rigorous eligibility criteria and program requirements, as well as, its integrated relationship with the System and both organizations’ ability to deliver quality outcomes at lower costs factored into the selection process. This ACO Shared Savings contract with CMS involves 25,000 patients and demonstrated improvements in quality and achieved over \$27 million dollars in saving in the first contract year, ending December 31, 2014. The ACO performance was ranked third in the country of all participating ACO’s.

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