

2022 Community Health Needs Assessment

Erie County
Community Health Improvement Plan 2022-2024



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December 2022

Dear Community Resident:

As the healthcare quality and safety leader in WNY, Catholic Health continues to look for ways to lead the transformation of healthcare and create healthier communities. To help support this important work, we conduct a Community Health Needs Assessment (CHNA) every three years in Erie and Niagara counties to gain a better understanding of the health concerns of area residents and collaborate with others to improve healthcare across the region. We are pleased to share with you the results of our CHNA as well as Catholic Health's 2022-2024 Community Health Improvement Plan.

The assessment process was a collaborative effort between Catholic Health and other local organizations concerned about the health of our community, including the Erie County Department of Health and Niagara County Department of Health. Additionally, we solicited input from a variety of organizations, groups, and individuals in the form of surveys and community meetings. This input helped us identify how Catholic Health can best address the health and wellness needs of the people who rely on us for care.

Dating back generations, Catholic Health's mission has been to reveal the healing love of Jesus to all. Whether it was our industry-leading response to the COVID pandemic or implementing Epic, one of the world's most advanced electronic health record systems designed to improve patient safety and community health, our mission has always been our guiding star. To that end, in 2021, Catholic Health provided nearly \$9 million in charity care and \$210 million in community benefit to the people of WNY, while continuing to receive local and national recognitions for high quality care and patient safety.

While the COVID pandemic consumed much of our time as we responded to pressing needs of our patients and the broader community, our commitment to provide safe, high quality care never wavered. Now, as life begins to return to normal, we are looking forward to continuing to address the needs identified in the 2022 CHNA as well as partner with our county health departments to focus on priority health issues, including food insecurity, substance use treatment, and women's and children's health.

We encourage you to resume your individual health journey as well by focusing on preventative care, including regular check-ups and health screenings, and following prescribed medical plans to manage existing health conditions. We look forward to working with our community partners to improve your health and the quality of life for individuals and families throughout Erie and Niagara Counties. We invite you to learn more about Catholic Health by visiting chsbuffalo.org or calling 716-447-6205.

Sincerely,



Mark A. Sullivan
President & CEO



Catholic Health Mission, Vision, and Values

Our Mission

We are called to reveal the healing love of Jesus to all.

Our Vision

As a trusted partner, inspired by faith and committed to excellence, we lead the transformation of healthcare and create healthier communities.

Our Values

Reverence

We honor the inherent dignity and uniqueness of each person.

Compassion

We unconditionally demonstrate empathy, kindness, and acceptance.

Integrity

We are honest, transparent, and accountable.

Innovation

We continually learn, find creative solutions, and embrace change.

Community

We work together to build community and promote social justice in our organization and in society.

Excellence

We commit to achieve the highest standards of quality, safety, and service.



Catholic Health System

Community Needs Assessment (CHNA)
Community Health Improvement Plan (CHIP)
New York State 2022 – 2024

COUNTY COVERED:
Erie County

PARTICIPATING LOCAL HEALTH DEPARTMENT:
Erie County Department of Health

95 Franklin Street, Buffalo, NY 14202
(716) 858-7690
Web: www.erie.gov

COALITION/ENTITY COMPLETING ASSESSMENT AND PLAN:

Catholic Health System has completed its assessment and plan in collaboration with the Erie County Department of Health and local hospital and community partner organizations.

PARTICIPATING HOSPITALS:

Catholic Health System

Kenmore Mercy Hospital
2950 Elmwood Avenue
Buffalo, NY 14217
(716) 447-6100

Sisters of Charity Hospital
2157 Main Street
Buffalo, NY 14217
(716) 862-1000

Sisters of Charity Hospital, St. Joseph Campus
2605 Harlem Road
Cheektowaga, NY 14225
(716) 891-2400

Mercy Hospital
565 Abbott Road
Buffalo, NY 14220
(716) 826-7000
Web: www.chsbuffalo.org

Kaleida Health System

Buffalo General Medical Center
100 High Street
Buffalo, NY 14203
(716) 859-5600

Gates Vascular Institute
875 Ellicott Street
Buffalo, NY 14203
(716) 748-2000

Millard Fillmore Suburban Hospital
1540 Maple Road
Williamsville, NY 14221
(716) 568-3600

Oishei Children's Hospital
818 Ellicott Street
Buffalo, NY 14203
(716) 323-2000
Web: www.kaleidahealth.org

ERIE COUNTY CHA/CHIP STEERING COMMITTEE

Kelly Asher Smalt	Erie County Health Department	kelly.asher@erie.gov
Lisa Neff	American Heart Association	lisa.neff@heart.org
Lauri McCoy	Catholic Health	lmccoy1@chsbuffalo.org
Bernadette Franjoine	Catholic Health	bfranjoine@chsbuffalo.org
Kathleen Tompkins	Kaleida Health	ktompkins@kaleidahealth.org
Karl Wende	Buffalo State College	wendeke@buffalostate.edu
Cheryll Moore	Erie County Health Department	cheryll.moore@erie.ogv
Laurene Tumiel Behalter	University at Buffalo	tumiel@buffalo.edu
Renee Cadzow	D'Youville College	cadzowr@dyc.edu
Mary K. Comtois	United Way of Buffalo & Erie County	mary.k.comtois@uwbec.org
Alessandra Duarte	Population Health Collaborative of WNY	aduarte@phcwny.org
Kelly Wofford	Erie County Health Department	kelly.wofford@erie.gov
Arica Rouse	Erie County Health Department	aricayrouse@gmail.com
Margaret Barbalato	Erie County Health Department	margaret.barbalato@erie.gove
Alan Delmerico	Buffalo State University	delmeram@buffalostate.edu
John Gaeddert	Erie County Health Department	john.gaeddert@erie.gov
Brian Meade	Kaleida Health	bmeade@kaleidahealth.org
Karen Hall	Population Health Collaborative of WNY	khall@phcwny.org

B. Executive Summary

As one of the largest health care providers in Western New York, Catholic Health continually looks for ways to improve the health of those who reside in our community to achieve equitable outcomes through high quality, patient focused care. The New York State Prevention Agenda's vision to be the healthiest state for people across all ages is used as the framework to support this effort through our Community Health Improvement Plan (CHIP). As directed by the state, every three years a Community Health Needs Assessment (CHNA) is conducted to better understand the health concerns and issues facing community residents in the counties we serve.

We are in unprecedented times due to the ongoing global COVID-19 Pandemic. Its impact on the community and county operations continues to stretch resources, as well as the health and livelihood of many. As a result, the Erie County Health Department announced the county's focus will remain on the Prevention Agenda Priorities that were identified for the 2019-2021 CHNA. The priorities that will continue through 2024 are Prevent Chronic Disease and Promote Well-Being and Prevent Mental and Substance Use Disorders. The insight gained from the 2022 community survey results, as well as the community and stakeholder conversations, would however be reviewed by the steering committee and any necessary updates would be incorporated. Those updates, as well as the overall results, will continue to be shared by the county and community leaders and organizations, including Catholic Health, as we collectively work to support residents during this unprecedented time.

The healing love of Jesus is revealed in all we do at Catholic Health. In 2021, Catholic Health provided \$210 million in charity care and community benefit for the people of Western New York. Catholic Health associates across the geographic footprint of the health system are also engaged with a wide range of community based organizations as volunteers. This service to community is a fundamental component of the organization's culture. Our associates also provide a tangible, diverse response to this calling through which relationships deepen and feedback from the community is garnered. In addition, Catholic Health has actively identified and been awarded funding from the Federal Emergency Management Agency (FEMA) and other national, regional, and local agencies to support specific needs that align with our mission and the needs of the community. Catholic Health, with the support of our associates, is committed to our Social Responsibility and Community Benefit Framework.



Catholic Health 2022-2024 Prevention Agenda Priorities and Disparity

In collaboration with the Erie County Department of Health and other community partners, the following priorities, goals, focus areas and interventions were selected for the Catholic Health Community Health Improvement Plans. Priority Area #1 and Priority Area #2 were priorities identified by the Erie County Department of Health and selected for our community collaboration. Catholic Health is required to align with at least two county Priority Areas as part of the CHNA process. Of note, the Niagara County Department of Health identified the same priorities.

Priority Area #1: Prevent Chronic Diseases

Disparity: Socioeconomic

Focus Area 1: Healthy Eating and Food Security

Overarching Goal: Reduce obesity and the risk of chronic disease

Goal 1.13: Increase the percentage of adults with perceived food security

Priority Area #2: Promote Well-Being and Prevent Mental and Substance Use Disorders

Disparity: Socioeconomic

Focus Area 1: Promote Well-Being

Goal 1.2: Facilitate supportive environments that promote respect and dignity for people of all ages

Goal 2.2: Prevent opioid and other substance misuse and deaths

Focus Area 2: Prevent Mental and Substance Use Disorders

Goal 2.2: Prevent opioid and other substance misuse and deaths

Priority Area #3: Promote Healthy Women, Infants, and Children

Disparity: Ethnicity

Focus Area 1: Maternal and Women's Health

Goal 1.2: Reduce maternal mortality and morbidity

Focus Area 2: Perinatal and Infant Health

Goal 2.2: Increase breastfeeding

A comprehensive review of outcome data from a variety of state and national resources were reviewed as part of the CHNA process. Primary resources utilized included the New York Prevention Agenda Dashboard, data from the United States census reporting, the University of Wisconsin's Population Health Institute's County Health Rankings and Roadmaps, as well as others. Due to the proximity and nature of the interrelationships between Erie and Niagara counties, as well as the reach of the Catholic Health service area and goal for high level of inclusivity for community health, data from both counties is represented in the following report. This provides a more comprehensive view of the overall service area while still allowing county specific needs to be identified.

The overall assessment process is a collaborative effort between Catholic Health, Erie County Department of Health, and other local organizations and hospitals. More than 15 organizations directly participated in planning meetings and feedback sessions and over 1,300 residents responded to the CHNA survey. Input was also solicited from a broad range of other community organizations, individuals, and groups. This input helped validate and bring focus to areas of specific need and disparity, as well as helped prioritize interventions to address the needs of those we serve. The completed assessment and analysis of the data provided a framework for the health system's overall implementation plan to support priority needs that were identified for the community over the next three years.

The progress and overall improvement related to the Prevention Agenda priorities in the Catholic Health improvement plan will be monitored by the internal leaders who are coordinating the interventions identified by the teams to support the priorities identified and as outlined on the CHIP template provided by the New York State Department of Health. Catholic Health will submit updates on progress towards each intervention annually, or as requested. The county's steering committee representatives will also continue to meet at least annually and review progress as well as explore new opportunities to collaborate on to support the priority areas. The Prevention Agenda Dashboard will continue to serve as the primary resource to track latest available trending details and monitor outcome data.

While Catholic Health is committed to serving the community through the CHNA priorities in this report, there are a number of needs that were not incorporated into Catholic Health's individual 2022-2024 Community Health Improvement Plan at this time for one or more of the following reasons:

- Requires resources that Catholic Health does not currently have available without compromising other important initiatives.
- Is being targeted or addressed by other entities within the community.
- Was deemed not as impactful on the overall health of the community as compared to other identified needs.

Should community circumstances change or additional resources become available, Catholic Health will consider incorporating other initiatives into its plan.

The Community Health Needs Assessment and Community Health Improvement Plan 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, the Internal Revenue Service requires all state-licensed, tax-exempt hospitals to develop a Community Health Needs Assessment and Community Health Improvement Plan 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 to plan and implement a strategy for local health improvement focused on the Prevention Agenda 2022-2024: New York State Health Improvement Plan.

C. Community Health Assessment

1. Community Description

Catholic Health is a not-for-profit integrated healthcare delivery system that operates four acute care operations in Erie County (two facilities located within the City of Buffalo). Two facilities are in the first-ring suburban communities of Kenmore and Cheektowaga, and one is in neighboring Niagara County. In addition, Catholic Health has Home and Community Based Care, Primary Care Centers, as well as Diagnostic and Testing Centers. The target populations include our general community population including those who may be at risk or disadvantaged.

Catholic Health serves eight counties of Western New York. Erie County, Catholic Health System's primary service area, 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, further encompassed by a ring of newly developed suburbs, with rural communities on the outskirts.

Geographic Location

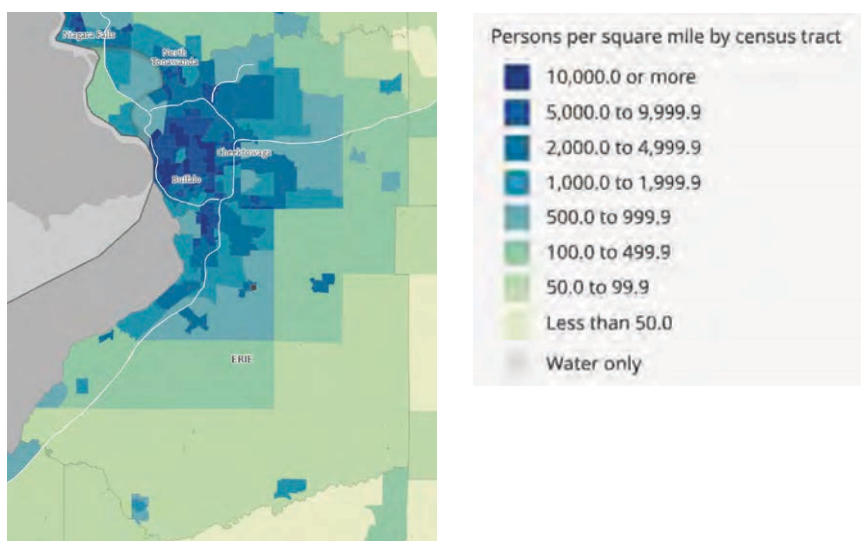
Erie County is a metropolitan center located on the western border of New York State covering 1,058 square miles and consisting of three cities and 25 town governments. Buffalo serves as the county seat and is the second largest city in the State. Buffalo is the second most-populous city in New York behind New York City.

Population

The population of Erie County, New York in 2020 was 917,241, down 0.2% from 918,992 in 2016. For comparison, the US population grew 2% and New York state's population shrank by 1.5% during that period.

The largest **ethnic** groups in **Erie County** are White (Non-Hispanic) 74.5% and Black or African American (Non-Hispanic) 12.8%. White (Hispanic) accounts for 1.78% of the population and Asian (Non-Hispanic) accounts for 1.1%.

Population Density – Erie County



Source: 2020 US Census Demographic Data Map Viewer

Population Trend – Erie County

YEAR	POPULATION	GROWTH	ANNUAL GROWTH RATE
2022*	915,657	-1,015	-0.11%
2021*	916,672	-1,015	-0.11%
2020	917,687	-1,015	-0.11%
2019	918,702	-1,015	-0.11%
2018	919,717	683	0.07%

*2021 and 2022 data is projected

Source: worldpopulationreview.com

Population Distribution by Age – Erie County

Age

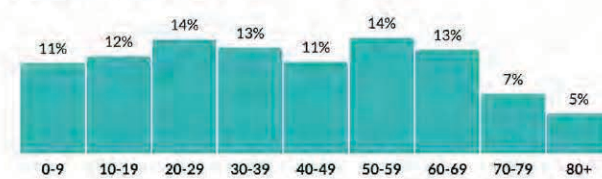
40.2

Median age

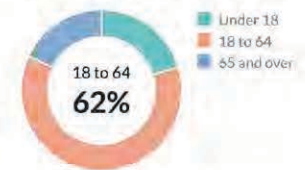
a little higher than the figure in New York: 39

a little higher than the figure in United States: 38.2

Population by age range



Population by age category



Source: Censusreporter.org

a. Population Demographics

SELECT DEMOGRAPHICS	ERIE COUNTY	NIAGARA COUNTY
Population (4/1/20)	954,236	212,666
Median Age (2020)	40.2	43.4
Gender		
Female persons percent (2020)	51.20%	50.9%
Male	48.80%	49%
Race/Ethnicity (2020)		
White alone	78.8%	87.2%
Black or African American alone	14%	7.40%
Hispanic or Latino	6.0%	3.7%
Asian alone	4.3%	1.2%
American Indian and Alaska Native alone	0.8%	1.2%
Foreign-born persons, percent, 2016-2020	7.2%	3.9%
Not proficient in English	2%	1%
Median household income (in 2020 \$), 2016-2020	\$59,464	\$57,252
Persons in poverty (2015-2019)	13.20%	11.70%
Persons with a disability, under age 65 years, 2016-2020	9.5%	10.2%
Persons without health insurance, under age 65 years	4.10%	4.30%
High school graduate or higher, percent of persons aged 25 years +, 2016-2020	92%	92%
Bachelor's degree or higher, percent of persons aged 25 years +, 2016-2020	35%	26%
Owner-occupied housing unit rate, 2016-2020	64.8	71.7
Median gross rent, 2016-2020	\$852	\$714
In civilian labor force, total, percent of population aged 16 years +, 2016-2020	62.50%	60.70%
Adults who have a regular health care provider, age-adjusted percentage (2018)	85.6	83.9
Language other than English spoken at home, percent of persons age 5 years +, 2015-2019	10.7	4.3
Veterans, 2016-2020	50,200	14,239
Percent of people using alternate modes of transportation (e.g., public trans, carpool, bike/walk) or who telecommute (2015-2019)	17.40%	13.10%
Households with a computer, percent 2016-2020	89.70%	88.60%

Source: <https://www.census.gov/quickfacts/fact/table/US/PST045221>

b. Community Health Status

New York State Prevention Agenda Tracking Indicators

The New York State Prevention Agenda Tracking Indicators were reviewed to identify where Erie and Niagara County residents showed worsening health trends. These trends were considered and integrated into the 2022-2024 plans when appropriate. The following issues were identified as among the most pressing for both Erie and Niagara Counties:

- Percentage of children with obesity, among children ages 2-4 years participating in the WIC program
- Opportunity Index Score. The Opportunity Index is made up of 20 indicators across four dimensions (Economy, Education, Health, and Community).
- Community Score (component access to healthy food). The Community Score is compiled from seven data sources: volunteering, voter registration, youth disconnection, violent crime, access to primary health care, access to healthy food, and incarceration.
- Suicide mortality among youth, rate per 100,000, ages 15-19 years
- Suicide mortality, age-adjusted rate per 100,000 population

Data Source: New York State Department of Health

https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/sources.htm

Distribution of Health Issues and Health Outcomes

County Health Rankings and Roadmaps (CHR&R) is recognized as the primary source for data to improve health equity. The Health Outcomes data provides an indication of the health status of Erie County residents. The overall data for Erie County morbidity and mortality shows that Erie County is ranked 46 out of the 62 counties in New York (lower middle range of counties in New York, 25%-50%).

In terms of health factors identified by CHR&R, those factors that influence how well and how long we live, Erie County is ranked 29 of 62 (higher middle range for New York counties, 50%-75%). Our focus remains committed to the health factors of today as they are an indicator of the overall health outcomes of the future.

The County Health Rankings recognize that 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.

Health Outcomes – Erie County

RANKING CATEGORY OUT OF 62 NY COUNTIES	YEAR 2019	YEAR 2020	YEAR 2021	YEAR 2022	TREND
Health Outcomes: based on mortality and morbidity	56	56	46	46	Positive
Health Factors: based on behavioral, clinical, social, economic and environmental	32	43	26	29	Positive

Source: County Health Rankings & Roadmaps, 2018

Physical and Mental Disease Burden

The 2022 County Health Rankings used data from 2018-2020 and reported that the residents of Erie and Niagara County report more physical unhealthy days compared to the state rates, which indicates a greater burden of chronic diseases in the community.

They also reported that the number of mentally unhealthy days for Erie and Niagara County residents is higher than the state rate, indicating a greater need for mental health services in this community.

Health Behaviors

Health risk behaviors identified in the County Health Ranking data review of Erie County included tobacco, alcohol, and obesity. Erie and Niagara County residents report a higher percentage of smoking, heavy drinking, and obesity than the state.

Health Outcome Detail

	New York	Erie (ER), NY ✘	Niagara (NI), NY ✘
Health Outcomes			
Length of Life			
Premature Death	6,000	7,300	7,900
Quality of Life			
Poor or Fair Health	i 16%	17%	17%
Poor Physical Health Days	i 3.6	3.8	4.0
Poor Mental Health Days	i 3.9	4.6	4.9
Low Birthweight	8%	9%	8%
Health Factors			
Health Behaviors			
Adult Smoking	i 13%	18%	21%
Adult Obesity	i 27%	32%	32%
Food Environment Index	i 9.0	8.1	8.0
Physical Inactivity	i 27%	25%	27%
Access to Exercise Opportunities	88%	93%	83%
Excessive Drinking	i 19%	22%	21%
Alcohol-Impaired Driving Deaths	20%	22%	11%
Sexually Transmitted Infections	i 640.6	598.2	449.2
Teen Births	13	16	18

Source: County Health Rankings & Roadmaps, 2018

Neighborhood Economics

Income and poverty are key indicators associated with the health and well-being of the community. Catholic Health has programs and resources throughout the county including geographic areas designated as some of the poorest census tracts in the county. The health system is dedicated to providing improved access to services to support a healthier community.

The Mercy Comprehensive Care Center is located within Census Tract 164 in Erie County. Per capita income is \$24,935 (+/- \$4,646) which is well below the Erie County average of \$35,050 (+/- \$385). The median household

income is \$38,170 which is almost two-thirds of the Erie County median household income of \$59,464. The percentage of persons below the poverty line is 28% in this area, twice the rate of Erie County overall (13.7%).

Source: *Censusreporter.org* (Census data: American Community Survey 2020)

Life Expectancy and Preventable Deaths

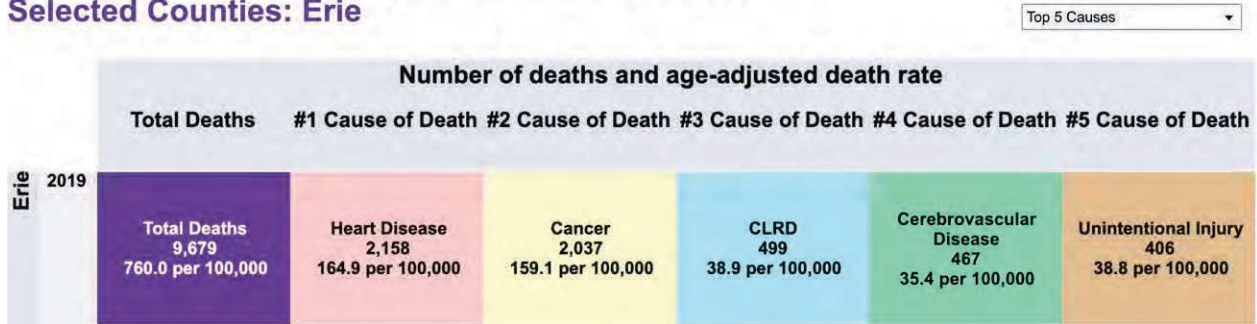
Compared to the state benchmark, Erie and Niagara County residents have a greater rate of potential life lost before age 75.

Within Erie County, Black and Hispanic populations have a greater rate of potential life lost before age 75 than the White population. Within Niagara County, American Indian/Native American, Black, and Hispanic populations have a greater rate of potential life lost before age 75 than the White population.

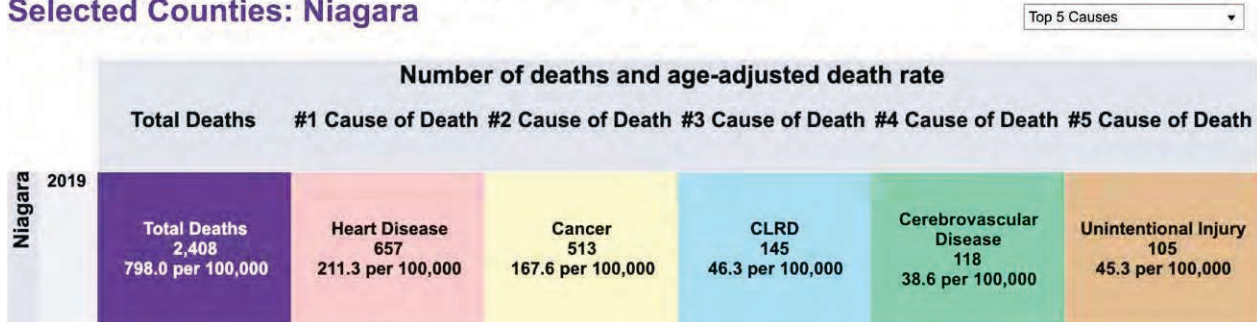
Leading Causes of Death Under Age 75 in Erie and Niagara County

The leading causes of death and rankings are the same for both Erie and Niagara County, and include Heart disease, Cancer, Chronic Lower Respiratory Disease, Cerebrovascular Disease, and Unintentional Injury.

Leading Causes of All Deaths for Total Population Selected Counties: Erie



Leading Causes of All Deaths for Total Population Selected Counties: Niagara



CLRD: Chronic Lower Respiratory Diseases

*Rates based on fewer than 10 events in the numerator are unstable.

Note: Ranks are based on numbers of deaths, then on mortality rates. Where county's death counts and rates are tied, '(tie)' appears at the bottom of the corresponding cells, and causes are further ranked alphabetically.

If a cell is blank, then there were no deaths from any of the 25 causes used in our tables. These causes are listed in the technical notes.

Source: *Vital Statistics Data as of January 2022*

Substance Abuse

Throughout the pandemic, New York and the entire nation saw an increase in opioid overdoses. More than 93,000 people in the United States died from drug overdoses in 2020, a 29.4% increase from 2019, according to the Centers for Disease Control and Prevention.

Erie and Niagara County residents experience a higher number of drug overdose deaths compared to New York State overall.

Drug Overdose Mortality Rate

NUMBER OF DRUG POISONING DEATHS PER 100,000 POPULATION.	
New York State	21
Erie County	25
Niagara County	27

Source: *Health Behaviors in the County Health Rankings & Roadmaps, 2018*

Opioid Related Metrics

OPIOID INDICATOR	DATA YEARS	NEW YORK STATE		ERIE		NIAGARA	
		COUNT	RATE	COUNT	RATE	COUNT	RATE
Overdose deaths involving any opioid, crude rate per 100,000 population	2019	2,955	15.1	143	15.5	37	17.6
All emergency department visits (including outpatients and admitted patients) involving any opioid overdose, crude rate per 100,000 population	2019	10,628	54.4	625	67.9	137	65.1
Patients who received at least one buprenorphine prescription for opioid use disorder, crude rate per 100,000 population	2020	79,864	408.7	6,408	696.7	2,474	1175.7

Source: <https://www.health.ny.gov/statistics/opioid/>

2. Main Health Challenges Facing the Community

Impact and Successes Achieved

Several of the health challenges that impact the residents of Erie and Niagara counties, as previously stated, have consistently proven to negatively impact the poor and vulnerable residents of Erie and Niagara counties. Improvement of the community's well-being and health status has been a specific focus for Catholic Health regarding disparity, social determinants, and prevalence of chronic disease as guided by our Mission, Vision, and Values. Despite the global pandemic that started in 2020 and continued through 2022, the 2019 – 2021 Community Health Improvement Plans for Erie and Niagara Counties showed significant progress.

Examples of Impact and Successes Achieved in the 2019-2021 Community Health Improvement Plans

- Depression screenings are done on every patient. The nationally recognized Patient Health Questionnaire-2 (PHQ-2) and 9 (PHQ-9) are done in provider offices as well as on admission with patient and then every 10 days thereafter. The assessment is now integrated into the hospital system electronic health record.
- A Doula training program was developed for maternity staff and matches the New York Governor's Task Force requirements for reduction of Maternal Mortality for African American women.
- Care Managers were hired for the Emergency Department at Sisters of Charity Hospital (Erie County). The goal is to improve self-management skills for those patients with chronic conditions.
- Health literacy principles are incorporated into patient education material design.
- The Catholic Health Diversity, Equity and Inclusion Initiative was founded to identify and inventory educational initiatives across the health system.



Deferred due to COVID-19 Pandemic

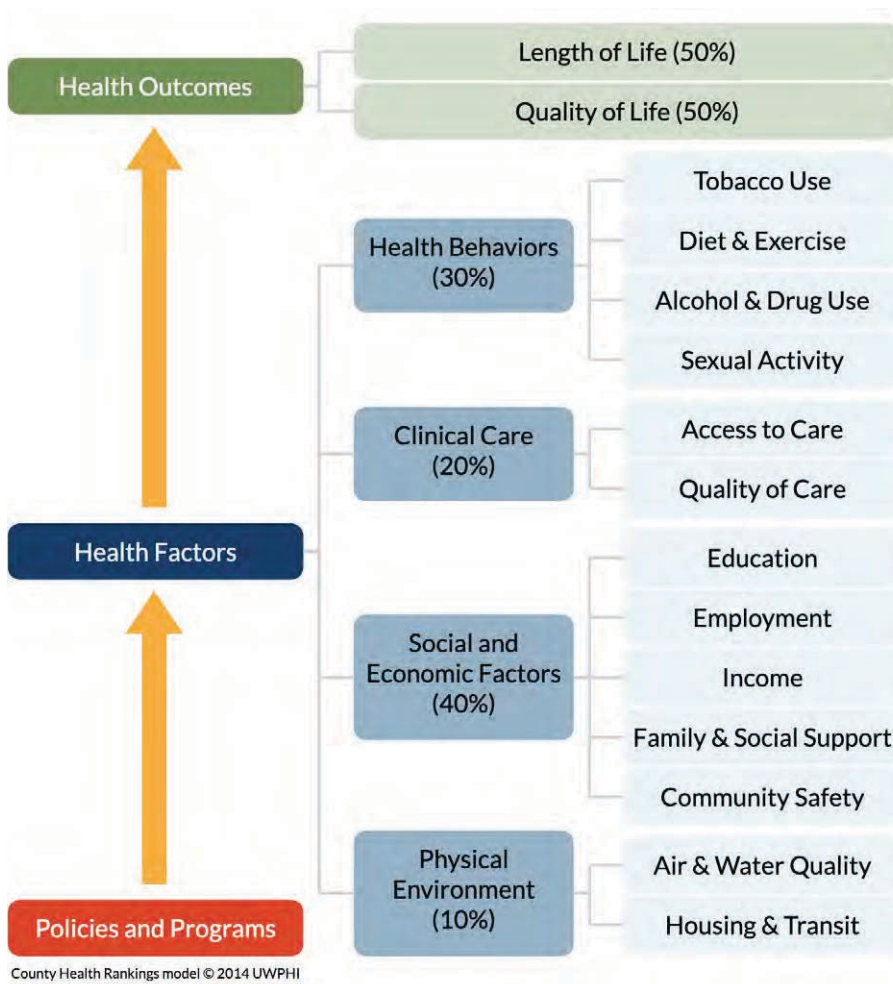
- Planning a speaker series with Erie County Health Department to offer continuing medical education credits for providers to expand understanding of pain classification for musculoskeletal providers.

Due to the unprecedented times that have resulted as the nation continues to respond to the global pandemic, both the Erie County Health Department, as well as the Niagara County Health Department, announced that they would continue their existing New York State Prevention priorities for the new report cycle. This provides Catholic Health facilities the opportunity to support and further their efforts to address the two priorities which are aligned with each of the counties. The aligned priorities for both counties are the same and include: 1. Prevent Chronic Diseases and 2. Promote Well-Being and Prevent Mental and Substance Use Disorders.

New York State Health Rankings for Erie County and Niagara County

While the Prevention Agenda priorities for each county remain unchanged, a review was conducted to validate and identify any new trends as a result of the global pandemic, changes in identified needs, outcomes or population changes. The current health challenges of each county were reviewed in detail using the 2022 County Health Rankings and Roadmaps Model (CHR&R). CHR&R is a program of the University of Wisconsin Population Health Institute and provides data, evidence, guidance, and examples to build awareness of the multiple factors that influence health and support leaders in growing community power to improve health equity. CHR&R rankings are derived from more than 30 measures that include health behaviors (30%), clinical care (20%), social and economic factors (40%), and physical environment (10%). The most recently available data is used to calculate CHR&R measures. Data from New York state and both Erie and Niagara counties is included below to allow for a comprehensive review of the data.

County Health Rankings Model



University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2022. www.countyhealthrankings.org.

New York State Health Factor Rankings by County

*New York State has a total of 62 counties

	ERIE COUNTY	NIAGARA COUNTY
Overall Health Factors	29	50
Health Behaviors	23	34
Clinical Care	11	52
Social and Economic Factors	43	46
Physical Environment	29	44

Data source: County Health Rankings & Roadmaps 2022

Overview of Contributing Causes of Health Challenges Compared to New York State Median

Behavioral Risk Factors

The 2022 County Health Rankings and Roadmaps Health Behaviors group include measures related to tobacco use, diet and exercise, alcohol and drug use, and sexual activity. The rates for all measures for both Erie and Niagara counties are higher as compared to New York State.

	NEW YORK STATE	ERIE COUNTY	NIAGARA COUNTY
Percentage of adults who are current smokers (age-adjusted)	13	18	21
Obesity, Adult ⁽¹⁾	27	32	32
Excessive Drinking ⁽²⁾	19	22	21
Teen Births ⁽³⁾	13	16	18

Data source: County Health Rankings & Roadmaps 2022

(1) Percentage of the adult population (age 18 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m² (age-adjusted)

(2) Percentage of adults reporting binge or heavy drinking (age-adjusted).

(3) Number of births per 1,000 female population ages 15-19.

Environmental Risk Factors

The 2022 County Health Rankings and Roadmaps Physical Environment group include measures related to air and water quality, housing, and transit. The rate for both Erie and Niagara counties is higher than New York State.

	NEW YORK STATE	ERIE COUNTY	NIAGARA COUNTY
Air Pollution - Particulate Matter*	6.9	7.6	8.7

*Average daily density of particulate matter in micrograms per cubic meter.

Socioeconomic Factors

The 2022 County Health Rankings and Roadmaps Social and Economic group include measures related to education, employment, income, family and social support, and community safety. This category includes a broad range of components that significantly influence the health status of individuals and communities. Notably, the level of income can be viewed as the fundamental metric in that greater health risks and outcomes (i.e. food security, obesity) are associated with lower income levels in comparison to those from a higher socioeconomic group.

Percentage of Children Living Below Poverty Level

The rate of children living below poverty level for Erie County is higher than New York State. The Niagara County rate is slightly lower than the percentage of children in New York overall. Both the state and Erie and Niagara County are higher than the national child poverty rates. According to the 2019 U.S. Census Poverty Data, the child poverty rate in the U.S. is 14.4 percent or nearly 1 in 7 children.

	NEW YORK STATE	ERIE COUNTY	NIAGARA COUNTY
Percentage of People under 18 Living in Poverty	17	18	15

Limited Access to Healthy Foods

Access to healthy foods is correlated to the availability of a grocery store in the New York Prevention Agenda Dashboard. Access is measured by the percentage of population who are low-income and do not live near a grocery store. Low access is defined as greater than one mile from a supermarket or grocery store in urban areas or greater than 10 miles for rural areas. The rate for both Erie and Niagara counties is higher than New York State.

	NEW YORK STATE	ERIE COUNTY	NIAGARA COUNTY
Percentage of population who are low-income and do not live close to a grocery store	2	6	5



Violent Crime

The rate for both Erie and Niagara counties is higher than New York State overall when excluding New York City. Only one county, Schenectady, is higher than Erie County. Schenectady has a rate of 429. Erie County and Niagara County rank at #2 and #3 respectively for violent crimes in New York State, excluding New York City.

	NEW YORK STATE	ERIE COUNTY	NIAGARA COUNTY
Number of reported violent crime offenses per 100,000 population	379	428	395

Policy Environment

Policy changes have the opportunity to impact a multitude of factors that directly affect the health of the community across every sector. County and City Government representatives seek opportunities to change the environment and resources of our geographic locations in order to retain and attract new businesses. Partnerships with the many trade and academic institutions in the region have provided a workforce development focus. The global pandemic has identified and exacerbated equity issues in both Erie and Niagara counties. This heightened awareness has resulted in multiple collaborative efforts among partners in each county to address and support changes to facilitate actions to meet gaps and resources needed by the community. The communities in each county have also responded by supporting neighbors, neighborhoods and the community overall by advocating and taking positive steps to improve or support each other during times of significant stress and violence.

Other Unique Characteristics

Erie and Niagara counties both have highly ranked academic institutions and quaint villages and areas that are walkable destinations.

Over the past decade Erie County has experienced what many have described as a type of Renaissance which has resulted in positive and negative influences within the region related to demographic and socioeconomic factors. Erie County is home to multiple cultural centers and professional sports teams which offer opportunities for diverse experiences and interaction. For example, the Buffalo sports organizations and players are often present and engaged in the local communities to support grassroots efforts around health and wellness.

3. Assets and Resources to Address Health Issues Identified

Community Resources

Erie County Hospitals

1. Catholic Health

- Kenmore Mercy Hospital
- Mercy Hospital of Buffalo
- Sisters of Charity Hospital
- Sisters of Charity Hospital, St. Joseph Campus

2. Kaleida Health

- Buffalo General Medical Center
- Gates Vascular Institute
- Millard Fillmore Suburban Hospital
- Oishei Children's Hospital

3. Erie County Medical Center

4. BryLin Hospital – Inpatient Mental Health Care

5. VA Western New York Healthcare System

6. Roswell Park Comprehensive Cancer Center

Erie County Departments & Agencies

- Buffalo and Erie County Public Library
- Environment and Planning
- Erie County Department of Health
 - COVID-19
 - Opioids and Other Substances
 - Clinics and Health Care Services
 - Community Wellness, Disease Control and Prevention
 - Environmental Health
 - Emergency Medical Services (EMS) & Public Health Preparedness
 - Health Equity
 - Curbside Care
- Senior Services
- Social Services

Erie County Women, Infants and Children (WIC) Program

Catholic Charities of WNY

Buffalo Niagara American Heart Association

Population Health Collaborative

Cornell Cooperative Extension (CCE) – Department of Agriculture and Markets

FeedMore WNY (Western New York)

211 of WNY – Get Connected. Get Help.

United Way of Buffalo & Erie County

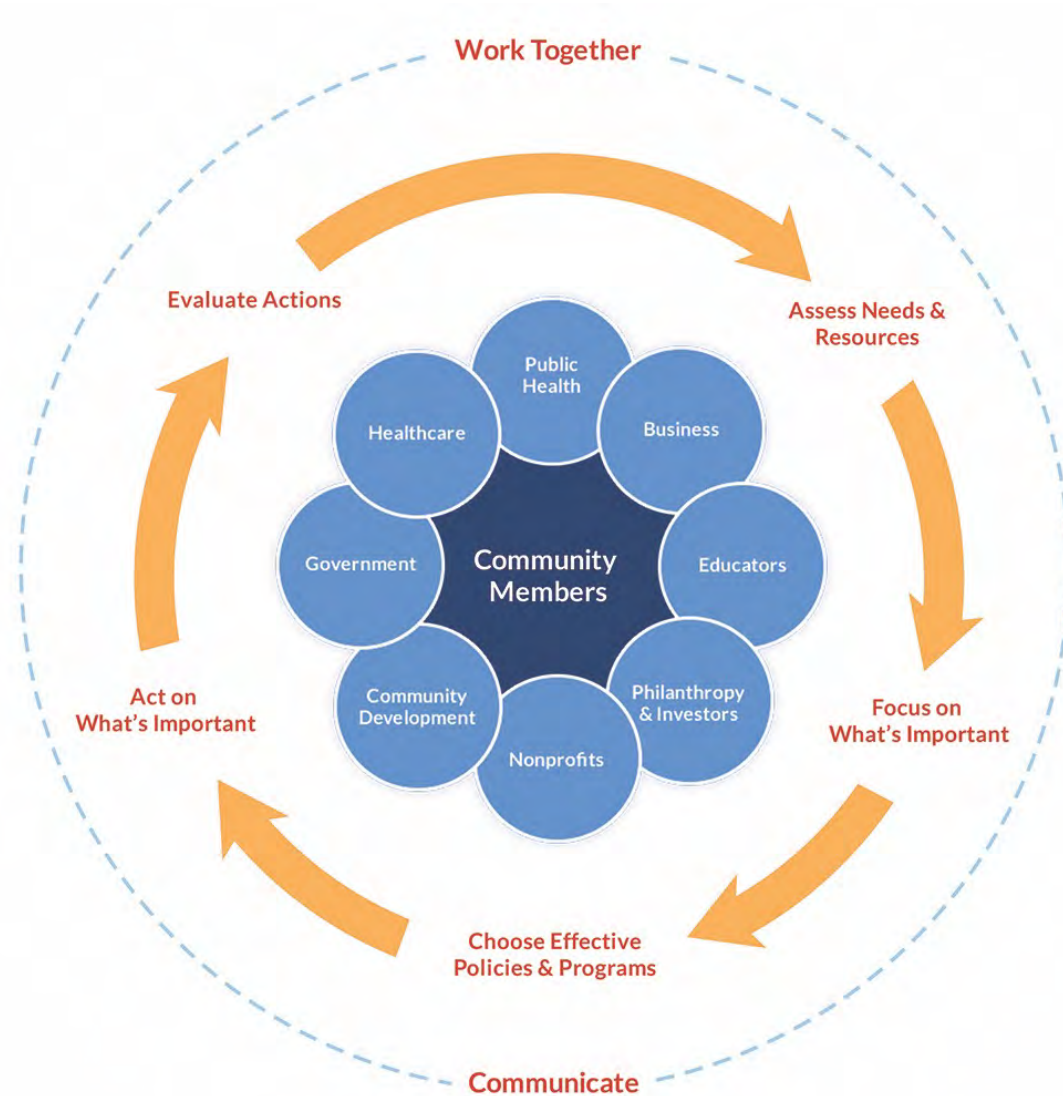
Buffalo Prenatal Perinatal Network

Colleges & Universities

- Bryant & Stratton College
- Canisius College
- D'Youville University
- Daemen University
- Erie County Community College
- Medaille College Buffalo Campus
- Niagara University
- SUNY Buffalo State College
- Trocaire College
- University at Buffalo

Process and Methods Used to Conduct Community Health Needs Assessment

The Community Health Needs Assessment is guided by a process that is outlined in The New York State Prevention Agenda 2019-2024. As seen in the County Health Rankings' Take Action Cycle model below, the overall objective is to work together to improve health.



Source: University of Wisconsin Population Health Institute.

County Health Rankings & Roadmaps 2022. www.countyhealthrankings.org.

The Steering Committee members collaborated to implement a comprehensive Community Health Needs Assessment (CHNA) process focused on strengthening 2019-2021 priorities while identifying and defining any changes in significant health needs. The six-month process centered on gathering and analyzing data as well as receiving input from people who represented the broad interests of the community to provide focus for the community and hospitals to create a plan to continue improving the health of our communities. Below is a summary of the process and methods used.

- Erie County Health Department – Assessed resources and determined that they would extend the 2019-2021 Priorities for the 2022-2024 cycle due to the COVID-19 pandemic.
- CHNA/CHIP Steering Committee – Monthly meetings held starting in December of 2021. Delayed start due to resource allocation resulting from the global COVID-19 pandemic.
- Consumer survey December 2021 through April 2022 – 1394 respondents, reviewed by zip code to ensure equitable geographic input.
- Focus Groups – March 2022
 - Professional Key Stakeholder Conversations – Three held with total of 16 participants.
 - Community Conversations – Five held, two of which were face-to-face with social distancing, facilitated by Erie County Health Department Staff as part of existing community groups.
- Findings of surveys and focus groups were compiled and reviewed by the Steering Committee which is comprised of the hospitals, county representatives and other community organizations, each of which disseminated results to their networks, county contacts, and other organizations. The results continue to be shared with county and community leaders as the county works to support residents during this unprecedented time.
- Catholic Health CHNA Summit – June 13, 2022. Health system clinical and non-clinical leaders were invited to review and approve priorities identified through above processes.
- Catholic Health Board Strategic Planning Committee Meeting – July 11, 2022. The overall CHNA/CHIP process was highlighted and the selected health priorities were presented.
- Catholic Health Mission Integration Committee – September 7, 2022. The 2022-2024 health priorities and initiatives were presented and the reporting dashboard was discussed.
- Catholic Health Ministry Services Board Meeting – November 17, 2022. The CHNA reports and CHIP for each of the hospitals were presented and approved by the board members.
- Catholic Health Board of Directors were informed of the Ministry Services Board’s approval of the 2022-2024 CHNA reports and CHIP during the December 1, 2022 Board of Directors meeting.
- All reports have been published electronically on the Catholic Health website (chsbuffalo.org) with hard copies available upon request from the Catholic Health Mission Integration office.

D. Community Health Improvement Plan

1. Identification of Priorities

Catholic Health 2022-2024 Prevention Agenda Priorities

1. Prevent Chronic Disease (addressing the disparity of poverty)
 - Healthy Eating and Food Security*
2. Promote Well-Being and Prevent Mental and Substance Use Disorders
 - Prevent opioid and other substance misuse and deaths*
3. Promote Healthy Women, Infants, and Children
 - Reduce infant mortality and morbidity**

*Aligns with Erie County Prevention Agenda Priority Area

**Disparity and Health Equity Focus Priority

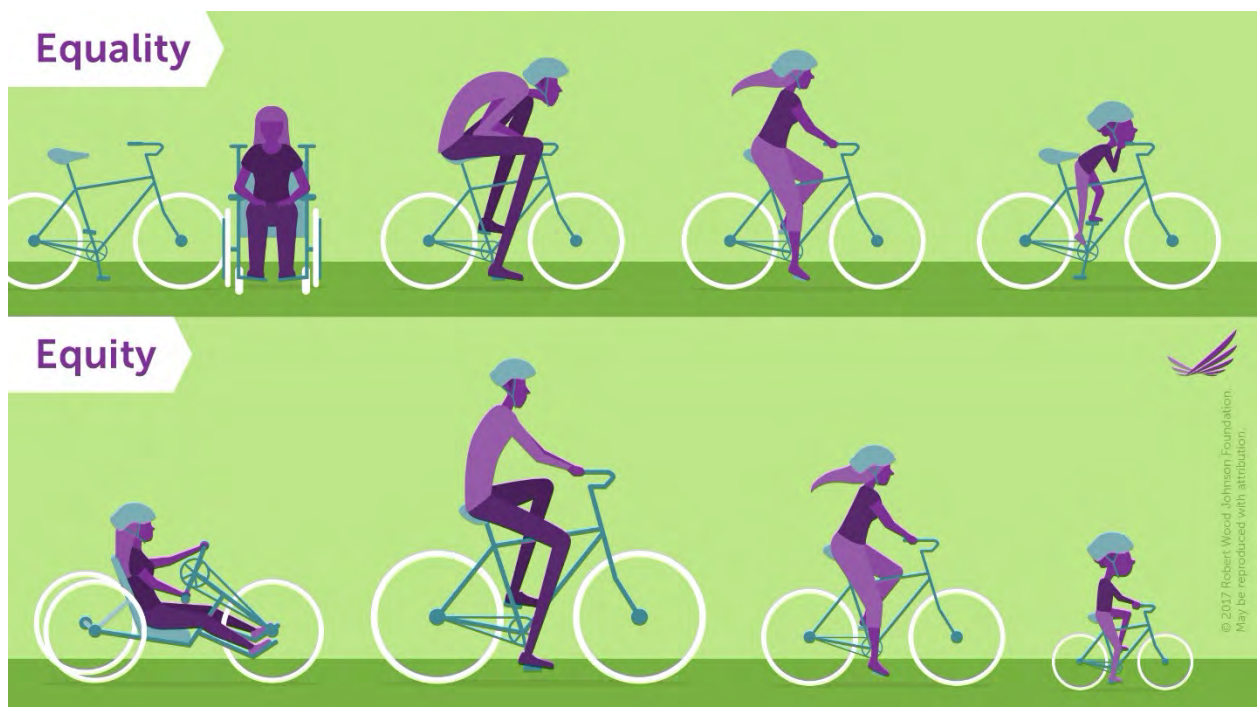
Description of the Community Engagement Process

- Due to the ongoing global COVID-19 Pandemic and its impact on the community and county operations, the Erie County Health Department announced it would continue to focus on the priorities that were identified in 2019-2021. These priorities include Prevent Chronic Disease and Promote Well-Being and Prevent Mental and Substance Use Disorders. Insights gained from the community survey results, as well as the community and stakeholder conversations, were reviewed by the CHA/CHIP Steering Committee. The recommendations were shared related to opportunities for updates to existing initiatives. The results continue to be shared with county and community leaders as the county works to support residents during this unprecedented time.
- From December through April 2022, residents of Erie County were invited to submit their responses to the CHA/CHIP Steering Committee's 2022 Erie County Community Health Needs Assessment. Catholic Health, the Erie County Health Department, and the other local hospital system and community organizations sought input from persons who represented the broad interests of the community. A total of 1,394 surveys were completed. Survey promotion was done by word of mouth, email, and social media. All promotion materials included a QR code a link to facilitate online survey completion. Paper surveys were also made available upon request in multiple settings and locations throughout the county.
- Five Community Conversations were held in March 2022. Three of the sessions were held via Zoom and open to the public. Two sessions were face to face. They were added to the agendas of existing community groups that Erie County Health Department staff assist in facilitating. Participants provided input into their perceptions on access to care and greatest health concerns.
- Three Professional Key Stakeholder Conversations were held late February/early March via Zoom during which a total of 16 participants shared their insights to four themes: Access to Care including Social Determinants of Health (SDOH), Care Coordination and Navigation, COVID-19 Pandemic, and Community Based Organizations.

Process and Criteria Used to Identify Priorities

- Eighteen people representing fifteen organizations collaborated to assess the input and responses from the Community Health Needs Assessment to understand the current priorities. The group was focused on identifying, validating, and defining significant health needs, issues, and concerns of Erie County.
- After review of the Community Health Needs Assessment survey results, Community Conversations, and Professional Key Stakeholder Conversations as well as the input of the Erie County Health Department and their recommendation to continue to focus on existing priorities, Catholic Health leaders identified the following New York State Prevention Agenda Priorities for the 2022-2024 Catholic Health Community Health Improvement Plan.
- The priority areas selected include Prevent Chronic Disease and Promote Well-Being, Prevent Mental and Substance Use Disorders as well as Promote Healthy Women, Infants, and Children.
- Catholic Health and Erie County are aligned on two priorities as required by the state. The two shared Prevention Agenda Priorities for 2022-2024 are the Prevention of Chronic Disease and the Prevention of Mental and Substance Use Disorders.
- The Catholic Health Maternity Team identified exclusive breastfeeding as a Prevention Priority based on their review of health system and county data. This priority area also reflects a disparity in the exclusivity by ethnicity reported by the New York Prevention Agenda Dashboard. Catholic Health will identify strategies that focus on how to improve ethnicity disparities and promote health equity related to exclusive breastfeeding with a focus on implicit bias staff training.

Health Equity: Fair and Just Opportunity for All



Source: Robert Wood Johnson Foundation Achieving Health Equity

2. Work Plans - Objectives, Intervention Strategies, Disparity, Activities, Process Measures, and Time Frame Targets to Track Progress Through 2024

Priority #1 Prevent Chronic Disease – Healthy Eating and Food Security

FOCUS AREA 1: HEALTHY EATING AND FOOD SECURITY

GOAL

Goal 1.3 Increase food security

OBJECTIVES THROUGH 2024

Objective 1.13 Increase the percentage of adults with perceived food security (among all adults). (CH Erie County and CH Niagara County) *Common priority with Erie County Health Department and Niagara County Health Department.

Target 80.2%

Baseline 76.4% (Baseline Year 2016)

2019 (released 2/9/22) 80.6 *pre-COVID

Data Source BRFSS

Data Level State (by sex, age, race/ethnicity, income educational attainments, disability and region), county

% Food Insecurity by County

New York State 9% / Erie County 11% / Niagara County 12%

County Health Rankings 2022 (2019 data)

Year 1 (2022):	Year 2 (2023)	Year 3 (2024)
<p>1. Catholic Health Trinity Medical Offices with Epic will establish a baseline of % of patients who come through the clinic and have an assessment completed. (CH Erie County and CH Niagara County)</p> <p>2. D’Youville Food Pantry will serve 700 households in 2022. (CH Erie County)</p> <p>3. The Mercy Comprehensive Care Center (MCCC) will host monthly Food Bank Days. (CH Erie County)</p> <p>4. Maintain Free Food Giveaway Table at Mount St. Mary’s Neighborhood Health Center offering clients variety of donated items received from other community sources. (CH Niagara County)</p>	<p>1. Catholic Health Trinity Medical Offices with Epic will establish a 2023 goal in quarter 1 of 2023 for the % of patients who visit clinic and are assessed using baseline as a starting point. (CH Erie County and CH Niagara County)</p> <p>2. D’Youville Food Pantry - Increase number of households served by 5%. (CH Erie County)</p> <p>3. MCCC will host monthly Food Bank Days. (CH Erie County)</p> <p>4. Maintain Free Food Giveaway Table at Mount St. Mary’s Neighborhood Health Center offering clients variety of donated items received from other community sources. (CH Niagara County)</p>	<p>1. Catholic Health Trinity Medical Offices with Epic will continue to show positive trend in the % of patients who come through the clinic and have an assessment complete. (CH Erie County and CH Niagara County)</p> <p>2. D’Youville Food Pantry - Increase number of households served by 5%. (CH Erie County)</p> <p>3. MCCC will host monthly Food Bank Days. (CH Erie County)</p> <p>4. Maintain Free Food Giveaway Table at Mount St. Mary’s Neighborhood Health Center offering clients variety of donated items received from other community sources. (CH Niagara County)</p>

DISPARITIES

Socioeconomic

INTERVENTIONS

Intervention 1.0.6

Screen for food insecurity, facilitate and actively support referrals. Catholic Health medical offices utilize Epic to guide and capture patient SDOH screening for Food Security in provider offices. If a need is identified there are referral options available by geographic location selected by patient. (Erie County and Niagara County)

Catholic Health will support D'Youville Food Pantry in planning and promotion of the site (Opened October 2021). (Erie County)

MCCC will continue to host Food Bank Days. (Erie County)

Mount St. Mary's Neighborhood Health Center will continue to maintain the Free Food Giveaway Table so patients are able to take from available options as desired. (Niagara County)

Evidence Based Intervention Reference:

Andermann A. Screening for social determinants of health in clinical care: moving from the margins to the mainstream. *Public Health Rev.* 2018 Jun 22;39:19. doi: 10.1186/s40985-018-0094-7. PMID: 29977645; PMCID: PMC6014006.

Andermann A; CLEAR Collaboration. Taking action on the social determinants of health in clinical practice: a framework for health professionals. *CMAJ.* 2016 Dec 6;188(17-18):E474-E483. doi: 10.1503/cmaj.160177. Epub 2016 Aug 8. PMID: 27503870; PMCID: PMC5135524.

Bertmann F, Rogomentich K, Belarmino EH, Niles MT. The Food Bank and Food Pantries Help Food Insecure Participants Maintain Fruit and Vegetable Intake During COVID-19. *Front Nutr.* 2021 Aug 6;8:673158. doi: 10.3389/fnut.2021.673158. PMID: 34422877; PMCID: PMC8378669.

Ahmad NSS, Sulaiman N, Sabri MF. Food Insecurity: Is It a Threat to University Students' Well-Being and Success? *Int J Environ Res Public Health.* 2021 May 25;18(11):5627. doi: 10.3390/ijerph18115627. PMID: 34070321; PMCID: PMC8197461.

FAMILY OF MEASURES

Input Measures:

1. Data entry by care team during client rooming. (Erie County and Niagara County)
2. Referral to D'Youville Food Pantry per Epic Referral options.(Erie County)
3. Food Bank Days scheduled by MCCC. (Erie County)
4. Manager and Care Team members collect food donations for Food Giveaway Table. (Niagara County)

Output measures:

1. Percent of clients screened for Food Security in CH Trinity Medical Offices with Epic. (Erie County and Niagara County)
2. Number of client served at D'Youville Food Pantry. (Erie County)
3. Number of Food Bank Days at MCCC. (Erie County)
4. Availability of food on Food Giveaway Table at Mount St. Mary's Neighborhood Health Center. (Niagara County)

Intermediate Outcome:

1. Clients screened and provided appropriate community resources identified as nearest to client per Epic. (Erie County)
2. Increase seen in number of clients served.
3. Food Bank Days maintained at MCCC. (Erie County)
4. Food Giveaway table is available and stocked for client selection. (Niagara County)

BY DECEMBER 2023, WE WILL HAVE COMPLETED

Year 1 (2022)	Year 2 (2023)	Year 3 (2024)
<ol style="list-style-type: none">1. Establish Baseline. Monitor % screenings documented for Food Security in CH Trinity Medical Offices with Epic. Education, outreach and data review provided as needed. (Erie County and Niagara County)2. Maintain the number of Food Bank Days at MCCC. (Erie County)3. Establish Baseline. Monitor monthly the number of households served by D’Youville Food Pantry. (Erie County)4. Maintain Food Giveaway table at the Mount St. Mary’s Neighborhood Health Center. (Niagara County)	<ol style="list-style-type: none">1. Quarter 1. Establish goal for 2023 % increase in screenings for Food Security. (Erie County and Niagara County)2. Maintain at least the same the number of Food Bank Days at MCCC as held in 2022. (Erie County)3. Achieve targets for number of households served by D’Youville Food Pantry. (Erie County)4. Maintain Food Giveaway table at the Mount St. Mary’s Neighborhood Health Center. (Niagara County)	<ol style="list-style-type: none">1. Monitor % increase in screenings for Food Security for positive trending. (Erie County and Niagara County)2. Maintain at least the same the number of Food Bank Days at MCCC as held in 2023. (Erie County)3. Achieve targets for number of households served by D’Youville Food Pantry. (Erie County)4. Maintain Food Giveaway table at the Mount St. Mary’s Neighborhood Health Center. (Niagara County)

Implementation Partner

Social Services

Partner Role(s) and Resources

Feedmore WNY. Role is to partner with Catholic Health to further both our missions and serve those in need of nutritious food in our most vulnerable Erie and Niagara County communities.

Erie County Health Department provides leadership and support in coordinating, promoting, educating and engaging in food distribution activities coordinated by the county as well as other local community organizations.

Niagara County Health Department provides leadership and support in coordinating, promoting, educating and engaging in food distribution activities coordinated by the county as well as other local community organizations.

Priority #2 Promote Well-Being and Prevent Mental and Substance Use Disorders

FOCUS AREA 1: PROMOTE WELL-BEING

GOAL

Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages

Goal 2.2 Prevent opioid and other substance misuse and deaths

OBJECTIVES THROUGH 2024

1.1.1 Increase New York State's Opportunity Scores by 5% to 59.2%. (CH Erie County and CH Niagara County)

Target 59.2%

Baseline 56.4%

Baseline Year 2017

Data Source Child Trends and Opportunity Nation with data from Opportunity Index, American Community Survey

Data Level - County

Erie County - 55.7

Niagara County - 52.1

*Note - Prevention Agenda suggests using Health Score however that is not found as a unique metric on the Prevention Agenda Dashboard. The Opportunity Index Score Data Views "i" definition indicates it compiles a dimension level Opportunity Score which includes dimensions of includes Economy, Education, Health and Community.

DISPARITIES

Socioeconomic

INTERVENTIONS

Intervention 1.2.4

1.2.4 Use thoughtful messaging on mental illness and substance use: Expert opinion in messaging about Mental, Emotional, and Behavioral Health humanize the experiences and struggles of person living with disorders; highlight structural barriers; avoid blaming people for the disorder or associate disorders with violence.

Evidence Based Intervention Reference:

Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment Improvement Protocol (TIP) Series, No. 57.) Chapter 1, Trauma-Informed Care: A Sociocultural Perspective. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK207195/>

Purkey E, Patel R, Phillips SP. Trauma-informed care: Better care for everyone. Can Fam Physician. 2018 Mar;64(3):170-172. PMID: 29540379; PMCID: PMC5851387.

FAMILY OF MEASURES

Short-term Outcome - Plan educational offerings with UB School of Social Work.

Intermediate-term Outcome - Evaluations of program offered indicate associates rated program relevance to their role as high.

BY DECEMBER 2023, WE WILL HAVE COMPLETED

Year 1 (2022)	Year 2 (2023)	Year 3 (2024)
1. Planning and scheduling of programs with the UB School of Social Work.	1. 100% of eligible associates will have completed the Trauma Informed Care program presented by the UB School of Social Work.	1. New Clearview and Pathways associates will be required to complete available trauma-informed care program or training as part of onboarding.

IMPLEMENTATION PARTNER

College

PARTNER ROLE(S) AND RESOURCES

University of Buffalo School of Social Work will plan and facilitate training program for the Clearview care team.

Erie County Health Department provides leadership and support in coordinating, promoting, educating and engaging in mental health related activities coordinated by the county as well as other local community organizations.

Niagara County Health Department provides leadership and support in coordinating, promoting, educating and engaging in mental health related activities coordinated by the county as well as other local community organizations.

FOCUS AREA 2: PREVENT MENTAL AND SUBSTANCE USER DISORDERS

GOAL

Goal 2.2 Prevent opioid overdose deaths

OBJECTIVES THROUGH 2024

2.2.2 Increase the age-adjusted rate of patients who received at least one Buprenorphine prescription for opioid use disorder by 20% to 415.6 per 100,000 population. (CH Erie County and CH Niagara County)

*Common priority with Erie County Health Department and Niagara County Health Department.

Target 415.6 per 100,000

Baseline 346.3 per 100,000

Baseline Year - 2017

Data Source - PMP Registry

Data Level - County

Erie County - 765.0 (2020)

Niagara County - 1374.4 (2020)

DISPARITIES

Health Care

INTERVENTIONS

Intervention 2.2.1

Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine.

Evidence Based Intervention Reference:

Mackey K, Veazie S, Anderson J, Bourne D, Peterson K. Barriers and Facilitators to the Use of Medications for Opioid Use Disorder: a Rapid Review. *J Gen Intern Med.* 2020 Dec;35(Suppl 3):954-963. doi: 10.1007/s11606-020-06257-4. Epub 2020 Nov 3. PMID: 33145687; PMCID: PMC7728943.

FAMILY OF MEASURES

Input Measure - Clearview Director plans and implements processes to support new regulation.

Output Measure - New processes operationalized to support referral prior to discharge and referral rate prior to discharged is tracked.

BY DECEMBER 2023, WE WILL HAVE COMPLETED

Year 1 (2022)	Year 2 (2023)	Year 3 (2024)
Develop and implement process to refer Clearview inpatients to Pathways Methadone outpatient program prior to discharge per new state regulation. Proposed state regulation 815s, Patient Rights regulation requires that inpatient program have agreement with a methadone provider to initiate use of methadone while patient is still inpatient.	Initiate at least 75% of Clearview inpatients that are referred to the Pathways Methadone outpatient program prior to discharge from Clearview residential program at St. Joseph (when opens) or Mount St. Mary's Clearview.	Increase to 80% are referred in 2024.

IMPLEMENTATION PARTNER

Hospital

PARTNER ROLE(S) AND RESOURCES

Pathways program will partner with Catholic Health Inpatient program to implement referral process.

Erie County Health Department provides leadership and support in coordinating, promoting, educating and engaging in mental health related activities coordinated by the county as well as other local community organizations.

Niagara County Health Department provides leadership and support in coordinating, promoting, educating and engaging in mental health related activities coordinated by the county as well as other local community organizations.

FOCUS AREA 2: PREVENT MENTAL AND SUBSTANCE USER DISORDERS

GOAL

Goal 2.2 Prevent opioid overdose deaths

OBJECTIVES THROUGH 2024

2.2.2 Increase the age-adjusted rate of patients who received at least one Buprenorphine prescription for opioid use disorder by 20% to 415.6 per 100,000 population. (CH Erie County)

*Common priority with Erie County Health Department.

Target 415.6 per 100,000

Baseline 346.3 per 100,000

Baseline Year - 2017

Data Source - PMP Registry

Data Level - County

Erie County - 765.0 (2020)

DISPARITIES

Health Care

INTERVENTIONS

Intervention 2.2.1

Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine.

Evidence Based Intervention Reference:

Mackey K, Veazie S, Anderson J, Bourne D, Peterson K. Barriers and Facilitators to the Use of Medications for Opioid Use Disorder: a Rapid Review. J Gen Intern Med. 2020 Dec;35(Suppl 3):954-963. doi: 10.1007/s11606-020-06257-4. Epub 2020 Nov 3. PMID: 33145687; PMCID: PMC7728943.

FAMILY OF MEASURES

Input Measure - CON granted for construction.

Short-term Outcome - initiation of build out of treatment beds at St. Joseph.

Long-term Outcome - completion of build out of treatment beds at St. Joseph by the end of 2023.

BY DECEMBER 2023, WE WILL HAVE COMPLETED

Year 1 (2022)	Year 2 (2023)	Year 3 (2024)
1. State approval for construction.	1. Catholic Health will increase the number of available treatment beds by 40 in the Erie/Niagara County region by the end of 2023.	1. New unit open and admitting patients.

IMPLEMENTATION PARTNER

Providers

PARTNER ROLE(S) AND RESOURCES

Providers and care team to support patients seeking MAT treatment from Catholic Health.

Erie County Health Department provides leadership and support in coordinating, promoting, educating and engaging in mental health related activities coordinated by the county as well as other local community organizations.

Niagara County Health Department provides leadership and support in coordinating, promoting, educating and engaging in mental health related activities coordinated by the county as well as other local community organizations.

Priority #3 Promote Healthy Women, Infants and Children

FOCUS AREA 1. MATERNAL & WOMEN'S HEALTH

GOAL

Goal 1.2: Reduce Maternal Mortality and Morbidity

OBJECTIVES THROUGH 2024

By December 31, 2024

Objective 2.1.1 Decrease the maternal mortality rate by 22% to 16.0 maternal deaths per 100,000 live births. (CH Erie County and CH Niagara County)

Target 16.0

Baseline 20.4

Baseline Year 2014-2016

Data Source NYS Vital Statistics

Data Level - State, Region, County

State 2019 19.3

Erie County 2019 -13.6 *(4)

Niagara County 2019 -31.8* (2)

*County rates unstable due to fewer than 10 deaths

Objective 2.1.2 Decrease the percentage of births that are preterm by 5% to 8.3 percent of live births. (CH Erie County and CH Niagara County)

Target 8.3

Baseline 8.7

Baseline Year 2015

Data Source Vital Statistics

Data Level State, Region, County

Erie County 2019 - 10.1

Niagara County 2019 - 9.8

DISPARITIES

Socioeconomic

INTERVENTIONS

Intervention 2.1.2

Increase the capacity and competencies of local maternal and infant home visiting programs

Evidence Based Intervention Reference:

<chrome-extension://efaidnbmninnibpcajpcglclefindmkaj/https://www.nursefamilypartnership.org/wp-content/uploads/2022/03/NFP-Research-Trials-and-Outcomes.pdf>

Miller TR. Projected Outcomes of Nurse-Family Partnership Home Visitation During 1996-2013, USA. *Prev Sci.* 2015 Aug;16(6):765-77. doi: 10.1007/s11121-015-0572-9. PMID: 26076883; PMCID: PMC4512284.

<https://www.nursefamilypartnership.org/wp-content/uploads/2020/07/NFP-NSO-M3-Response.pdf>

FAMILY OF MEASURES

Input Measures -

1. Positions posted and filled with support of Catholic Health Human Resources.
2. Provider offices detailed by NFP team to ensure providers and staff are aware of program and how to refer clients.

Intermediate Outcome - Client data is reviewed and reported to Nurse Family Partnership national office to validate outcomes are consistent with national program.

BY DECEMBER 2023, WE WILL HAVE COMPLETED

Year 1 (2022)	Year 2 (2023)	Year 3 (2024)
<ol style="list-style-type: none">1. With support of Human Resources all Catholic Health - Nurse Family Partnership positions filled. Current 4.5 and budgeted for 5.5.2. Data reviewed and uploaded to national NFP as requested.	<ol style="list-style-type: none">1. Catholic Health - Nurse Family Partnership Enrollment at full capacity of 138 clients.2. Data reviewed and uploaded to national NFP as requested.	<ol style="list-style-type: none">1. Catholic Health - Nurse Family Partnership Staffing ratio will be at 1 RN:25 clients.2. Data reviewed and uploaded to national NFP as requested.3. Review county and state Maternal Mortality Rates.4. Review county and state Preterm Birth percentages.

IMPLEMENTATION PARTNER

New York State Department of Health, Buffalo Prenatal-Perinatal Network, Health Families

PARTNER ROLE(S) AND RESOURCES

New York State Department of Health - MCVEY Funding

Erie County Health Department provides leadership and support in coordinating, promoting, educating and engaging in perinatal health related activities coordinated by the county as well as other local community organizations.

Niagara County Health Department provides leadership and support in coordinating, promoting, educating and engaging in perinatal health related activities coordinated by the county as well as other local community organizations.

FOCUS AREA 2. PERINATAL AND INFANT HEALTH

GOAL

Goal 2.2: Increase breastfeeding

OBJECTIVES THROUGH 2024

Objective 2.2.1.0: Increase the percentage of infants who are exclusively breastfed in the hospital by 10% from 47.0% (2016) to 51.7% among all infants. (CH Erie County and CH Niagara County)

2024 Target

NYS All 51.7%

Hispanic 37.4%

Black 38.4%

Baseline 47.0

Baseline Year 2016

Data Source - Vital Statistics

Data Level - State, Region, County

2019 Report (most recent)

Erie County

All 45.4%

Hispanic 30.9%

Black 28.2%

Niagara County

All 45.8%

Hispanic 30.8%

Black 30.2%

2021 Catholic Health Overall

All - 40.9%

Hispanic - 29.8%

Black - 25.3%

Sisters of Charity

All - 39.7%

Hispanic - 28.7%

Black - 24.6%

Mercy Hospital

All - 44.2%

Hispanic - 33.3%

Black - 28.2%

Mount St. Mary's

All - 35.1%

Hispanic - 27.2%

Black - 28.1%

DISPARITIES

Race

All

Hispanic

Black, Non-Hispanic

INTERVENTIONS

Intervention 2.2.1: Increase access to professional support, peer support, and formal education to change behavior and outcomes.

Evidence Based Intervention Reference:

Hall WJ, Chapman MV, Lee KM, Merino YM, Thomas TW, Payne BK, Eng E, Day SH, Coyne-Beasley T. Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. *Am J Public Health*. 2015 Dec;105(12):e60-76. doi: 10.2105/AJPH.2015.302903. Epub 2015 Oct 15. PMID: 26469668; PMCID: PMC4638275.

Interventions targeting implicit attitudes among health care professionals are needed because implicit bias may contribute to health disparities for people of color.

March of Dimes Implicit Bias Training: Awareness to Action: Dismantling Bias in Maternal and Infant Healthcare™ <https://www.aha.org/march-dimes-implicit-bias-training>

Training alone won't lead to immediate improvements in racial and ethnic disparities, but it can provide health care providers with important insights to recognize and remedy implicit bias. These actions can result in improved patient-provider communication, overall patient experience and quality of care, and a culture shift across committed organizations towards the broader goal of achieving equity for all moms and babies.

FAMILY OF MEASURES

Input Measures

1. Develop and offer implicit bias training/education/care focus for care team/cultural sensitivity based on leadership identified needs in each facility.

Output Measures -

1. Number of programs offered.
2. Number of care team associates that participate in program offered at each facility.
3. Exclusive breastfeeding rates at each facility and overall.

BY DECEMBER 2023, WE WILL HAVE COMPLETED

Year 1 (2022)	Year 2 (2023)	Year 3 (2024)
<ol style="list-style-type: none">1. Research and develop implicit bias training strategy for each of the maternity units.2. Identify goals for exclusive breastfeeding by ethnicity.3. Review policies and procedures to ensure reflect unit's focus on cultural sensitivity related to expectations for advocacy and support of exclusive breastfeeding.3. Schedule implicit bias training activities for Year 2.	<ol style="list-style-type: none">1. Implicit bias training activities made available to all maternity staff.2. Program Activities, Dates, and Attendance Numbers tracked for each unit.	<ol style="list-style-type: none">1. Monitor exclusive breastfeeding rates by facility and overall for Catholic Health.

IMPLEMENTATION PARTNER

Hospital

PARTNER ROLE(S) AND RESOURCES

Hospital maternity leaders will collaborate with care team, education department and the local and national resources to develop program or identify presenters to invite to facilitate programs for care team and providers practicing at each facility.

Erie County Health Department provides leadership and support in coordinating, promoting, educating and engaging in perinatal health related activities coordinated by the county as well as other local community organizations.

Niagara County Health Department provides leadership and support in coordinating, promoting, educating and engaging in perinatal health related activities coordinated by the county as well as other local community organizations.

3. Maintaining Engagement, Tracking Progress and Mid-Course Corrections

Catholic Health will continue to be an active partner in the CHA/CHIP Steering Committee. The Committee will continue to be convened regularly by the Erie County Health Department, at least annually. Catholic Health representatives are also engaged in a variety of local, regional, state, and national committees, as well as with organizations and other task force initiatives. Focuses for engagement include Prevention Agenda Priorities as well as other priority areas that are not specific to the 2022-2024 Community Health Improvement Plan but may be strategic initiatives to support the overall organization's mission and future. While the global pandemic and other recent organizational and community events have influenced many focuses, it has strengthened the organization's commitment to its overall mission of revealing the healing love of Jesus to all.

Progress towards the goals identified in the 2022-2024 Community Health Improvement Plan will be reviewed and measured using a variety of resources. Catholic Health will leverage access to data from the system wide Epic electronic medical record system when possible. Ongoing input from the community, CHA/CHIP partners, as well as Catholic Health associates will also be used to validate interventions and progress. Catholic Health's Mission Integration team will collect data and submit updates via the New York State Health Commerce System. The need for mid-course corrections will be monitored and discussed over the next three years as part of the organization's ongoing prioritization of continuous quality improvement. Updates will be documented and submitted per the state's documentation process.

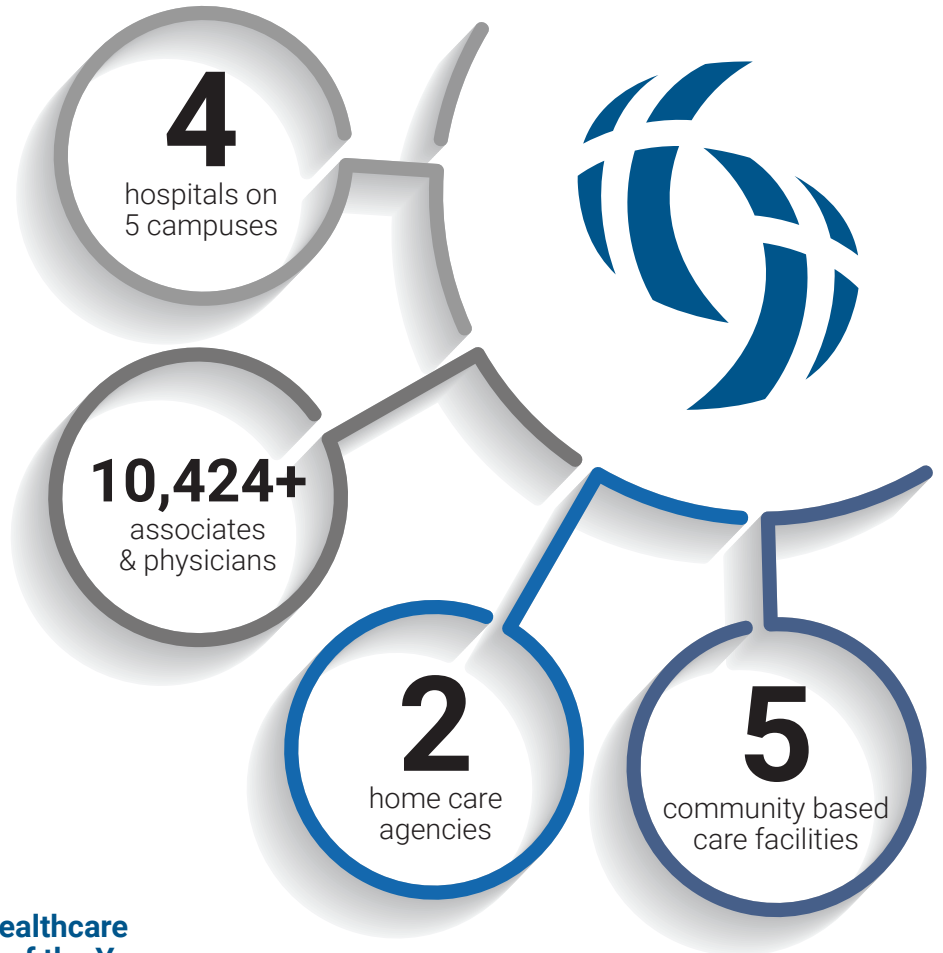
4. Dissemination of the Executive Summary and Community Health Improvement Plans

The 2022-2024 Catholic Health Needs Assessment and Community Health Improvement Plan for Erie County will be made widely available to the community via the Catholic Health System website (chsbuffalo.org). Paper copies may be requested at no charge by contacting Catholic Health attention: Mission Integration 144 Genesee Street, Buffalo, NY 14203.

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Catholic Health
the right way to care...



Five-Star Rated
Long Term Care facilities

Joint Commission Certified
for all hospitals

2020 Healthcare Company of the Year
in Western New York

Five-Star Rating
McAuley Seton Home Care for patient experience
(highest in WNY)



Catholic Health Locations



Hospitals & Emergency Care

Kenmore Mercy Hospital

2950 Elmwood Avenue
Kenmore, NY 14217
(716) 447-6100

Mercy Hospital of Buffalo

565 Abbott Road
Buffalo, NY 14220
(716) 826-7000

Mount St. Mary's Hospital

5300 Military Road
Lewiston, NY 14092
(716) 297-4800

Sisters of Charity Hospital

2157 Main Street
Buffalo, NY 14214
(716) 862-1000

Sisters of Charity Hospital, St. Joseph Campus

2605 Harlem Road
Cheektowaga, NY 14225
(716) 891-2400

Diagnostic & Testing Centers

Kenmore Medical Office Building

2914 Elmwood Avenue
Kenmore, NY 14217
(716) 447-6671

Mount St. Mary's Imaging & Lab Center

7300 Porter Road
Niagara Falls, NY 14304
(716) 298-8400

Mercy Ambulatory Care Center (MACC)

3669 Southwestern Boulevard
Orchard Park, NY 14127
(716) 662-0500

Mercy Diagnostic Center

94 Olean Street
East Aurora, NY 14052
(716) 655-2525

Mercy Diagnostic & Treatment Center

550 Orchard Park Road, Bldg. C
West Seneca, NY 14224
(716) 677-5000

Primary Care & OB/GYN Centers

Ken-Ton Family Care Center

2625 Delaware Avenue
Buffalo, NY 14216
(716) 447-6635

Mercy Comprehensive Care Center (MCCC)

397 Louisiana Street
Buffalo, NY 14204
(716) 847-6610

Mercy OB/GYN Center

515 Abbott Road, Suite 302
Buffalo, NY 14220
(716) 828-3520

Mount St. Mary's Center for Women

5300 Military Road
Lewiston, NY 14092
(716) 298-2224

Mount St. Mary's Primary Care Niagara Falls

5290 Military Road
Lewiston, NY 14092
(716) 298-3000

Mount St. Mary's Health Center Lockport

6000 Brockton Rd Suite 106
Lockport, NY 14094
(716) 342-3026

Mount St. Mary's Primary Care

1 Colomba Drive, Suite 2
Niagara Falls, NY 14305
(716) 298-8440

Mount St. Mary's Neighborhood Health Center

3101 9th Street
Niagara Falls, NY 14305
(716) 284-8917

M. Steven Piver, MD Center for Women's Health & Wellness
2121 Main Street, Suite 100
Buffalo, NY 14214
(716) 862-1965

OLV Family Care Center
227 Ridge Road
Lackawanna, NY 14218
(716) 822-5944

Sisters OB/GYN Center
2157 Main Street
Buffalo, NY 14214
(716) 862-1984

Sisters Health Center Caritas
2625 Harlem Rd Suite 160
Cheektowaga, NY 14225
(716) 862-2570

Sisters Health Center D'Youville
301 Connecticut St
Buffalo, NY 14213
(716) 862-1984

Springville OB/GYN Center
27 Franklin St
Springville, NY 14141
(716) 592-7400

St. Vincent Health Center
1500 Broadway Street
Buffalo, NY 14212
(716) 893-8550

Home & Community Based Care

McAuley Seton Home Care Erie County Office; Mercy Home Care of WNY; Nurse Family Partnership Program; Right Start Program; Health Home Program
144 Genesee Street
Buffalo, NY 14203
(716) 685-4870

McAuley Seton Home Care Niagara County Office
3571 Niagara Falls Blvd, Suite 10 (Meadowbrook Plaza)
North Tonawanda, NY 14120
(716) 433-2475

Catholic Health Infusion Pharmacy; Home Response Medical Alert System
6350 Transit Road
Depew NY, 14043
(716) 685-4870

LIFE – Living Independently for Elders (PACE Program)
OLV Senior Neighborhood
55 Melroy Avenue
Lackawanna, NY 14218
600 Doat Street
Buffalo, NY 14211
(716) 819-LIFE (5433)

St. Francis Park
5229 South Park Avenue
Hamburg, NY 14075
(716) 649-1205

Long-Term & Subacute Care

Father Baker Manor
6400 Powers Road
Orchard Park, NY 14127
(716) 667-0001

McAuley Residence
1503 Military Road
Kenmore, NY 14217
(716) 447-6600

Mercy Nursing Facility at OLV
55 Melroy Avenue
Lackawanna, NY 14218
(716) 819-5300

St. Catherine Labourè Health Care Center
2157 Main Street
Buffalo, NY 14214
(716) 862-1450

Administrative Services

Catholic Health Administrative & Regional Training Center (ARTC)
144 Genesee Street
Buffalo, NY 14203
(716) 923-9800



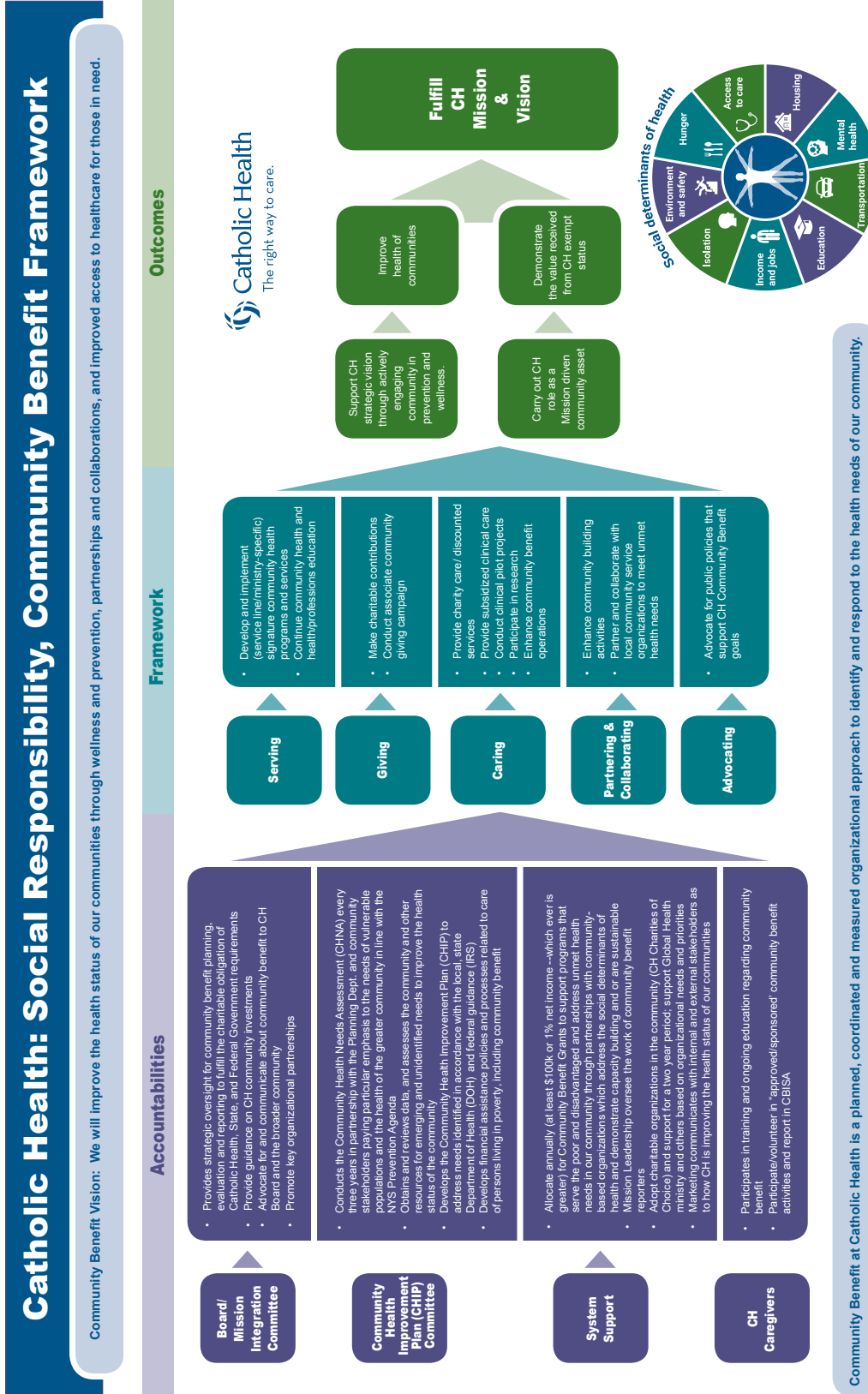
2022 Catholic Health Associate Community Involvement

- 11 Day Power Play
- Altus Managemnt / CRS Radiopharmaceutical
- American Red Cross
- Amherst Chamber of Commerce
- Antioch Missionary Baptist Church “
- Bar Association of Erie County, Volunteer Lawyers Project
- BSA (Troop 229G & Pack 816)
- Buffalo Prenatal Perinatal Network INC.
- Canopy of Neighbors
- Catholic Charities
- Catholic Daughters of the Americas
- Cheektowaga Senior Services
- Department of Family Services - Niagara Falls
- Diamonds in the Ruff Animal Rescue
- Diocese of Buffalo
- D’Youville College Governance Committee
- East Aurora Boys Volley Ball Boosters
- Ed Tech of WNY
- Empower
- Feed More WNY
- Fourteen Holy Helpers
- Franciscan Sisters of Saint Joseph
- Gerard Place
- Harvest House
- Health Association of NYS
- Healthcare Association of Western/Central NY
- Heart, Love and Soul Dining, Food Pantry, and Daybreak
- Holy Cross Church
- InTandem
- Juvenile Diabetes Research Foundation-JDRF
- Kappa Alpha Psi
- Lions Club of Hamburg
- Literacy Buffalo Niagara
- Little Portion Friary
- Make-A-Wish of WNY
- Masjid Al-Eiman and Islamic Cultural Association of WNY
- Nativity Miguel
- Near East and West Side (NEWS) Task Force
- Niagara Organizing Alliance for Hope
- Niagara River Region Chamber of Commerce
- Operation Home Front for Military Families
- Parish Nurse Ministries of NY, Inc
- Paws for Love, Erie County SPCA
- Pendleton Athletic Boosters Association
- People Inc
- Pinnacle Community Services
- Save the Michaels
- Sigma Pi Phi (Boule)
- Squeaky Wheel Film & Media Arts Center
- Stella Niagara Education Park
- St. Leo the Great RC Church
- St. Peter RC Church
- The Buffalo Zoo
- The Fellowship of God’s Word
- Trinidad Neighborhood Association
- Urban Christian Ministries
- Value Network Advisory Board
- Western New York Invention Convention
- WNY Church Unleashed/St. Paul’s Lutheran Church
- WNY Professional Nurses Association
- WNYNYON-NY Organization of Nursing Leaders
- Worldwide Community First Responders (WCFR)

Note: The above list reflects names of organizations associates reported involvement with as part of a 2022 survey coordinated by the Catholic Health Diversity, Equity and Inclusion Committee as well as organizations identified by associates and providers through the Catholic Health Community Benefit Occurrence Tracker system.



Catholic Health: Social Responsibility, Community Benefit Framework



Community Benefit at Catholic Health is a planned, coordinated and measured organizational approach to identify and respond to the health needs of our community.

September 3, 2019

Learn about
financial assistance at
Catholic Health



Healthcare Assistance Program

Catholic Health is proud of its mission
to provide care to all who need it.

Catholic Health's Healthcare Assistance Program (HAP) benefits in this brochure are effective January 1, 2007 and are subject to change. HAP does not apply to long-term and home care programs. Information in this brochure is also available online at chsbuffalo.org.



Catholic Health was founded in 1998 by four religious sponsors: the Diocese of Buffalo, the Daughters of Charity of St. Vincent dePaul, the Franciscan Sisters of St. Joseph, and the Sisters of Mercy.

Our Mission

We are called to reveal the healing love of Jesus to all.

Our 2025 Vision

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

We believe in the basic right to healthcare, with the responsibility to take care of the most vulnerable people in our community. Our Healthcare Assistance Program was created to make sure members of our community are able to receive the medical care they need regardless of what they can afford to pay.

Financial Aid Statement

If you do not have health insurance, or worry that you may not be able to pay in full for your care, we can help. Catholic Health hospitals provide healthcare assistance to patients based on their income and needs. We also may be able to help you with information/assistance with obtaining free or low-cost health coverage, or work with you to arrange a manageable payment plan.

It is important that you let us know if you will have trouble paying your bill. Federal and state laws require all hospitals to seek full payment for what they bill patients. This means we may have to turn unpaid or ignored bills over to a collection agency. We want to work with you to make sure this does not happen.

Catholic Health Healthcare Assistance

Call for more information about financial aid available at Catholic Health Hospitals, Primary Care, and Ambulatory Sites.

(716) 601-3600

Kenmore Mercy Hospital
2950 Elmwood Avenue, Kenmore, NY 14217

- Ken-Ton Family Care Center
- Kenmore Mercy Medical Office Building
- Kenmore Specialty Care Center

Mercy Hospital of Buffalo
565 Abbott Road, Buffalo, NY 14220

- Mercy Ambulatory Care Center
- Mercy Comprehensive Care Center
- Mercy Diagnostic Center - East Aurora
- Mercy Diagnostic & Treatment Center - West Seneca
- Mercy OB/GYN Center
- OLV Family Care Center
- Springville OB/GYN Center

Mount St. Mary's Hospital
5300 Military Road, Lewiston NY 14092

- Center for Women
- MSM Imaging and Laboratory Center
- MSM Neighborhood Health Center
- MSM Primary Care

Sisters of Charity Hospital
2157 Main Street, Buffalo NY 14214

- Sisters OB/GYN Center
- St. Vincent Health Center
- M. Steven Piver, MD Center for Women's Health and Wellness

Sisters, St. Joseph Campus
2605 Harlem Road, Cheektowaga, NY 14225



chsbuffalo.org



What is Catholic Health's Healthcare Assistance Program?

Healthcare Assistance is a program that allows people to receive medically necessary services at no charge or reduced charge, if they are eligible, at Catholic Health facilities. It is not an insurance program and does not replace benefits and payments that are, or could be, received from government programs that pay for care. Some of these programs include Medicaid and Exchange plans. HAP covers the cost of healthcare "forgiven" by Catholic Health hospitals and services for people who are unable (through private payment, employer payment, or public aid) to pay for healthcare services.

The HAP program does not apply to long-term and home care programs, however, other assistance is available. (For information on these other programs, refer to the Charity Care Policy located online at chsbuffalo.org).

Who Qualifies for Catholic Health Healthcare Assistance?

Catholic Health extends discounts to uninsured and underinsured patients who receive medically necessary services. Discount amounts are based on the Federal Poverty Level (FPL) guidelines and sliding income scales, and patients who qualify for financial assistance will not be financially responsible for more than the Medicaid discounted rate.

While Catholic Health primarily serves the five counties of Western New York, everyone in New York State who needs emergency services can receive care and get a discount if they do not have health insurance. Additionally, everyone in New York State can get a discount on non-emergency medically necessary services in Catholic Health Acute Care Facilities if they do not have health insurance. ***You will not be denied medically necessary care because you need financial assistance.*** You may apply for a discount regardless of immigration status.

What is NOT Covered?

Catholic Health's Healthcare Assistance Program (HAP) does have limits to what it will cover.

Please read the information below carefully.

- This program does NOT cover doctor fees even if that doctor's office is located at one of our hospitals. Only physician fees/services at our hospital-operated primary care sites listed in this brochure are covered.
- Cosmetic surgery is NOT covered.
- Charges for medical equipment and supplies are NOT covered.
- Physician services such as radiology, anesthesia, emergency room physicians, consulting visits, or any private provider are NOT covered. For these services you will need to make private/separate payment arrangements.

What Other Assistance is Available?

MEDICAID Medicaid is a program for New York State residents who cannot afford to pay for medical care. People may be covered by Medicaid if they have high medical bills, receive Supplemental Security Income (SSI), or if they meet certain income, resource, age or disability requirements.

For more information contact **1 (855) 355-5777** or go to nystateofhealth.ny.gov.

HEALTHCARE INSURANCE MARKETPLACE The Affordable Care Act (ACA) requires everyone legally living in the U.S. to have health insurance as of January 1, 2014. It also gives millions of individuals with too little or no insurance access to health plans at different cost levels. The law also provides financial assistance to those who qualify based on family size and income.

NEW YORK STATE OF HEALTH (Exchange Plans)

New York State of Health is a new Health Plan Marketplace. Individuals and families can use it to buy health insurance. It lets you shop and compare many health plans. It is the only place to get help lowering the cost of health insurance coverage.

For additional assistance call **1 (855) 355-5777** or go to nystateofhealth.ny.gov.

PRESCRIPTION DRUG COVERAGE

Elderly Pharmaceutical Insurance Coverage (EPIC) is a New York State sponsored prescription plan for senior citizens who need help paying for prescriptions. New York State residents can join EPIC if they are 65 or older and meet income requirements. EPIC members will be required to pay fees, deductibles, or co-payments. Seniors who receive full Medicaid benefits or have other prescription coverage that is better than EPIC are not eligible. EPIC will not pay for medication dispensed by a Catholic Health pharmacy.

To apply, call **1 (800) 332-3742**.



New York State Prevention Agenda 2019-2024: An Overview

Updated: April 27, 2021

The Prevention Agenda 2019-2024 is New York State's health improvement plan, the blueprint for state and local action to improve the health and well-being of all New Yorkers and promote health equity across populations who experience disparities. In partnership with more than 100 organizations across the state, the Prevention Agenda is updated by the New York State Public Health and Health Planning Council at the request of the Department of Health. This is the third cycle for this statewide initiative that started in 2008.

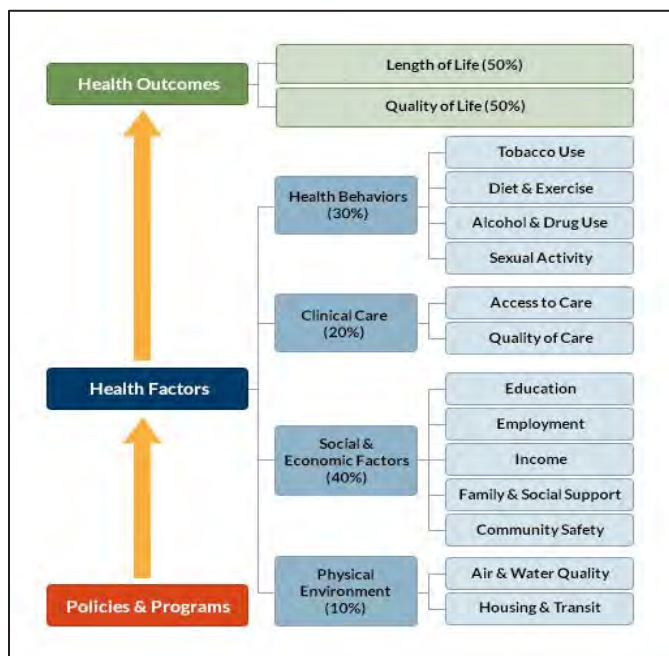
The vision of the Prevention Agenda for 2019-2024 is that New York is the Healthiest State in the Nation for People of All Ages. We are proud that, since 2008, New York has moved from the 28th to 10th healthiest state on America's Health Rankings,¹ demonstrating real progress toward achieving our vision.

The Prevention Agenda is based on a comprehensive statewide assessment of health status and health disparities, changing demographics, and the underlying causes of death and diseases. We used the County Health Rankings model (*Figure 1*) as the framework for understanding the modifiable determinants of health (without discounting the role of genetics).² New to this 2019-2024 cycle is the incorporation of a Health Across All Policies approach, initiated by New York State in 2017, which calls on all State agencies to identify and strengthen the ways that their policies and programs can have a positive impact on health. It embraces Healthy Aging to support the State's commitment to making New York the first age-friendly state. The 2019-2024 cycle also builds on the important experiences—both successes and challenges—of local

Prevention Agenda coalitions from across the state, who were formed in previous cycles of the Prevention Agenda to identify and address their local communities' health priorities.

The overarching strategy of the Prevention Agenda is to implement public health approaches that improve the health and well-being of entire populations and achieve health equity. This strategy includes an emphasis on social determinants of health – defined by Healthy People 2020 as the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Figure 1: County Health Rankings model © 2014 UWPHI



New York State Prevention Agenda 2019-2024: An Overview

continued

Such determinants include social and economic opportunities, education, safety in neighborhoods and communities, the quality of physical environments (e.g., the cleanliness of our water, food, air, and housing), and social interactions and relationships. Health behaviors and access to health care are also important (*Figure 2*).

Figure 2^{3,4}

Examples of Social Determinants

- Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- Access to educational, economic and job opportunities
- Access to health care services
- Quality of education and job training
- Availability of community-based resources that support healthy lifestyles and opportunities for recreational and leisure-time activities
- Transportation options
- Public safety
- Social support
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- Exposure to crime, violence, and social disorder (e.g., presence of trash, lack of cooperation in a community)
- Socioeconomic conditions (e.g., concentrated poverty and the accompanying stressful conditions)
- Residential segregation
- Language and literacy
- Access to mass media and emerging technologies (e.g., cell phones, the Internet and social media)
- Culture
- Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change)
- Built environment, such as buildings, sidewalks, bike lanes, and roads
- Worksites, schools, and recreational settings
- Housing and community design
- Exposure to toxic substances and other physical hazards
- Physical barriers, especially for people with disabilities
- Aesthetic elements (e.g., good lighting, trees, and benches)

The conditions in the environments where people live, work and play have a significant influence on health status and quality of life and are root causes of poor health and adverse outcomes. Changing these outcomes requires us to address collaboratively the social, economic, and physical conditions that contribute to poor health and well-being.

New York State Prevention Agenda 2019-2024: An Overview

continued

To achieve our vision, the Prevention Agenda calls for cross-sector partnerships (e.g., public health, health care, housing, education, and social services, etc.) to address social determinants of health across five key areas (*Figure 3*):

1. Economic Stability
2. Education
3. Social and Community Context
4. Health and Health Care
5. Neighborhood and Built Environment

especially by encouraging alignment of investments in primary prevention⁵ and using community and policy-level interventions to have widespread and lasting positive health impacts (*Figure 4*).

Figure 3: Social Determinants of Health



Figure 4: Social Ecological Model⁶



New York State Prevention Agenda 2019-2024: An Overview

continued

Process for Developing the Updated Prevention Agenda

Active participation and feedback from the Ad Hoc Committee to Lead the Prevention Agenda and stakeholders across the state were essential for updating the Prevention Agenda for 2019-2024. Many organizations were engaged in developing this updated plan, including local health departments, health care providers, community-based organizations, advocacy groups, academia, employers, schools, and businesses. These organizations reviewed the data on health status and emerging health issues, participated in finalizing the Cross-Cutting Principles (*Figure 5*), updated the list of priorities and developed priority-specific action plans.

Figure 5

Cross-Cutting Principles

To improve health outcomes, enable well-being, and promote equity across the lifespan, the Prevention Agenda:

- Focuses on addressing social determinants of health and reducing health disparities
- Incorporates a Health Across All Policies approach
- Emphasizes healthy aging across the lifespan
- Promotes community engagement and collaboration across sectors in the development and implementation of local plans
- Maximizes impact with evidence-based interventions for state and local action
- Advocates for increased investments in prevention from all sources
- Concentrates on primary and secondary prevention, rather than on health care design or reimbursement

The New York State Office of Mental Health and the New York State Office of Alcoholism and Substance Abuse Services have been core partners since 2013. New in this 2019-2024 cycle is the involvement of the New York State Office for the Aging and other State agencies in identifying specific interventions that they will implement to advance the Prevention Agenda in improving the health of individuals of all ages. These collaborations are the foundation of the 2019-2024 plan.

The Prevention Agenda 2019-2024 has five priorities with priority-specific action plans developed collaboratively with input from community stakeholders (*Figure 6*).

New York State Prevention Agenda 2019-2024: An Overview

continued

Figure 6: New York State Prevention Agenda 2019-2024 – Priority Areas, Focus Areas, and Goals

Priority Area: Prevent Chronic Diseases	Focus Area 1: Healthy Eating and Food Security
	Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 1.1: Increase access to healthy and affordable foods and beverages
	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices
	Goal 1.3: Increase food security
	Focus Area 2: Physical Activity
	Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
	Goal 2.2: Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities
	Goal 2.3: Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity
	Focus Area 3: Tobacco Prevention
	Goal 3.1: Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products (electronic cigarettes and similar devices) by youth and young adults
	Goal 3.2: Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low SES; frequent mental distress/substance use disorder; LGBT; and disability
	Goal 3.3: Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products
	Focus Area 4: Preventive Care and Management
	Goal 4.1: Increase cancer screening rates for breast, cervical, and colorectal cancer
Goal 4.2: Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	
Goal 4.3: Promote the use of evidence-based care to manage chronic diseases	
Goal 4.4: Improve self-management skills for individuals with chronic conditions	
Priority Area: Promote a Healthy and Safe Environment	Focus Area 1: Injuries, Violence and Occupational Health
	Goal 1.1: Reduce falls among vulnerable populations
	Goal 1.2: Reduce violence by targeting prevention programs particularly to highest risk populations
	Goal 1.3: Reduce occupational injuries and illness
	Goal 1.4: Reduce traffic related injuries for pedestrians and bicyclists
	Focus Area 2: Outdoor Air Quality
	Goal 2.1: Reduce exposure to outdoor air pollutants
	Focus Area 3: Built and Indoor Environments
	Goal 3.1: Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
	Goal 3.2: Promote healthy home and school environments
	Focus Area 4: Water Quality
	Goal 4.1: Protect water sources and ensure quality drinking water
	Goal 4.2: Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water
	Focus Area 5: Food and Consumer Products
	Goal 5.1: Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure
	Goal 5.2: Improve food safety management

New York State Prevention Agenda 2019-2024: An Overview

continued

Figure 6 Continued: New York State Prevention Agenda 2019-2024 – Priority Areas, Focus Areas, and Goals

Priority Area: Promote Healthy Women, Infants and Children	Focus Area 1: Maternal & Women’s Health
	Goal 1.1: Increase use of primary and preventive health care services by women of all ages, with a focus on women of reproductive age
	Goal 1.2: Reduce maternal mortality and morbidity
	Focus Area 2: Perinatal & Infant Health
	Goal 2.1: Reduce infant mortality and morbidity
	Goal 2.2: Increase breastfeeding
	Focus Area 3: Child & Adolescent Health
	Goal 3.1: Support and enhance children and adolescents’ social-emotional development and relationships
	Goal 3.2: Increase supports for children and youth with special health care needs
	Goal 3.3: Reduce dental caries among children
Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 4: Cross Cutting Healthy Women, Infants, & Children
	Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
	Focus Area 1: Promote Well-Being
	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan
	Goal 1.2: Facilitate supportive environments that promote respect and dignity for people of all ages
	Focus Area 2: Prevent Mental and Substance Use Disorders
	Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults
	Goal 2.2: Prevent opioid and other substance misuse and deaths
	Goal 2.3: Prevent and address adverse childhood experiences (ACEs)
	Goal 2.4: Reduce the prevalence of major depressive disorders
Goal 2.5: Prevent suicides	
Goal 2.6: Reduce the mortality gap between those living with serious mental illness and the general population	
Priority Area: Prevent Communicable Diseases	Focus Area 1: Vaccine-Preventable Diseases
	Goal 1.1: Improve vaccination rates
	Goal 1.2: Reduce vaccination coverage disparities
	Focus Area 2: Human Immunodeficiency Virus (HIV)
	Goal 2.1: Decrease HIV morbidity (new HIV diagnoses)
	Goal 2.2: Increase viral suppression
	Focus Area 3: Sexually Transmitted Infections (STIs)
	Goal 3.1: Reduce the annual rate of growth for STIs
	Focus Area 4: Hepatitis C Virus (HCV)
	Goal 4.1: Increase the number of persons treated for HCV
	Goal 4.2: Reduce the number of new HCV cases among people who inject drugs
	Focus Area 5: Antibiotic Resistance and Healthcare-Associated Infections
	Goal 5.1: Improve infection control in healthcare facilities
	Goal 5.2: Reduce infections caused by multidrug resistant organisms and <i>C. difficile</i>
	Goal 5.3: Reduce inappropriate antibiotic use

New York State Prevention Agenda 2019-2024: An Overview

continued

Each priority-specific action plan includes focus areas, goals, objectives, and measures for evidence-based interventions to track their impacts – including reductions in health disparities among racial, ethnic, and socioeconomic groups, age groups, and persons with disabilities. These objectives will be tracked on the New York State [Prevention Agenda Dashboard](#). The Prevention Agenda Action Plans provide communities with recommended evidence-based interventions, promising practices, and guidance to support implementation (e.g., by highlighting organizations that are well-positioned to take leading or supporting roles). The plans emphasize interventions that address social determinants of health, promote health equity across communities, and support healthy and active aging.

Implementing the five priority-specific action plans in the Prevention Agenda 2019-2024 will improve major cross-cutting health outcomes and reduce health disparities (*Figure 7*), as measured by the following indicators:

Figure 7: New York State Prevention Agenda 2019-2024 Cross-Cutting Objectives

Prevention Agenda (PA) Indicator	Baseline Year	Baseline	Prevention Agenda 2024 Objective	Percent Improvement from Baseline
Cross-Cutting Objectives to Improve Health Status and Reduce Health Disparities				
Percentage of premature deaths (before age 65 years)	2016	24	22.8	-5%
Difference in percentage (Black non-Hispanic and White non-Hispanic) of premature deaths	2016	18.2	17.3	-5%
Difference in percentage (Hispanic and White non-Hispanic) of premature deaths	2016	17.1	16.2	-5%
Preventable hospitalizations among adults, age-adjusted rate per 10,000	2016	121.1	115.0	-5%
Preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black non-Hispanics and White non-Hispanics	2016	98.9	94.0	-5%
Preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White non-Hispanics	2016	25.2	23.9	-5%
Percentage of adults (aged 18-64) with health insurance	2016	91.4	97.0	+ 6%
Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	2016	82.6	86.7	+ 5%

New York State Prevention Agenda 2019-2024: An Overview

continued

The Prevention Agenda aims to be a dynamic plan and a catalyst for action. Key to its success will be the alignment of efforts across State agencies, working with local governments and Prevention Agenda coalitions, and facilitating active community engagement. The Ad Hoc Committee will encourage its members and partners across the state to share effective strategies for improving community health. The Public Health and Health Planning Council will oversee implementation and use lessons learned to advance the Prevention Agenda.

References

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<https://www.americashealthrankings.org/about/methodology/our-reports>

² Our Methods. County Health Rankings and Roadmaps web site.

<http://www.countyhealthrankings.org/explore-health-rankings/our-methods>. Accessed November 2, 2018.

³ US Department of Health and Human Services. Healthy People 2020. Social Determinants of Health. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

⁴ Social Determinants of Health, 2nd Edition. M Marmot and R Wilkinson (eds). Oxford University Press, 2006.

⁵ NYS Department of Health Letter and Community Health Planning Guidance 2016-18

https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/letter_community_planning_guidance_2016_18.pdf

⁶ Social Ecological Model. Centers for Disease Control and Prevention web site. Updated January 28, 2013. <https://www.cdc.gov/cancer/nbccedp/sem.htm>. Accessed November 2, 2018.

Erie County Health Indicators by Race/Ethnicity, 2017-2019

Health Indicator	Non-Hispanic			Hispanic	Total
	White	Black	Asian/Pacific Islander		
Socio-Demographic Indicators					
Population (2018)	699,654	125,737	35,673	53,013	919,941
Percentage of population (2018)	76.1%	13.7%	3.9%	5.8%	100.0%
Median annual household income in US dollars (2015-2019) [~]	65,710	31,402	50,725	31,298	58,121
Percentage of families below poverty (2015-2019) [~]	5.4%	25.9%	25.8%	32.8%	9.8%
General Health Indicators					
Total mortality per 100,000 population, age-adjusted	744.7	968.0	343.5	629.7	768.6
Percentage of premature deaths (< 75 years)	35.8%	60.8%	50.8%	67.9%	39.8%
Years of potential life lost per 100,000 population, age-adjusted	6,007.1	11,434.9	2,219.3	7,389.3	6,824.7
Birth-Related Indicators					
Number of births per year (3 year average)	5,980	1,867	605	800	9,774
Percentage of births with early (1st trimester) prenatal care	85.0%	70.5%	71.6%	77.2%	79.9%
Percentage of births with adequate prenatal care (APNCU) [^]	80.0%	69.1%	71.4%	74.2%	76.3%
Percentage of premature births (< 37 weeks gestation - clinical estimate)	8.8%	13.8%	8.7%	13.8%	10.1%
Percentage of low birthweight births (< 2.5 kg)	6.9%	14.0%	8.2%	12.7%	8.8%
Teen pregnancies per 1,000 females aged under 18 years	1.7	13.7	1.8	9.2	5.5
Pregnancies per 1,000 females aged 15-44 years	56.6	98.2	66.1	82.7	76.7
Fertility per 1,000 females aged 15-44 years	48.2	66.8	62.6	62.3	55.6
Infant mortality per 1,000 live births	4.0	9.6	1.7*	9.6	5.6
Injury-Related Indicators					
Motor vehicle-related mortality per 100,000 population, age-adjusted	4.5	7.6	0.7*	6.3*	4.8
Unintentional injury mortality per 100,000 population, age-adjusted	43.9	47.3	6.5*	47.8	43.2
Unintentional injury hospitalizations per 10,000 population, age-adjusted	53.5	69.3	18.8	43.2	56.9
Fall hospitalizations per 10,000 population, aged 65+ years	198.3	132.9	56.5	109.6	191.4
Poisoning hospitalizations per 10,000 population, age-adjusted	7.1	13.3	1.5	7.2	8.0
Opioid burden per 100,000 population	244.9	177.2	13.2	272.9	242.0
Suicide mortality per 100,000 population, age-adjusted	12.3	5.8	3.5*	8.2	11.0

New York State Erie County Health Indicators Report by Race/Ethnicity 2017-2019

continued

Respiratory Disease Indicators					
Asthma hospitalizations per 10,000 population, age-adjusted	3.9	19.6	6.1	17.6	7.5
Asthma hospitalizations per 10,000 population, aged 0-17 years	9.0	39.0	14.0	32.8	17.5
Chronic lower respiratory disease mortality per 100,000 population, age-adjusted	38.8	38.4	9.7*	21.9	38.3
Chronic lower respiratory disease hospitalizations per 10,000 population, age-adjusted	17.1	52.7	13.7	33.7	23.0
Heart Disease and Stroke Indicators					
Diseases of the heart mortality per 100,000 population, age-adjusted	168.4	199.5	70.1	132.3	171.2
Diseases of the heart hospitalizations per 10,000 population, age-adjusted	75.5	141.8	45.4	92.5	84.8
Cerebrovascular disease (stroke) mortality per 100,000 population, age-adjusted	32.8	43.7	37.8	38.8	34.5
Cerebrovascular disease (stroke) hospitalizations per 10,000 population, age-adjusted	23.6	45.4	21.1	26.0	26.5
Coronary heart disease mortality per 100,000 population, age-adjusted	111.2	128.9	50.7	90.7	112.7
Coronary heart disease hospitalizations per 10,000 population, age-adjusted	23.1	29.7	19.2	30.7	24.9
Congestive heart failure mortality per 100,000 population, age-adjusted	18.3	17.3	8.2*	9.9*	18.1
Potentially preventable heart failure hospitalization rate per 10,000 population - Aged 18 years and older (2017-2018)	34.4	88.4	11.5	29.1	40.7
Diabetes Indicators					
Diabetes mortality per 100,000 population, age-adjusted	18.9	50.7	8.5*	29.1	22.7
Diabetes (primary diagnosis) hospitalizations per 10,000 population, age-adjusted	12.7	50.3	5.1	32.8	18.5
Diabetes (any diagnosis) hospitalizations per 10,000 population, age-adjusted	150.7	419.6	118.8	307.1	190.7
Potentially preventable diabetes short-term complications hospitalization rate per 10,000 population - Aged 18+ Years	4.9	23.2	2.4	11.7	7.6

New York State Erie County Health Indicators Report by Race/Ethnicity 2017-2019

continued

Cancer Indicators					
Lung cancer incidence per 100,000 population, age-adjusted (2016-2018)	71.3	81.0	29.0	45.4	71.1
Colorectal cancer mortality per 100,000 population, age-adjusted (2016-2018)	11.9	17.8	<u>s</u>	7.2*	12.4
Colorectal cancer incidence per 100,000 population, age-adjusted (2016-2018)	36.1	48.0	42.2	44.0	38.0
Female breast cancer mortality per 100,000 female population, age-adjusted (2016-2018)	21.7	34.1	<u>s</u>	<u>s</u>	23.0
Female late stage breast cancer incidence per 100,000 female population, age-adjusted (2016-2018)	41.3	62.9	34.1	42.7	43.4
Cervix uteri cancer mortality per 100,000 female population, age-adjusted (2016-2018)	1.7	3.0*	0.0*	<u>s</u>	1.9
Cervical cancer incidence per 100,000 female population, age-adjusted (2016-2018)	7.1	10.3	<u>s</u>	<u>s</u>	7.1

Symbol	Meaning
*	The rate or percentage is unstable. See the “About” page .
s	Data are suppressed. The data do not meet the criteria for confidentiality.
~	White non-Hispanic, Black (including Hispanic), Asian (including Hispanic, excluding Pacific Islanders), and Hispanic.
NA	Data do not meet the criteria for statistical reliability or data quality, or data not available.
^	APNCU: Adequacy of Prenatal Care Utilization Index.
	In 2015, SPARCS transitioned from ICD-9-CM to ICD-10-CM diagnosis codes. These two are not comparable, so ED and hospitalization data for 2016-and-forward should not be compared with earlier data.
	The 2018 population estimates are also used to calculate rates for 2019 and 2020.

Questions or comments phiginfo@health.ny.gov

Revised: March 2022

<https://www.health.ny.gov/statistics/community/minority/county/niagara.htm>

County Health Rankings and Roadmaps Compare Counties 2022 Rankings

The 2022 Rankings include deaths attributable to COVID-19 from 2020. See our FAQs for more information on COVID-specific data.

Compare Counties 2022 Rankings

	New York	Erie (ER), NY X	Niagara (NI), NY X
Health Outcomes			
Length of Life			
Premature Death	6,000	7,300	7,900
Quality of Life			
Poor or Fair Health**	16%	17%	17%
Poor Physical Health Days**	3.6	3.8	4.0
Poor Mental Health Days**	3.9	4.6	4.9
Low Birthweight	8%	9%	8%
Health Factors			
Health Behaviors			
Adult Smoking**	13%	18%	21%
Adult Obesity**	27%	32%	32%
Food Environment Index**	9.0	8.1	8.0
Physical Inactivity**	27%	25%	27%
Access to Exercise Opportunities	88%	93%	83%
Excessive Drinking**	19%	22%	21%
Alcohol-Impaired Driving Deaths	20%	22%	11%
Sexually Transmitted Infections**	640.6	598.2	449.2
Teen Births	13	16	18
Clinical Care			
Uninsured	6%	4%	4%
Primary Care Physicians	1,180:1	1,250:1	2,430:1
Dentists	1,190:1	1,170:1	1,950:1
Mental Health Providers	310:1	280:1	720:1
Preventable Hospital Stays	3,717	3,257	4,279
Mammography Screening	43%	44%	42%

County Health Rankings and Roadmaps Compare Counties 2022 Rankings

continued

	New York	Erie (ER), NY X	Niagara (NI), NY X
Flu Vaccinations	49%	46%	42%
Social & Economic Factors			
High School Completion	87%	92%	92%
Some College	70%	74%	69%
Unemployment**	10.0%	9.5%	10.4%
Children in Poverty	17%	18%	15%
Income Inequality	5.7	5.0	4.7
Children in Single-Parent Households	26%	29%	26%
Social Associations	8.1	10.1	10.0
Violent Crime**	379	428	395
Injury Deaths	53	71	71
Physical Environment			
Air Pollution - Particulate Matter	6.9	7.6	8.7
Drinking Water Violations		No	No
Severe Housing Problems	23%	15%	13%
Driving Alone to Work	52%	80%	83%
Long Commute - Driving Alone	39%	24%	32%

** Compare across states with caution

^ This measure should not be compared across states

Note: Blank values reflect unreliable or missing data

Community Survey 2022-2024 Erie County Community Health Assessment

1/21/22, 9:15 AM

Consumer Survey 2022-2024 Erie County Community Health Assessment

Consumer Survey 2022-2024 Erie County Community Health Assessment

The Erie County Department of Health is currently working with community partners to gather information from county residents to help with public health planning. We want to know what you think! Please take a few minutes to fill out this survey. Your responses will help us identify gaps in and barriers to services, as well as the health issues that are most concerning to county residents. We will take what we learn from you and use it to help create a Community Health Improvement Plan. This plan will be completed by December 2022 and will be used to guide our health efforts over the next three years.

Please be honest; we guarantee your identity will never be known or sought. Please take this survey only once.

Thank you for contributing to our efforts to improve the health of Erie County

* Required

Demographics

1. Are you an Erie County Resident? *

If you are not an Erie County resident please check with the Health Department in your county of residence if you are interested in contributing to their survey. Thank you for your interest in shaping our community health improvement plan.

Mark only one oval.

- Yes
- No (If no, please go no further)

2. Zip code where you live: *

3. What language(s) do you speak in your household?

Mark only one oval.

- English
- Spanish
- Arabic
- Urdu Hindi
- Tamil
- Bengali
- Swahili
- Chinese (including Mandarin & Cantonese)
- Italian
- French
- German
- Polish
- Russian
- Other _____

1/21/22, 9:15 AM

Consumer Survey 2022-2024 Erie County Community Health Assessment

4. Your age range:
Mark only one oval.

- 17 or under
- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75+
- Prefer not to answer

5. Gender
Mark only one oval.

- Male
- Female
- Transgender
- Non-binary
- Prefer not to answer
- Other: _____

6. Race/Ethnicity
Check all that apply.

- Native American or American Indian
- Hispanic or Latino
- Black or African American
- White
- Asian
- Native Hawaiian or Other Pacific Islander
- Prefer not to answer
- Other: _____

7. How many children live in your home aged 17 and under?
Please enter as a number (example 7).

1/21/22, 9:15 AM

Consumer Survey 2022-2024 Erie County Community Health Assessment

8. How many adults live in your home, including yourself, between age 18 and 64?
Please enter as a number (example 7)

9. What is the highest grade or year of school you have completed?
Mark only one oval.

- Less than 9th grade
- Some High School, No Diploma
- High School Graduate (or GED)
- Trade School/Apprenticeship
- Some College, No Degree
- Associate Degree
- Bachelor's Degree
- Master's Degree
- Doctorate Degree
- Professional School Degree
- Prefer not to answer
- Other: _____

10. Do you own or rent your home?
Choose only 1 Mark only one oval.

- Own
- Rent
- I do not have a stable address (homeless, stay with friends/family, live in a shelter or vehicle)
- Other: _____

11. Has the COVID-19 pandemic negatively impacted your employment and/or finances?
Mark only one oval.

- Yes
- No

12. For what period of time was your household able to access reliable, high speed internet when needed for work and/or school throughout the COVID-19 pandemic? Mark only one oval.

- I have not had internet access since before the pandemic
- The last month
- The last six months
- The last year
- The last year and a half
- The whole time
- Other

Community
Health Issues &
Information

We want to know what you think are most important issues related to health in your community, the health related issues you are interested in learning about and how you get your information

13. What five health issues in your community are you most concerned about? *

Please pick up to five.

Check all that apply.

- Alcohol Use/Abuse
- Arthritis
- Asthma
- Cancer
- Cannabis Use/Abuse
- Cholesterol
- Climate change
- COVID-19
- Dental care
- Depression
- Diabetes
- E-cigarettes/Vaping
- Heart disease
- High blood pressure
- HIV and AIDS
- Immunizations Injury
- Lack of primary care providers in your area
- Lead Issues
- Mental health
- Nutrition
- Obesity/overweight
- Opioid Use Disorder/Substance Use Disorder
- Physical activity
- Pollutants (air, water, soil quality)
- Safety
- Sexually transmitted diseases
- Suicide
- Tobacco/Cigarettes/Cigars
- Teen pregnancy
- Water Quality
- Violence
- Other _____

1/21/22, 9:15 AM

Consumer Survey 2022-2024 Erie County Community Health Assessment

14. What health topics are you interested in learning more about? *

Please pick up to five.

Check all that apply.

- Alcohol Use/Abuse
- Arthritis
- Asthma
- Cancer
- Cannabis Use/Abuse
- Cholesterol
- Climate change
- COVID-19
- Dental care
- Depression
- Diabetes
- E-cigarettes/Vaping
- Fertility
- Health Disparities/ Social Determinants of Health Heart disease
- High blood pressure
- HIV and AIDS
- Immunizations Injury
- Lead Issues
- Mental health
- Nutrition
- Obesity/overweight
- Opioid Use Disorder/Substance Use Disorder
- Physical activity
- Pollutants (air, water, soil quality)
- Safety
- Sexually transmitted diseases
- Suicide
- Tobacco/Cigarettes/Cigars
- Teen pregnancy
- Water Quality
- Wellness
- Violence

Other: _____

15. Where do you get most of your health information? *

Mark up to 3 choices

Check all that apply.

- Community Health Worker
- Community organization (Clubs, Community-centers)
- Continuing Education
- Doctor/Medical Provider/Primary Care Provider
- Faith-based organization
- Friends and Family
- Government
- Health Insurance Company
- Internet/websites
- Healthcare journals/peer-reviewed articles
- Library
- Newspaper/Magazine
- Peer Navigator
- School
- Seminars
- Social Media (Facebook, Twitter, Instagram, Tik Tok, etc.)
- Social Services
- Television (TV) or Radio
- WIC (Nutrition program for children and pregnant/nursing women) Workplace
-

Your Habits and Health

In this section we want to learn about behaviors associated with your individual health status.

Physical Activity

The following questions ask about your physical activity.

16. How often do you participate in physical activity or exercise? *

Mark only one oval.

- 5-7 times per week for at least 30 minutes each time
- 4 times per week for at least 30 minutes each time
- 3 times per week for at least 30 minutes each time
- I don't exercise regularly, but try to add physical activity when possible
- No physical activity or exercise beyond regular daily activities

17. Which, if any, of the following would help you become more active? * Mark all that apply.

- Transportation to the park
- Groups to participate
- Workshops/classes about exercise
- Safe place to walk or exercise (i.e. designated bike lanes, recreational paths, safe/accessible sidewalks)
- Individual instruction/personal trainer
- Information about exercise programs or gym memberships
- Discounts for exercise programs or gym memberships
- Workplace program or equipment
- A friend to exercise with
- Activities you can do with your children
- Access to free, virtual exercise classes
- None of the above

Other: _____

18. Please choose all statements below that apply to you: * Mark all that apply.

- I eat 5 servings of fruit and vegetables a day
- I have difficulty getting fruits and vegetables on a regular basis I don't
- know how to prepare/cook healthy foods
- I and/or my family doesn't like to eat most fruits and vegetables
- Within the past 12 months, we worried about whether our food would run out before we got money to buy more
- Within the past 12 months, the food we bought just didn't last and we didn't have money to get more
- None of the above

19. In the future, what might help you make healthy changes in your life? * Mark all that apply.

- Access to virtual and/or in person free workshops or classes in your community on exercise, diet, stress reduction, chronic disease management and/or quit smoking
- Being part of a support group that supports and encourages healthy habits (for example through your local church or YMCA)
- Getting more information from local newspapers and TV
- Getting reminders when you are due for certain tests (such as annual doctor visits)
- Having more trust/comfort with the medical system
- Having safe areas to exercise within your community
- Having more affordable fresh fruits and vegetables and/or healthy food choices available at local convenience stores
- Local hospitals and businesses offering free health screenings (blood pressure, diabetes, etc.)
- More affordable and accessible recreational and/or sports opportunities that are appropriate for your age and skill level
- Taking more time to talk with health care professionals (doctors, nurses, dieticians, counselors)
- Reliable and affordable transportation
- Incentives such as gift card, prize for participation or discounted service
- More free time
- Access to affordable childcare
- None of the Above

Substance Use

The following set of questions ask about your substance use. Please be truthful, your anonymity is guaranteed.

20. How many cigarettes have you smoked in the past 30 days? *

If you smoke tobacco other than cigarettes, please use the information provided to estimate.

Equivalency Chart	
Small cigar	1.5 cigarettes
Medium cigar	2 cigarettes
Large cigar	4 cigarettes
4 bowls of tobacco	10 cigarettes
8 bowls of tobacco	20 cigarettes

Mark only one oval.

- 0 cigarettes/I don't smoke
- Less than 5 cigarettes
- 5-10 cigarettes
- 11-20 cigarettes
- More than 20 cigarettes

21. During the past 30 days, did you use an electronic vapor product (Electronic vapor products include e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods.)? *Mark only one oval.

- Yes
- No

22. If you use nicotine products, are you aware of assistance available to you, if you want to quit? *
Mark only one oval.

- I do not use nicotine products
- Yes
- No
- Yes

23. During the past 30 days, on how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours? *

Mark only one oval.

- 0 days
- 1 day
- 2 days
- 3 to 5 days
- 6 to 9 days
- 10 to 19 days
- 20 or more days

24. During the past 30 days, what drugs have you used in excess? *

Please be truthful, your anonymity is guaranteed. Mark all that apply.

- I have not used drugs recreationally/in excess in the last 30 days
- Benzodiazepines (Anxiety medication, e.g. Xanax, Valium, Ativan)
- Cocaine/crack
- Club drugs (GHB, Molly, Ecstasy, etc.)
- Hallucinogens (psilocybin/mushrooms, LSD, dextromethorphan, salvia)
- Marijuana
- OTC Pain Killers (Tylenol, Motrin, Aspirin, other over the counter drugs)
- Stimulants including prescription drugs like Adderall or Illegal drugs like Methamphetamine
- Opioids including prescription drugs like Morphine, Suboxone, Methadone, Oxycontin, Lortabs, Fentanyl, Vicodin and others
- Opiates (Heroin, Opium)

Other: _____

25. If you chose Opiates or Opioids in the previous question, please indicate which ones you have used (prescription or illegal) Mark all that apply.

- I did not use opiates/opioids in excess during the last 30 days. Heroin/Opium
- Morphine
- Fentanyl
- Dilaudid
- Demerol
- Norco
- Vicodin
- Codeine
- Methadone
- Hydrocodone
- Oxycodone
- Lortab
- Percocet
- Opana
- Suboxone/Buprenorphin/Subsolve

Other: _____

Narcan The following questions ask about the medication Narcan(R) (naloxone)

26. Are you aware of what the medication Narcan(R) (naloxone) is? *

Mark only one oval.

- Yes
- No

27. Have you been trained to reverse an opioid overdose using Narcan(R) (naloxone)? *
Mark only one oval.
 Yes
 No *Skip to question 31*
28. Did your training program provide you with a Narcan(R) (naloxone) administration kit? *
Mark only one oval.
 Yes *Skip to question 32*
 No *Skip to question 32*
29. Would you be interested in being trained to administer Narcan(R) (naloxone)? *
Mark only one oval.
 Yes *Skip to question 32*
 No *Skip to question 32*
30. Have you ever administered Narcan(R) (naloxone)? *
Mark only one oval.
 Yes
 No

Health Care

The following questions are related to your health care.

31. Do any of the following affect your ability to receive health or health related services?
Mark all that apply.
- Mobility Disability
 - Intellectual and/or Developmental Disability
 - Visual Disability
 - Hearing Disability
 - Speech Disability
 - Hidden Disability (i.e. learning disability, psychiatric disability, mental health, chronic conditions)
 - Sensory Processing Disability
 - Chemical Sensitivities
 - Access to reliable transportation
 - Racism or discrimination
 - Language barriers
 - I have a hard time understanding information/instructions provided by my health care providers
 - Cost of services
 - Nothing affects my ability to receive health services
- Other: _____
32. Do you get your yearly flu shot? *
Mark only one oval.
 Yes
 No

33. Have you received your COVID-19 vaccination? *

Mark only one oval.

- Yes
- No *Skip to question 37*

34. Why did you get your COVID 19 vaccine?

Mark all that apply.

- Protect self and family
- Requirement for school, work, events
- Incentives
- Was advised to by healthcare provider
- Reduced risk of community spread

Skip to question 38

35. Why haven't you gotten your COVID vaccine?

Mark all that apply.

- Doctor/medical professional advised against it
- Don't trust the government/doctor/manufacturer
- I haven't had time to get it
- Not concerned about getting COVID-19
- Safety
- Personal/Religious beliefs
- Fertility/Pregnancy
- Side Effects
- I don't know what's in it

Other: _____

36. Where do you usually seek medical care? *

Mark only one oval.

- Primary Care Provider (Doctor, Physician's Assistant, Nurse Practitioner)
- Emergency Room
- Urgent Care (MASH, Immediate Care, etc.)
- Clinic
- OB/GYN
- Other: _____

37. Have you used virtual or telehealth services? *

Mark only one oval.

Yes

No *Skip to question 42*

I don't know what virtual or telehealth is *Skip to question 43*

38. Would you use virtual or telehealth again?

Mark only one oval.

Yes *Skip to question 43*

No

39. If you would not use virtual or telehealth again, please state your reason(s) below:

Skip to question 43

40. Why haven't you used virtual or telehealth?

Mark all that apply.

Never been offered

Don't know how to use it

I have concerns about privacy and the security of my information

I don't believe my doctor is able to get the information they need through a phone call

have not needed to use it

Other: _____

41. How often do you see your primary care provider (doctor/nurse practitioner/physician's assistant)? *

Mark only one oval.

Several times a year

Yearly checkup

Only when I'm sick

I don't go see my primary care provider

don't have a primary care provider

42. In the past two years, was there any time that you needed medical care but could not - or did not - get it? * *Mark only one oval.*

Yes

No *Skip to question 47*

43. If yes, how many times? *

44. What were the main reasons you did not get the medical care you needed? *

Check all that apply

- Had no health insurance/without health insurance, the cost of care was too high
- Care/Specialist needed was unavailable in the area where I live
- Could not get an appointment for a long time
- Could not get a referral to see a specialist
- Didn't know where to get the care I needed
- Don't like Doctors so I didn't go
- Health insurance does not cover the cost of needed care/co-pay is too expensive Hours
- They weren't open when I could get there
- Could not get time off from work
- Could not afford to lose pay for leaving for appointment. I did not have paid sick time. No
- one to watch my children
- Medical staff didn't speak my language
- Transportation - it was too hard to get there
- COVID 19 pandemic shut downs - no available doctors/health care providers
- COVID 19 pandemic - I was too afraid to go
- COVID 19 pandemic - I had COVID symptoms but no private vehicle to take me for testing

Other: _____

45. What type of health insurance, if any, do you have? *

Mark all that apply.

- No health insurance
- Private insurance from your (or spouse's or parent's) employer
- Medicaid
- Medicare
- Purchased by you directly from the insurance company (NYS Marketplace/Health Exchange)
- Child Health Plus
- Tribal Health Services/Insurance
- Health Care is covered by Veteran's Administration (VA)

Other: _____

General

The following questions ask about your general health.

46. How would you rate your overall health? *

Mark only one oval.

- Excellent
- Good
- Fair
- Poor

1/21/22, 9:15 AM

Consumer Survey 2022-2024 Erie County Community Health Assessment

47. Over the last 2 weeks, I've had little interest or pleasure in doing things. *
Mark only one oval.

- Not at all
- Several days
- More than half the days
- Nearly every day

48. Over the last 2 weeks, I've felt down, depressed, or hopeless.
Mark only one oval.

- Not at all
- Several days
- More than half the days
- Nearly every day

49. Have you or a household family member been diagnosed with cancer in the past five years?
*Mark only one oval.

- Yes
- No

50. Please indicate if you or a household family member have had one of these forms of cancer in your/their lifetime(s). *

Check all that apply.

- Prostate
- Cervical
- Breast
- Colorectal
- Lung
- N/A

51. Are you aware of the free services provided through the Erie County Cancer Services Program? * Mark only one oval.

- Yes
- No

52. If you have been diagnosed with high blood pressure by your health care provider is it currently well controlled? *
Mark only one oval.

- I have been diagnosed with high blood pressure and it is well controlled
- I have been diagnosed with high blood pressure and it is NOT controlled well
- I have been diagnosed with high blood pressure but I am not sure if it is controlled well
- I have NOT been diagnosed with high blood pressure

53. How often do you self-monitor your blood pressure? *

Mark only one oval.

- Daily
- Weekly
- Monthly
- Occasionally
- Never

54. If you have been diagnosed with high cholesterol by your health care provider, is it being effectively managed? (through exercise, diet and/or use of medications) *

Mark only one oval.

- I have NOT been diagnosed with high cholesterol
- Yes, it is being managed well
- No, it is not being managed well
- I am not sure if it is being managed well

55. Have you been diagnosed with Type 2 Diabetes?

Please choose which type, if any, of diabetes you have been diagnosed with
Mark only one oval.

- I have NOT been diagnosed with Diabetes. *Skip to question 60*
- Yes, I have been diagnosed with Type 2 Diabetes

56. Is your diabetes effectively managed?

Mark only one oval.

- Yes *Skip to question 60*
- No

57. What would help you better manage your Diabetes?

Maternal Health

The following questions ask about Maternal Health needs in our community.

58. Have you or your partner given birth in the past 2 years? *

Mark only one oval.

- Yes
- No *Skip to question 66*

59. At what point during you/your partner's pregnancy did you/your partner begin to receive regular prenatal care?

Choose only 1

- Never
- When the pregnancy was suspected and/or confirmed
- At 1-2 months of pregnancy
- At 3 - 4 months of pregnancy
- At 5 - 6 months of pregnancy
- At 7-8 months of pregnancy
- At 8 - 9 months of pregnancy
- Notsure

Other: _____

60. From whom did you or your partner receive prenatal care?

Mark all that apply.

- Mid-Wife
- OB/GYN
- Nurse Practitioner
- Community-Based Clinic
- General/family physician (treats men/women/children)
- Perinatologist or other any Maternal/Fetal Medicine Specialist (specialize in high-risk pregnancies)
- Doula
- Other _____

61. Did you or your partner breastfeed or attempt to breastfeed? *

Mark only one oval.

- Yes
- No

62. How long did you or your partner breastfeed? *

Mark only one oval.

- We did not attempt to breastfeed
- 1-2 days
- Up to 2 weeks
- Up to 1 month
- Up to 3 months
- Up to 6 months
- Up to 12 months
- More than 12 months

1/21/22, 9:15 AM

Consumer Survey 2022-2024 Erie County Community Health Assessment

63. Would any of the following programs/services have made it easier for you or your partner to choose to or continue breastfeeding? *

Mark all that apply.

- Access to Baby Cafes- free in person drop in centers for breastfeeding support
- Access to low or no cost breastfeeding counselors
- Online Support
- Education while you were pregnant on the benefits of breastfeeding
- Breastfeeding support in the hospital
- Workplace support
- Access to free or low cost breast pumps
- None of the Above

Other:

64. You have reached the end of the survey. Thank you for taking the time to help us understand your needs. The input and thoughts from every member of our community is valued. Please share this survey on your Social Media and encourage all of your Erie County friends, family and colleagues to take part in creating a healthier Erie County for everyone. Thank you for valuable your input. Please add comments or ask questions below.

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Google Forms

Erie County Community Survey Distribution

Consumer Survey In-Person Collection Sites				
SITE	Active/Passive	Target Population	Responsible PGM Staff	# Paper Surveys
St. Luke's Mission of Mercy	Active	Lower Income/poverty level; Multiple races/cultures	ECDOH Interns & Program / OR Staff	53
Tops Market Grant/ Amherst	Active	Multiple, but particularly Hispanic/African American/ Refuge - low-income	ECDOH Interns & Program / OR Staff	23
Tops Market Niagara	Active	Multiple, but particularly Hispanic/African American; low-income	ECDOH Interns & Program / OR Staff	29
Save-a-Lot – Abbott Road Lackawanna	Active	Multiple, but particularly ALICE families	ECDOH Interns & Program / OR Staff	33
Erie County Dept. of Social Services	Both	Low-income	ECDOH Interns & Program / OR Staff	61
Erie County Vaccination Pods (Various locations)	Both	ALL	ECDOH Interns & Program / OR Staff	87

Erie County Consumer Survey Collection Sites 2022

Location or website	Social Media Platform	Printed Materials	Target Population	CHA Partner
ECDOH Facebook	X		All EC residents who use Facebook	ECDOH
ECDOH Twitter	X		All EC residents who use Twitter	ECDOH
ECDOH Instagram	X		All EC residents who use Instagram	ECDOH
Catholic Health Website	X		Erie County residents	Catholic Health
Catholic Health Associate Intranet	X		Catholic Health associates and providers	Catholic Health
Catholic Health Facebook	X		Erie County residents	Catholic Health
Catholic Health Instagram	X		Erie County residents	Catholic Health
Kaleida Health Public Website	X		Erie County Residents	Kaleida Health
Kaleida Health Employee Intranet including "Kaleida Everyone" and "Site-Specific E-News" including hospitals, clinics, home-care, labs	X		Erie County Residents	Kaleida Health
Kaleida Health Facebook, Twitter, Instagram	X		Erie County Residents	Kaleida Health

2022 Erie County Community Needs Assessment Summary

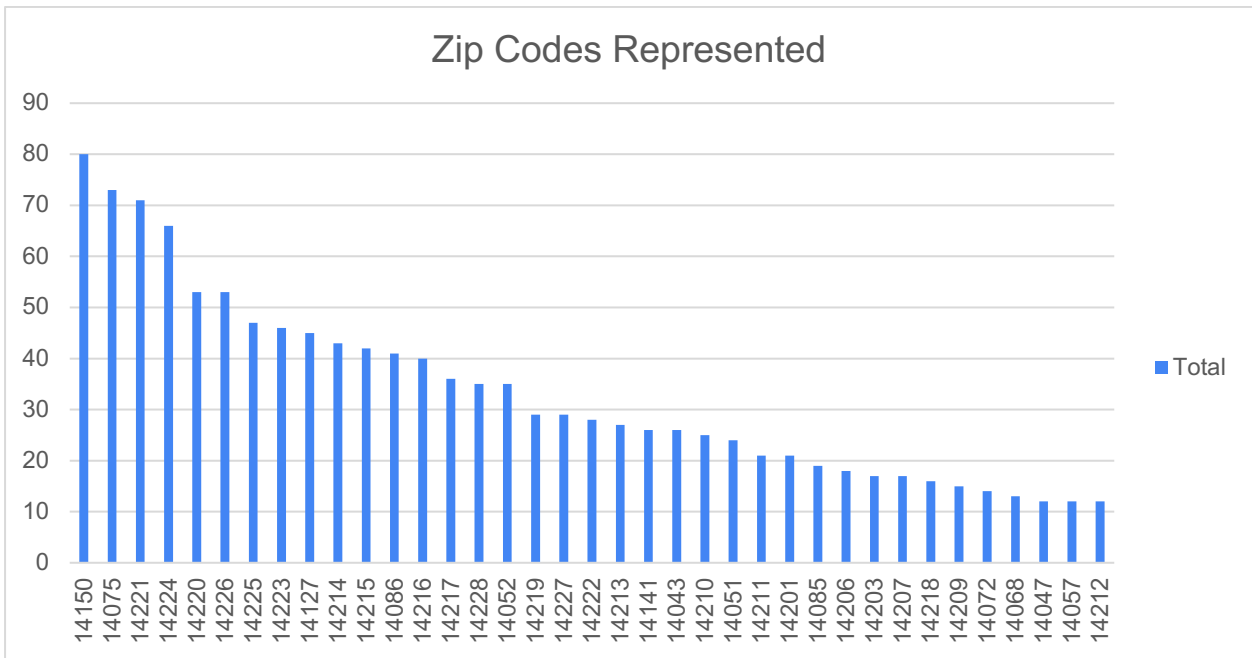
2022 Erie County Community Needs Assessment Summary

Survey Dates: December 28, 2021 – April 21, 2022

Total Completed Surveys: 1394

Results as of 6/30/22

Q2. Zip Code Review



Areas Represented by Zip Codes

Zip Code	Total Responses	Zip Code Area
14150	80	Tonawanda
14075	73	Hamburg
14221	71	Williamsville, Cheektowaga, Harris Hill, Getzville, Woodstream Farms
14224	66	West Seneca, East Seneca, Gardenville
14220	53	Buffalo, West Seneca
14226	53	Amherst, Snyder, Eggertsville, Getzville
14225	47	Cheektowaga, Pine Hill
14223	46	Buffalo, Amherst
14127	45	Orchard Park, Webster Corners, Ellicott, Windom
14214	43	Buffalo

2022 Erie County Community Needs Assessment Summary *continued*

14215	42	Buffalo, Cheektowaga, Cleveland Hill
14086	41	Lancaster, Town Line
14216	40	Buffalo

Q5. Gender Review

Row Labels	Count of Gender
Female	1026
Male	282
Non-binary	12
Prefer not to answer	29
Really????	1
Transgender	5
Transgender woman	1
Tree	1
Grand Total	1357

Q6. Ethnicity

Race/Ethnicity, check all that apply:	Count of Race/Ethnicity
White	1062
Black or African American	118
Prefer not to answer	42
Asian	32
Hispanic or Latino	30
Hispanic or Latino, Black or African American	14
Hispanic or Latino, White	8
Native American or American Indian, White	6
Black or African American, White	6
Native American or American Indian, Hispanic or Latino	5
Native American or American Indian	5
Native American or American Indian, Black or African American	5
White, Asian	4
Human	2
American	1
Hispanic or Latino, Asian	1
Hispanic or Latino, White, Asian	1
Native American or American Indian, Hispanic or Latino, Black or African American, White	1

2022 Erie County Community Needs Assessment Summary *continued*

White, Human	1
Native American or American Indian, Hispanic or Latino, White	1
Lebanese	1
Mixed	1
Grand Total	1347

Q15. Top Five Health Concerns

Duplicate Top 5 Issue Responses:

What five health issues in your community are you most concerned about?	Count of Responses
Alcohol Use/Abuse, Depression, Mental health, Opioid Use Disorder/Substance Use Disorder, Suicide	3
COVID-19, Depression, Mental health, Opioid Use Disorder/Substance Use Disorder, Suicide	3
Climate change, COVID-19, Depression, Mental health, Violence	2
COVID-19, Mental health, Pollutants (air, water, soil quality), Water Quality, Violence	2
Alcohol Use/Abuse, COVID-19, Mental health, Opioid Use Disorder/Substance Use Disorder, Violence	2
Cancer, Climate change, COVID-19, Depression, Mental health	2
Climate change, COVID-19, Depression, Mental health, Opioid Use Disorder/Substance Use Disorder	2
Cancer, Climate change, COVID-19, Immunizations, Violence	2
Climate change, COVID-19, Mental health, Nutrition, Obesity/overweight	2
Climate change, COVID-19, Mental health, Opioid Use Disorder/Substance Use Disorder, Pollutants (air, water, soil quality)	2
COVID-19, Depression, Mental health, Safety, Suicide	2
Cancer, Climate change, COVID-19, Pollutants (air, water, soil quality), Water Quality	2
COVID-19, Mental health, Opioid Use Disorder/Substance Use Disorder, Pollutants (air, water, soil quality), Violence	2
Cancer, COVID-19, Heart disease, Mental health, Obesity/overweight	2
COVID-19, Mental health, Opioid Use Disorder/Substance Use Disorder, Suicide, Violence	2

Overall Top Health Issues Identified:

1. Mental Health – 244
2. COVID-19 - 158
3. Depression – 92
4. Cancer – 85
5. Opioids – 84
6. Suicide – 51

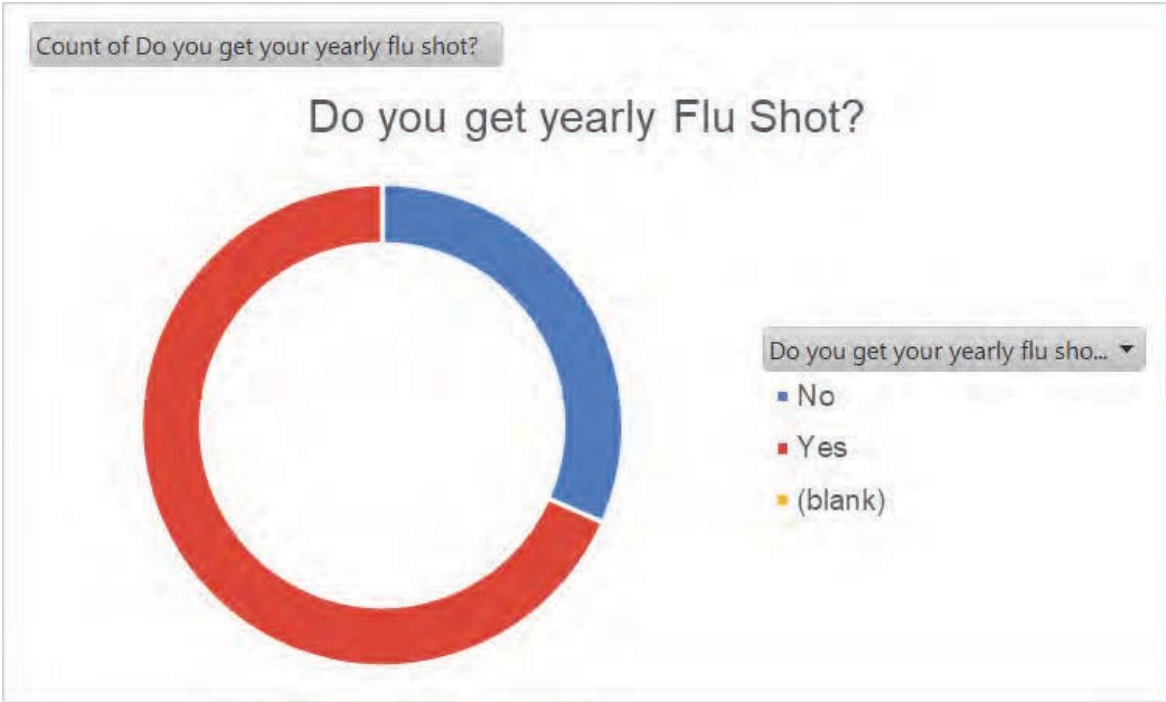
Q21. What might help you make healthy changes in your life?

Top 10 Responses:

In the future, what might help you make healthy changes in your life?	Count of Responses
More free time	607
More affordable and accessible recreational and/or sports opportunities that are appropriate for your age and skill level	461
Having more affordable fresh fruits and vegetables and/or healthy food choices available at local convenience stores	410
Access to virtual and/or in person free workshops or classes in your community on exercise, diet, stress reduction, chronic disease management and/or quit smoking	378
Having more trust/comfort with the medical system	361
Having safe areas to exercise within your community	353
Incentives such as gift card, prize for participation or discounted service	335
Getting reminders when you are due for certain tests (such as annual doctor visits),	249
Taking more time to talk with health care professionals (doctors, nurses, dieticians, counselors)	237
Access to affordable childcare	225

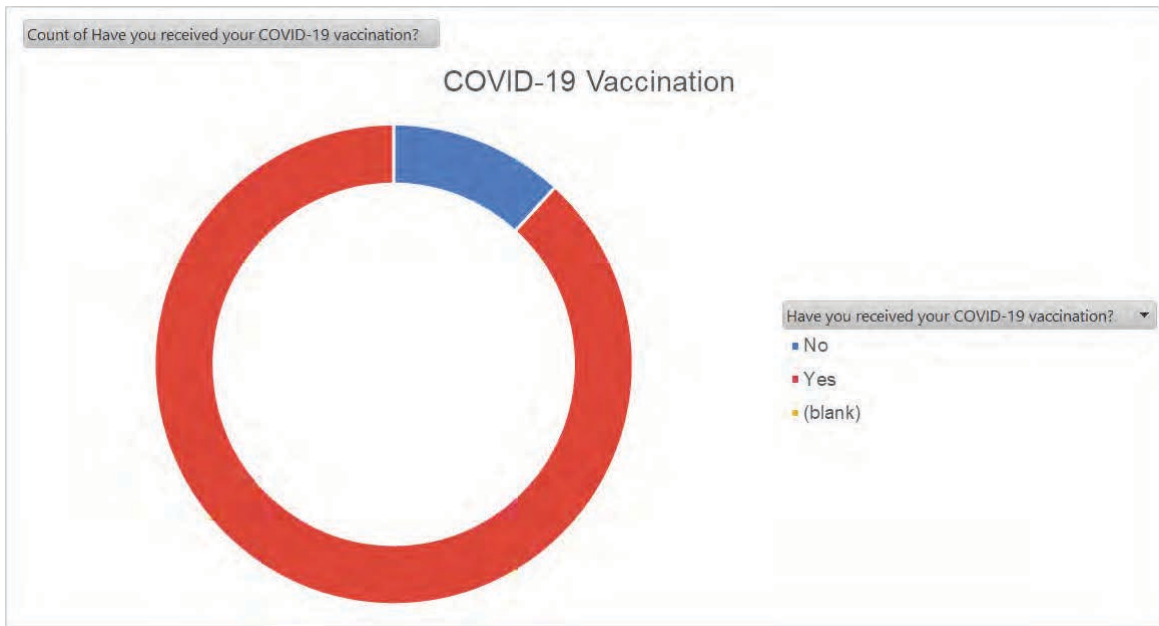
Q34. Yearly Flu Shot

Row Labels	Count of Do you get your yearly flu shot?
No	429
Yes	928
Grand Total	1357



Q35. COVID-19 Vaccination Status

Row Labels	Count of Have you received your COVID-19 vaccination?
No	160
Yes	1197
Grand Total	1357



Q48. Perceived Overall Health

	Count of How would you rate your overall health?
Excellent	229
Fair	260
Good	835
Poor	33
Grand Total	1357

Q63. Breastfeeding Review

	Count of Did you or your partner breastfeed or attempt to breastfeed?
No	23
Yes	76
Grand Total	99

Erie County Community Conversation Questions

Erie County

Community Conversation Questions

Spring 2022

Facilitated by Erie County Health Department

Access to Care

1. In the past two years have you been able to see or speak with a health care provider when you were ill, injured and/or needed follow-up or routine care for an already diagnosed chronic condition?
 - a. If not, how often did this occur and what prevented you from receiving the needed care?
2. Does your health care provider offer telehealth appointments (virtual and/or over the phone)? Is a telehealth appointment an option when you are unable to get an “in person” appointment?
3. When you see your health care provider for routine care for a current chronic health problem or are given a new diagnosis and treatment plan, does your HCP ask you if there is any part of the treatment plan and/or recommendations you have had or may have difficulty following? (ex. difficulty filling prescriptions, following up on referrals or recommendations, such as, quitting smoking-drinking, eating less, increase physical activity, get more sleep, eat more fruits and vegetables, reduce stress, go to a specialist - physical therapy - get further medical testing...)
4. What are some things preventing or that may prevent you from following a treatment plan? (ex: no transportation, lack of money/resources, mental health condition, religious/cultural restrictions, beliefs and expectations, substance use disorder, domestic violence ...)
5. Does your HCP offer services & treatment plans that:
 - a. take your culture into consideration?
 - b. consider the connection between physical and mental health
6. Does your HCP link or refer you to outside resources and community-based programs? If so, what type of community programs do they use to help their patients? (ex. Prescription Assistance Programs, Diabetes Self-Management, Diabetes Prevention Program, food pantry, nutrition classes, free or low-cost opportunities for physical activity or exercise, stress management help, programs that help with housing, utilities, home repairs to make your home healthier/safer and/or other financial resources, support groups, counseling, free educational opportunities, insurance enrollers)
 - a. Have you taken advantage of any of the programs?
 - i. If no, why not?
 - ii. If so, were the community programs helpful?
7. During the first several months of the COVID Pandemic everybody’s health care suffered. Some people say they have experienced better and more coordinated health care, that considers financial, social and cultural barriers, than they had before COVID. Some people report no difference and others say that the health care they received during the peak of COVID, and since, is worse than before. How would you describe your health care experience before, through and since COVID? Can you please give some reasons for your answer?

General questions

1. What do you think is biggest health concern in your community?
2. What gets in the way of your community becoming healthier?
3. What resources would help your community become healthier?

Erie County Community Conversation Summary

Erie County Community Conversations March – April 2022

Three virtual community conversations and four, in-person community conversations were held in March and April 2022. Additionally, 63 individual conversations took place in March, April and June 2022, utilizing the same questions posed to the groups. With the exception of one suburban location, the locations of the conversations were chosen in an effort to increase input from the Hispanic, African American, low income, male and rural populations, whose views were underrepresented in Community Survey responses.

The questions posed were about:

- experiences with healthcare during and since the COVID-19 pandemic,
- health care access,
- barriers to health service access,
- health concerns of the community; and
- participants’ thoughts as to how we can best achieve a healthy community.

Community Conversation Location	Population	Facilitator(s)	Date(s)	Site Group	Virtual Group	Individual Conversation(s)	Participants #
St. Luke's Mission of Mercy	22 Social Security assistance-eligible, 14 African Americans, 1 Native American, 2 Hispanic, 5 white, 13 Male, 9 Female, all staying in the urban area	Kelly A. & Yasmine Fox	March 24 th , April 7 th	X		X	13, 9
Springville Auction – Farmer’s Market	All rural population, 5 white, 2 AA, 2 Native Americans, 5 females 4 males mixed income	Kelly A.	June 8, June 15			X	9
East Aurora Flea Market	7 Rural, 3 suburban, 1 urban, 2 AA, 1 Hispanic 5 White, 3 MENA, 3 male, 8 females	Kelly A.	April 16, April 30			X	11
Erie County Department of Social Services offices	Low-income Social Security assistance-eligible, 10 white, 6 AA, 1 NA, 2 MENA, 2 Hispanic, 14 urban, 3 rural, 4 suburban	Kelly A.	April 5, April 12			X	21
Los Tainos-- Senior Group	5 Seniors; 5 Hispanic 4 women, 1 man, 5 Social Security assistance-eligible. All urban.	Yasmine Fox & Kelly A.	April 8	X			5
Bridge Masters Group	Middle and upper middle class, 8 suburban, 2 rural, 6	Kelly A.	March 27	X			10

	females, 4 males. 2 AA, 3 MENA, 5 white					
Virtual – 3 sessions	2 Social Security assistance-eligible, 6 lower income (ALICE Designation), 7 middle class.8 white, 4 AA, 1 MENA, 2 Hispanic, 9 urban, 2 rural, 4 suburban. 9 female. 6 male.	Kelly A.	March 26, March 30, March 31		X	4, 6 and 5

ACCESS-TO-CARE QUESTIONS

1. In the past two years have you been able to see or speak with a health care provider when you were ill, injured and/or needed follow-up or routine care for an already diagnosed chronic condition?
 - a. 64% reported that they were not able to see or speak to a health care provider at least one time over the past 2 years (April 2020 – April 2022).

2. **Does your health care provider offer telehealth appointments (virtual and/or over the phone)?**
 - a. 52% answered that telehealth was offered by their HCP;
 - b. For those who said they were unable to get an in-person appointment, 20% said a telehealth appointment was an option, but they declined.

3. **When you see your health care provider for routine care for a current chronic health problem or are given a new diagnosis and treatment plan, does your HCP ask you if there is any part of the treatment plan and/or recommendations you have had or may have difficulty following?**
 - a. 23% responded that they were asked by their provider if they had or could foresee a problem with carrying out their treatment plan;
 - b. 12% were asked (specifically) if the cost of their prescription or medical equipment was prohibitive;
 - c. 19% were asked if they would like a referral for assistance with a specific part of their treatment plan.

Listed below are questions HCPs most often asked those participants reporting that were asked if they needed assistance with a specific part of their plan:

- i. did they need a nutritionist or dietician to help them with a healthy eating plan?
- ii. did they want to speak to a diabetes or asthma educator?
- iii. did they need medication, nicotine replacement therapy (patches, gum, lozenges) or other type of smoking cessation support?
- iv. did they need a referral to:
 1. an agency or program that offers a support group?
 2. financial assistance for prescriptions, transportation or other need? or
 3. a mental health provider or other specialist?

4. What are some things preventing or that may prevent you from following a treatment plan?

- a. 9% said they have no health insurance and could not afford any prescribed treatment even if they were to see a provider for free.
- b. 91% of those engaged in a community conversation said that they were covered by an employer-provided, self-purchased group plan, or a self-purchased plan found on the NYS Health Insurance Marketplace.
- c. 85% of those covered by an employer health plan and 100% of those covered by a self-purchased plan, reported that over the last decade, their employer-provided or other self-purchased plan premiums, have continually increased, while their costs for services and treatment covered by their plans have steadily increased. Current plans have very high deductibles, high copays and lack of coverage for many medical or medical related services that were most often covered in the past.
- d. 39% of these participants said they simply lacked the money or resources to pay the copays for partially covered treatment or the entire cost of uncovered treatment so they often did not have the money or resources pay for the prescribed medication, medical equipment, ongoing therapy/treatment sessions or prescribed activity or eating plan.
- e. 8% said they could not get an appointment with the prescribed/recommended specialist or the appointment was so far in the future that they were discouraged because they were unable to adhere to their treatment plan.
- f. 21% said there are no specialist or providers taking new patients located close enough to where they lived to be accessible. Of those 21% of individuals, slightly more than half participated in a discussion in a rural setting. Slightly less than half had participated in a discussion that was located in an urban zip code that has very low socio-economic indicators.
- g. 11% reported lack of time to attend ongoing therapy/treatment sessions due to work obligations. 3/4 of these respondents said they had very little or no paid time off and that the treatment was not offered during times when they were not scheduled to work and even if they had evening or week-end appointments, there were not enough available appointments for people that really needed them. You had to be one of the first to call when they opened scheduling for available appointment time slots. Once they open them up for scheduling, they are usually filled up in a matter of hours for the next month. One participant said that the people who usually got those appointments were the people that had the time to sit around and keep trying until they broke through.
- h. 22% said, because of a mental health-related condition (substance use disorder, addiction, anorexia, personality disorder, depression, bipolar disorder) they are having, or would have, trouble temporarily or permanently quitting a behavior that is restricted in a treatment plan (i.e. smoking or vaping tobacco or marijuana, overeating or eating too many sweet or fatty foods, drinking alcohol, using illicit/illegal drug/s, drinking sugar sweetened beverages, using caffeine, purging after eating, having sex (for a period of time), engaging in unhealthy/risky sexual behaviors, self-mutilating and taking extreme risks to achieve an adrenalin rush).
- i. 54% said because of a lack of personal motivation or a strong aversion to a prescribed activity they are having or may have trouble meeting the requirements of a treatment plan (i.e. eat healthy, drink more water, lose weight, increase physical activity, meditation, get more sleep).
- j. One person said that religious/cultural restrictions keep her from adhering to a prescribed treatment plan.
- k. Two people said that they were living in a domestic violence situation that made it difficult for them to follow a treatment plan.

5. Does your HCP offer services & treatment plans that take your culture into consideration?

- a. 61% of participants said that their HCP providers were considerate of culture. However, upon further prompting, the majority of those making that statement saw a HCP of the same race, from a similar culture located in a culturally and racially homogenous service area.
- b. 23% said that they did not know.
- c. 16% said that their provider did not take their culture into consideration (about half of those reporting that their provider did not take their culture into consideration said that when they brought this to the provider's attention, the provider was very willing to try to understand and work through cultural considerations).

6. Does your HCP offer services and treatment plans that consider the connection between physical and mental health?

- a. 73% of participants believed that their HCP did consider the connection between mental and physical health,
- b. 20% said they did not know, and
- c. 7% said their provider did not consider that connection.

7. Did the COVID-19 pandemic have any effect on your health care?

- a. 98% of participants that answered this question reported that their health care was negatively affected during the first six months of the pandemic. Below is a summary and compilation of the comments made. Comments listed were mentioned at a minimum, 10 times (with the exception of four participants who said a member of their family died due to lack of treatment):
 - i. They could not get in to see their HCP when they were sick,
 - ii. They had trouble getting refills for their medication,
 - iii. Ongoing treatments and therapy that required hands-on application ceased. Many people suffered great setbacks in recovery and/or their conditions worsened.
 - iv. Four participants reported that a family member had died during the first two months of the pandemic from a pre-existing disease/condition because they were unable to access treatment and services.
 - v. It often took days for their HCP provider to call them back and sometimes they never heard back from their provider.
 - vi. If someone had to find a new provider it was almost impossible to find one taking new patients, especially for patients insured with Medicaid or Medicare.
 - vii. They were unable to get tested for COVID early on. This was due to:
 1. Lack of tests and/or inability to get transportation to a testing site.
 2. Drive-through testing clinics were not accessible to people who did not have their own vehicles.
 3. Public transportation, metro, subway, taxis and other livery services could not be used to get to a testing site (drive-through or walk-up). If the test for the person being transported was positive for COVID-19, the person providing the transportation would be considered exposed and would need to be quarantined and be tested. Friends and relatives, for the same reasons, did not want to take people for testing. If they were exposed they too would be quarantined and unable to work. So, many people did not get tested or treated.
 4. Many of the participants that we spoke to were considered essential workers. Most of the essential workers we spoke to held blue-collar or service jobs that typically do not have high wages or great benefits. If they didn't work they didn't get paid. Even with the NYS mandated two-weeks' pay, one time allotment for people quarantined/isolated due to COVID or who were caring for a child who was quarantined/isolated, it was not enough to cover the amount of time and money they lost or would lose from not working.

- viii. Of those that reported a negative effect from COVID-19 on their health care, 64% said that it began to improve by the end of 2020.
- ix. 34% say that their health care continues to be worse than before COVID – it is still difficult, if not impossible to find a new provider taking on new patients (especially Medicaid and Medicare patients), there are long waits for appointments, lack of accessible specialists and high insurance deductibles, high co-pays, high premiums and many services are not covered.
- x. 2% said they didn't really see any difference.

GENERAL QUESTIONS

1. What do you think is the biggest health concern in your community?

- a. There were many health concerns expressed. Responses were categorized into 5 groups. These groups are as follows:

- i. 47% - Social Determinants of Health (broken down further into 2 categories)
 - 1. 31% - Income/Cost of Living/Poverty related (income, lack of resources, inflation, high costs of insurance, low wage –long hours, underinsured, unemployment, increasing housing cost, poor housing making most working people housing-burdened (by federal definition, over 30% of income used for basic housing costs)
 - 2. 16%- Access to Essential Resources (education, transportation, good jobs, health care, healthy and affordable food and affordable and/or free wellness and physical activity opportunities) This also includes concerns about environmental conditions and concerns about distance from healthcare provider.
- ii. 21% - Mental Health (includes substance use disorders),
- iii. 16% - Disease Specific (This was surprising because, in past years, most people reported something disease specific as the biggest concern), and
- iv. 16% - Distrust of Large Institutions (government, political & corporate conspiracies, distrust of research, the medical profession, traditional media, social media and mis/disinformation).

2. What gets in the way of your community becoming healthier? (The answers mirrored the responses to the first General Question fairly closely.)

- a. The largest number of responses were related to social determinants of health:
 - i. Low income, environmental (unsafe, unhealthy and/or high crime environment, air quality, high costs and lack of access to resources, access to essential resources like education, transportation, good jobs, health care, healthy & affordable food and affordable and/or free wellness & physical activity opportunities),
 - ii. Old, run-down housing,
 - iii. High housing costs, and
 - iv. High insurance costs
- b. Mental Health
- c. Access to resources.

Comments made about things getting in the way of the community getting healthier:

- I have to work way too many hours in 1,2 or even 3 jobs to make ends meet.
- There is too much attention and money being put into the same old government services and programs that have never worked. It is no wonder we have not solved any of our problems that I have seen over the last 40 years.
- Politics is what keeps our communities unhealthy.
- Funding programs that are created by people that do not have any lived experience rather funding the grass roots solutions created by the people that have experienced the effects of policies that have perpetuated poverty, poor health, incarceration and despair.
- There are too many cheap unhealthy, fast and convenient food choices available and not enough reasonably priced and convenient healthy choices.
- Poverty is killing people.
- Poor air quality is making people very sick.
- There is a huge problem with housing. You can't find affordable, quality housing and housing, just housing takes up half of your income! People are forced to live in unsafe neighborhood. This keeps people from being healthy. Ignorance and unhealthy conveniences that effect make it easier to make an unhealthy choice, don't help the problem either.
- There are too many fast food places, people constantly working and struggling do not have the time to focus on getting healthier. It's hard to get affordable and healthy food.
- Poverty is killing people.
- Structural racism is keeping folks from getting anywhere and that includes healthy.
- Poor air quality is making people very sick.
- Climate Change is what we should be focusing on. If we got no place to live, we'll be so unhealthy, we'll be dead.
- There is a huge problem with housing. You can't find affordable, quality housing and housing, just housing takes up half of your income! People are forced to live in unsafe neighborhood. This keeps people from being healthy. Ignorance and unhealthy conveniences that effect make it easier to make an unhealthy choice, don't help the problem either.
- There are too many fast food places, people constantly working and struggling do not have the time to focus on getting healthier. It's hard to get affordable and healthy food.

3. What resources would help your community become healthier?

- a. One participant's comment was representative of most other comments and description of personal experiences: "Where I live, most of the people around me are not very healthy. They cough a lot, they have high blood pressure, diabetes, back problems, headaches, poor eyesight,

dental problems, carpal tunnel, MS, poor cholesterol and a \$#!load of unhealthy coping skills, that add to their poor health and high-risk factors for bad health outcomes. They say they would love to be blessed with good health yet, it seems like they won't do anything to make their health better. They won't even try to eat better, get more sleep or engage in the minimum recommended amount of weekly physical activity. Are they stupid? Are they lazy? Do they not care about their health and being around for their children? No, no and no, again. They're poor. Worse than that, they're the working poor. It is not a lack of caring about themselves. We know we are not healthy and that the way we live is not helping us get any healthier, but we're unhealthy because we are the working poor. When you work hard, long hours and you still struggle to keep a roof over your family's heads, food in their stomachs, clothes on their backs, give them a decent education, keep them safe and healthy, give them all the things they need to have a chance in this life, yet, you still often find yourself falling short, you live in a constant state of stress. You do not spend any time taking care of yourself or your health needs. In fact, even if you have health insurance, you are probably extremely underinsured. You're working, so you make too much money for government health insurance (which has no high deductibles, big copays and covers most everything, including wellness benefits), you don't get food, utility, rental or childcare assistance. You definitely don't get a phone paid for by the government, or assistance with transportation. You work hard and you're still poor. You live in a constant state of stress. You are always worried about simple things, like keeping a roof over your head, paying the electric, water and heating bill, having enough food to get you through the month, having the money for school clothes, school supplies, laundry soap (coins for the laundromat), dish soap, toothpaste, shampoo, bleach and other cleaning supplies, diapers, lunch stuff we (the working poor) got it the worst. We don't have time to get and prepare healthy food, we never get enough sleep, eat healthy, sleep well, exercise, enjoy life, teach and spend time with our children, go to the doctor or take time off from the doctor when we are sick, or go to the doctor for regular checkups. We work so hard to just get our mouth above the water enough of the time to take a breath. Then we go under, hold our breath until we can struggle up enough to catch another one. Nobody is going to be healthy when they live like that. The government can't fix these problems with programs that don't work. They need to give the people the resources they need to fix things for themselves. There are so many grassroots initiatives that are working but would work even better if the government would give these grassroots the funding currently given to not-for-profits."

- b. More, cheaper, quality healthy food availability.
- c. Programs that really helped people get out of poverty.
- d. Full-service medical homes should be developed and located in communities of need based on population level. All medical homes should be staffed at a ratio of 20 Family Medicine Physicians per 1,000 population and 5 General Surgery physicians per 1,000 population. All MDs, as a condition of their license should be required to work, pro-bono for 182 hours a year at one of these centers. MDs paying off student loans should be given ½ of the going rate per hour for general practitioners per hour or half the going rate of their particular specialty per hour credit toward their student loan. Can choose to work up to 15 hours per week. That is how the centers can be staffed.
- e. Community gardens.
- f. Better job opportunities and educational opportunities.
- g. People need to help each other instead of depending on the government.

- h. Business located in poor communities should have to hire a certain percentage of their workers that live within a ten-block radius of their location. Also, should have apprenticeship programs.
- i. Make streets more walkable and friendly.
- j. Improve our public transportation system.
- k. Limit the number of fast food places in a given community.

Erie County Professional/Stakeholder Questions

Erie County

Professional Stakeholder Discussion Group Questions

Spring 2022

Facilitated by Erie County Health Department

**Similar themes guided Community Conversations.*

1. Access to Care
 - a. In your experience, are your patients/clients getting the care they need? What are the barriers?
 - b. Do you offer culturally appropriate services? What barriers are you facing with cultural competencies?
 - c. Does telehealth help with any access barriers? If you do not offer telehealth, what are the barriers to doing so?
 - d. How do SDOH factors impact the care you provide?

2. Care Coordination and Navigation
 - a. Is there an integration between physical and mental health in your practice / organization?

3. How has COVID impacted your capacity in regard to access to care or care coordination and navigation?

4. What type of community programs do you utilize for your patients/clients? Are you reaching the intended audience?

Stakeholder Engagement Focus Group Summary



Creating Connections for Western New York Health

A Stakeholder Engagement Focus Group

2021-2022 Erie County Community Health Assessment Summary Report

Prepared by:

Alessandra Duarte, MSW

Program Coordinator, PHC

A Stakeholder Engagement Focus Group

2021-2022 Erie County Community Health Assessment

Summary Report

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I. Part One: Background

A health assessment is “a systematic examination of the health status indicators for a given population” that is used to identify factors that contribute to health status and health challenges and identify assets that can be used to improve population health. The New York State Prevention Agenda was implemented to prevent health problems before the problems progress and worsen. Health promotion and disease prevention activities might include investigating disease outbreaks, labeling foods that are high in fat, counseling, and drug treatments to help people quit smoking, and testing water supplies to make sure they are free from chemicals or other pollution. Another goal of the Prevention Agenda is to involve a wide range of organizations and community members in developing community health plans that identify and address problems that affect the health of New Yorkers.

The Prevention Agenda calls on local health departments and hospitals to identify two or three of the ten Prevention Agenda priorities and to work with community providers, insurers, community-based organizations, and others to address them. Statewide program and policy initiatives will complement local efforts. The community health assessment and community service plans are a useful first step for understanding health status and health risks in a community. Catholic Health System and Kaleida Health, two (2) of the biggest health systems in Erie County conducted joint stakeholder focus group sessions and discussions as recommended and required by the Prevention Agenda guidelines.

To invite a variety of participants, a specialized list of contact information of health-related community-based organizations was compiled and contacted. These participants were representatives of organizations that provide different services: behavioral health and mental health, geriatric, pediatric, suicide prevention, domestic & sexual violence, trauma, pediatric mental health, and many more. Three stakeholder discussion sessions were completed.

Part Two: Identified Themes

As the stakeholder focus group discussions follow the same format each year, the 2021-2022 Stakeholder questions were based on 4 (four) previously identified themes updated to reflect current issues in 2021-2022.

Theme I: Access to Care

Many stakeholders identified that access to care is a nuanced question. There is a need to define accessibility, and if the care accessed was appropriate and equitable.

According to stakeholders, patients may have received care, but it was not exemplary service, or they were treated in the wrong location for their situation (for example, an urgent care visit when a Primary Care Physician Office visit was indicated). Therefore, when discussing access to care, one should look beyond 'did they receive care' and investigate the quality of care, appropriateness of the location of care, and wait times that force people to look to quicker, less appropriate places for care. Areas of access to care that we investigated in depth were Social Determinants of Health, Telemedicine, and Culturally Appropriate Services.

A. Culturally Appropriate Services

For many Stakeholders, providing culturally appropriate services has always been important, but became a crucial focal point in 2020-2021. *“George Floyd and various other (events) that have happened over the last two years in addition to the pandemic has raised people’s consciousness about better equity, service, care, and treatment to a level where we couldn’t wait any longer.”* Additionally, many Stakeholders who were already providing services to diverse populations faced an influx of patients including those from Refugee and Immigrant populations. This created a strong need for staff and providers to be culturally competent. One stakeholder commented that as part of being culturally competent, providers should never assume a patient’s cultural needs or language. *“You could lay out a lovely nutrition plan, but culturally they eat one time a day, or there are days where they fast, and you can’t assume that they are going to comply with your plan. You have to consider the whole person and be sure you’re making adjustments or ensuring the doctor who’s ordering the services is aware of the cultural differences.”*

Other stakeholders whose staff work in less diverse clinics noted they (their staff) may not have the same awareness and cultural competence as those in larger or more diverse health systems.

While Stakeholders made it clear that most healthcare systems are now prioritizing culturally appropriate services, it is not without barriers. Most Stakeholders felt their organizations could use more support and resources to improve the level of culturally appropriate care they provide. Some Stakeholders noted that while efforts to implement Diversity, Equity, and Inclusion (DEI) strategies are well received, some staff members have been resistant to change. This has required additional time and training to ease staff through the transition as well as raise awareness of the importance of culturally appropriate care.

Fortunately, Stakeholders shared that many organizations are currently working on solutions to overcome these barriers. One Stakeholder shared that they have switched from using phone service interpretation such as Language Line to in-person Interpreters. These Interpreters are of and from the community and can participate in the treatment process, providing additional support to the families in treatment. Other stakeholders reported that the use of Web-Based training for staff on DEI topics has been helpful in providing education and increasing culturally appropriate care. Large hospital systems, such as Kalida and ECMC were named as having really invested in Culturally Responsive services. *“There’s been a lot of changes- including hiring a Director of Diversity Equity and Inclusion (DEI) and pushing DEI strategies throughout the system.”* At D’Youville, grant funding has been acquired to bring on two Community Health Workers. Community Health Workers (CHW) are an effective way to engage with culturally diverse communities. CHWs tend to be informal health providers, who are of and from the community and can engage with traditionally hard-to-reach populations. At the D’Youville location, Community Health Workers will attend community-facing events and provide culturally appropriate health education for patients.

B. How do Social Determinants of Health (SDOH) factors impact the care you provide?

The largest barrier and concern for access to care was Social Determinants of Health (SDOH). While all stakeholders recognized this barrier, they also noted that there is a need for increased screening and data collection to identify specific SDOH factors and their impact on patients' ability to access care.

Social Determinants of Health Identified by Stakeholders

Transportation
Food Insecurity and Nutrition
Financial Insecurity
Lack of Support Systems and Caregivers
Domestic Partner Violence
Housing Insecurity
Implicit Bias from the medical system
Mental Health and Substance Use Disorders.

Transportation was listed as the number one SDOH that bars patients from accessing care. Lack of transportation almost always coincided with financial insecurity. Patients without financial means may not be able to afford a car, gas prices, or a ride-sharing service to get to their doctor's appointments. Furthermore, when prioritizing cost, most patients will forgo follow-up care, which creates issues with compliance in aftercare such as obtaining bloodwork or tests. One Stakeholder expressed the difficulty with locating resources for patients who struggle with transportation. *"Unless you have Medicaid, there's not a whole lot of resources out there to help patients get to where they need to go to. I wish it was something that could be covered through other insurance companies."*

Stakeholders also noted an increase in housing insecurity, with many patients living with family members or moving from place to place. When patients are overwhelmed with financial burdens such as housing, transportation, and food insecurity, they are less likely to engage in routine medical care. Some stakeholders identified ways in which their organization is attempting to address SDOH and reduce the impact they have on their patient's access to care.

The Office of Mental Health has Developed in-house programs to respond to SDOH concerns that impact a family's ability to engage successfully in care and be a healthy family. Another Stakeholder stated their hospital system has devised an intake screening tool with questions on SDOH, which are then reviewed by staff navigators who help to address those barriers. The Stakeholder who discussed the need for transportation resources is currently looking for grant funding to cover transportation costs, either directly or through stipends that would cover ridesharing.

C. Does telehealth help with any access barriers? If you do not offer telehealth, what are the barriers to doing so?

The Covid-19 Pandemic certainly created many issues within the Healthcare System, but the pandemic also pushed forward innovations within patient care as providers looked for ways to reach their patients. One such innovation was the widespread acceptance and use of Telemedicine. Many of the Stakeholder's felt Telemedicine was a positive addition to their practices. Telemedicine has helped to address barriers to patient care, reduce wait times for patients, and reduce the impact of SDOH on some patients.

Financially, telemedicine helps with the cost of care for both the provider and the patient. The Covid-19 Pandemic expanded coverage for Telemedicine from mainly Medicare to most major insurance companies. Patients were able to access medical care without the burden of finding childcare, paying for transportation, or taking unpaid work absences. The increased availability of Telemedicine also expanded its use, as stakeholders noted that there are even more opportunities for other services to be delivered to the home.

While the reception to Telemedicine was largely positive, not all providers were able to access Telemedicine, and others found it created new issues with patients. Technology in particular was a barrier to providing Telemedicine. In order to attend a Telehealth appointment, patients need to have Internet Access, A Smart Device (Laptop, Cellphone, Tablet), and the ability to navigate the Telehealth technology. Stakeholders stated that while patients could benefit from Telemedicine, they simply did not have the

technology needed to access the appointment. For other stakeholders, their patients relied too heavily on Telemedicine. For example, one Stakeholder said *“(Telemedicine) is not meant to be a replacement for in-person care. Especially for cases that require a physical exam. We get push-back from patients who don’t want to come in but need to.”* For pediatric providers, Telemedicine brought up issues surrounding privacy and the ability to gauge child safety. Children had a harder time staying present for medical appointments when done virtually versus in person due to distractions or lack of privacy. Without the ability to see children physically in the office, cases of neglect or abuse were more easily hidden by family members.

Theme II: Care Coordination & Navigation

In Healthcare, there has been increased importance placed on the impact of mental health on physical medical care. We asked Stakeholders to identify the ways in which they integrate mental health and physical health in their organization. Most stakeholders recognized that while their organizations are often doing their best to address the mental health and well-being of their patients, they often fall short due to a variety of barriers. One stakeholder stated, *“We have to go beyond crisis care, and do better recognizing when a client needs mental health care before the crisis happens.”* Stakeholders across all three (3) conversations fell into two (2) groups: Those who provided both linkage and in-house mental health services, and those who rely solely on linkage to outside mental health organizations. In-house services mentioned included on-site Social Workers, Safe Rooms in the Emergency Room, Therapy Dogs, Child-Life Specialists, Screening Tools, and services to follow up with clients post linkage. The most common linkage service was to outside Community Mental Health Programs and Mental Health Counselors. The main reason cited for outsourcing mental health care was the lack of staff and programming within an organization. One stakeholder noted that increasing the number of social workers on staff would reduce the need to outsource mental health care. In terms of barriers, both groups identified access to care as the largest barrier to linking their patients to mental health services. Long wait times combined with a limited number of available mental health professionals create a barrier for health care providers referring patients.

Overall, organizations with built-in mental health programs, screenings, and initiatives were better equipped to address clients' mental health needs than those who relied on linkage to outside services. Stakeholders recognized that increasing staffing may not be possible, and instead recommended focusing on early screening tools and developing initiatives that would allow health care providers to follow up with clients post referral.

Theme III: Covid-19 Pandemic

By 2022 the Covid-19 Global Pandemic had overwhelmed healthcare systems and reduced the capacity to deliver essential health services across the world. COVID-19 was a major point of discussion for Stakeholders, who recognized its broad impact across all areas of care. COVID-19 was brought up many times over the course of the three Focus Groups. While the responses are being listed under one central question, it's important to note that Stakeholders brought in Covid-19 as a response to nearly every question asked, demonstrating the immense impact the pandemic had on healthcare services.

While all areas of care were impacted by Covid-19, there was one area hit particularly hard according to stakeholders: routine care. Stakeholders noted that routine care was a service deemed non-essential in the pandemic. Therefore, patients who were not comfortable leaving their house would cancel non-essential appointments. Additionally, some stakeholders noted that the required restrictions placed on doctors' offices led to patients getting turned away. This included covid-19 symptom screenings and visitor limitations. A stakeholder in the Obstetrics field noted that patients were not attending appointments because Covid-19 protocols reduced the number of people allowed in the waiting room. Patients unable to secure childcare, who previously would have brought their children along, canceled appointments. Another Stakeholder said, *"For a portion of our patients, (the shut-down of services) made them more comfortable with neglecting their routine visits when they haven't been seen in a year or two years, and everything seems okay."*

Attempts at bridging this gap in services created more issues later for patients. One stakeholder noted that in the case of pediatrics, children were not able to get their routine physicals done for school. To address this, school districts waived requirements on annual physicals and set up school nurses to provide basic physicals. As such, children are now behind on vaccinations and other care that could only be provided by clinical providers.

For Stakeholders, the current phase of the pandemic is seen as the aftermath of 2020. Doctor's offices are re-opening, restrictions have been lifted, and patients can now easily access care through either in-person or telemedicine appointments. However, they are seeing the effects of two years of missed care across all specialties. One Stakeholder in the Home Health field expressed the difficulties of continuing care with patients discharged from the hospital. Home health providers rely on Primary Care Physicians for order refills, follow-up visits, and care coordination. *"We get the initial order to start care, then they need to reach out to a PCP to continue orders, but they (the PCP) haven't seen the patient in 2 years so they can't order anything."*

Along with routine care, preventative screenings were also neglected during the pandemic. Stakeholders discussed how screenings were already on the decline, and Covid-19 only worsened the situation. Under Covid-19 restrictions, elective procedures had to be canceled. As such, crucial screenings that went along with those procedures were not completed. Now that restrictions have been lifted, stakeholders are grappling with addressing the gap in screenings. One Stakeholder stated that there has been a large push to address this issue. *"We've been trying to figure out what our current state looks like for screenings and to try and really educate the community."* In an effort to combat this, they have been reaching out to communities with health disparities and providing education on the importance of preventive screenings. Another Stakeholder who identified as working with Univera stated that Univera is focusing on closing the gaps in care, such as long lists of women who haven't gone for their mammography, patients who haven't gotten routine colonoscopies, and patients who are afraid to leave the home and aren't sure if the screenings are necessary. Per the stakeholder, while this is a huge challenge, Univera is re-enforcing patient education and supporting providers to encourage patients to get their screenings.

For Stakeholders in the Mental and Behavioral Health Fields, the pandemic created a different set of issues, which they described as a "Community Crisis". Stakeholders working with Pediatric Mental Health, in particular, have seen an increase in children in need of care. There has been a large number of new referrals to mental health services, and more children presenting with eating disorders, anxiety and depression, and suicidal behaviors.

Stakeholders remain hopeful that with COVID-19 cases dwindling, and restrictions being lifted, some of these issues will be resolved. Though some Stakeholders worry about the deep impact Covid-19 has had fiscally on hospital systems in the area, there is hope that recovery is possible. Additionally, some stakeholders recognized the ways in which the pandemic brought crucial issues to light. For example, one Stakeholder commended the way Health Insurance Plans have recognized the efforts providers have had to make with the transition. Stakeholders also discussed the ways in which Marginalized People in the healthcare system were impacted far worse than other groups. They discussed how those in marginalized groups already had pre-existing conditions and were not being serviced to the level they should when the pandemic hit. These issues were already present, but Covid-19 forced health care systems to address the ongoing needs of marginalized patients. One Stakeholder summed it up for the group *“Crisis breeds opportunity- we may be on the way to remedy many things that we have waited too long for.”*

Theme IV Community Based Organizations:

Across all three Focus Groups, Stakeholders discussed the ongoing need to refer and link patients to outside Community-Based Organizations (CBOs). According to one stakeholder *“Hospital Systems are pushing to increase connections and use of community programs, due to the higher needs in the community.”* The two most common reasons for referrals were to address SDOH factors and for mental health services. Stakeholders were quick to discuss the incredible work being done to better address these issues and expand services for their patients.

Community-Based Organizations and Programs Listed by Stakeholders:

211- Currently developing a Discharge Planning solution to address patients who can't be discharged due to a lack of appropriate residential settings available.
Oishei Partners- United Way, Child and Family Services, The March of Dimes, Buffalo Urban League, BRAVE program at ECMC for victims of gun violence.
Women's Sexual Health Group for Breast Cancer survivors.
National Breast Cancer Support Groups.
NYS Quit Line for Smoking Patients with plans to add in-person Tobacco Treatment Specialists.
Best Self Behavioral Health
Horizon Health Services
D'Youville Food Pantry
Feedmore Western New York
Meals on Wheels
Community Health Workers

While the discussion around Community Programs was largely positive, there were also barriers identified when referring patients to CBOs. One Stakeholder noted that grant-funded programs can lack sustainability when the funding expires. This can be especially detrimental for marginalized communities, who may not have the resources to continue these programs without funding. Other Stakeholders noted that their patients may access CBOs, but they have no way to track that data or conduct follow-ups to assess the quality of services provided. One Stakeholder shared that they are now able to track CBO data to increase precision when referring patients, whereas previously they relied on word of mouth or flyers, they can now refer to programs with better compliance and attendance rates.

Appendices

A. Stakeholder Participants

Sessions Held Via Zoom on the Following Days:

- 1) February 28th, 2022.
- 2) March 1st, 2022.
- 2) March 4th, 2022.

First Name	Last Name	Company
Kathleen	Thompkins	Kaleida Health
Shari	Curry	Kaleida Health
Karen	Kelly	Kaleida Health
Smita	Bakhai	University at Buffalo
Broderick	Cason	Univera
Michelle	Hubert-Fiscus	Kaleida Health -
Sarah	Losi	Catholic Health System
Hailey	Cych	Kaleida Health
Sarah	Sweeney	Kaleida Health
Bonnie	Thompsdon	Kaleida Health

Stakeholder Engagement Focus Group Summary *continued*

First Name	Last Name	Company
Cassandra	Church	Kaleida Health
Tiffany	Fabiano	Kaleida Health
Olivia	Link	Univera
Karen	Kelly	Kaleida Health
Victoria	Dante	Kaleida Health
Laura	Benedict	Kaleida Health

Community Needs Assessment Marketing Materials

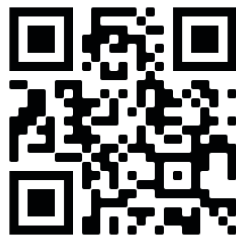
Your Voice Matters



WE CAN'T SPELL PUBLIC HEALTH WITHOUT U.

YOUR VOICE MATTERS.

The Erie County Department of Health is currently working with Kaleida Health, Catholic Health Systems and other community partners to identify public health priorities for Erie County for the next three years. We want to know about your health care experiences and health needs and give you the opportunity to tell us how we are doing, what we've done well and what we can do better. All responses are **anonymous** and will not be tied to you in any way. All comments are read and fielded to the program or person to which they apply. Submissions accepted through April 18, 2022. Please help us create a Community Health Improvement Plan that works for everyone. To take the survey, please scan the QR code or click on the link below. Thank you.



<https://ECDOHSurvey2022>



Community Needs Assessment Marketing Materials

We Can't Spell Public Health without U



CONSUMER SURVEY

2022-2024

ERIE COUNTY COMMUNITY HEALTH ASSESSMENT



WE CAN'T SPELL **P****U**BLIC HEALTH WITHOUT **U**.

YOUR OPINION MATTERS.

SCAN THIS QR CODE TO CONTRIBUTE TO A BRIGHTER AND HEALTHIER FUTURE FOR ERIE COUNTY.



ALL ANSWERS WILL REMAIN CONFIDENTIAL AND ANONYMOUS.

Community Needs Assessment Marketing Materials

Our Community's Health Matters! (Professional/Stakeholder Conversation)

OUR COMMUNITY'S HEALTH MATTERS!

LET'S CREATE A HEALTHIER ERIE COUNTY!

Catholic Health, Kaleida Health and the Erie County Department of Health are hosting professional stakeholder conversations as part of the 2022 Erie County Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP).

We want to hear what you have to say. Your knowledge of our community is needed to ensure that we have conducted a thorough, relevant and accurate community health assessment that can be used with confidence to create an effective community health improvement plan. Please select a date below to join us for one of our virtual sessions. If you are unable to attend please consider sending an alternative representative on behalf of your organization.

Register for a virtual session below:

Monday, February 28th
1:00pm

[Register here](#)

Tuesday, March 1st
11:00am

[Register here](#)

Friday, March 4th
12:00pm

[Register here](#)

Tell me more about the Community Health Assessments

Every three years local health departments and health systems are charged by the New York State Department of Health to work together to conduct a Community Health Assessment to identify and prioritize key health issues and health-related needs of the community. This assessment provides information, data, and analysis of the community's current health status needed to create a three-year Community Health Improvement Plan. The plan will be used by the local hospital systems and the Erie County Department of Health as a guide to address the identified health issues and health-related needs of the community.

The data and information contained in the CHA/CHIP are accessible to everyone and often provide other local organizations with relevant information and data needed to identify and prioritize the needs of their consumers, develop programs and services, and secure funding and support for their organization's initiatives.

Your participation in the process is extremely important. We are looking forward to hearing your valuable input at one of the Professional Key Stakeholder Conversations.



Contact Karen Hall at khall@phcwny.org

Community Needs Assessment Marketing Materials

Let Your Voice Be Heard and Make a Difference (Community Conversation)

Let your Voice Be Heard and Make a Difference

The Erie County Department of Health, Kaleida Health and Catholic Health need your help to create a Community Health Improvement Plan that works for everyone. Help us help our community by attending a virtual Community Conversation. Sharing your thoughts and telling us about your health needs, behaviors and concerns will help us identify service gaps, barriers to service access and the health issues that are most concerning to your community. Your opinion and ideas are welcomed.

Input will not be linked to individual participant. The sessions are virtual, so you can choose to participate anonymously. We will hold 3 virtual Community Conversations. You can join via internet or call in on your phone. Sessions will not be longer than an hour. Be a part of the solution and attend a Community Conversation.

Call **(716) 858-6153** to register for a session or send an email to Margaret.Barbalato@erie.gov with your contact information (first name, phone number and email) and choice of session and you will be contacted with log in instructions.

Session 1

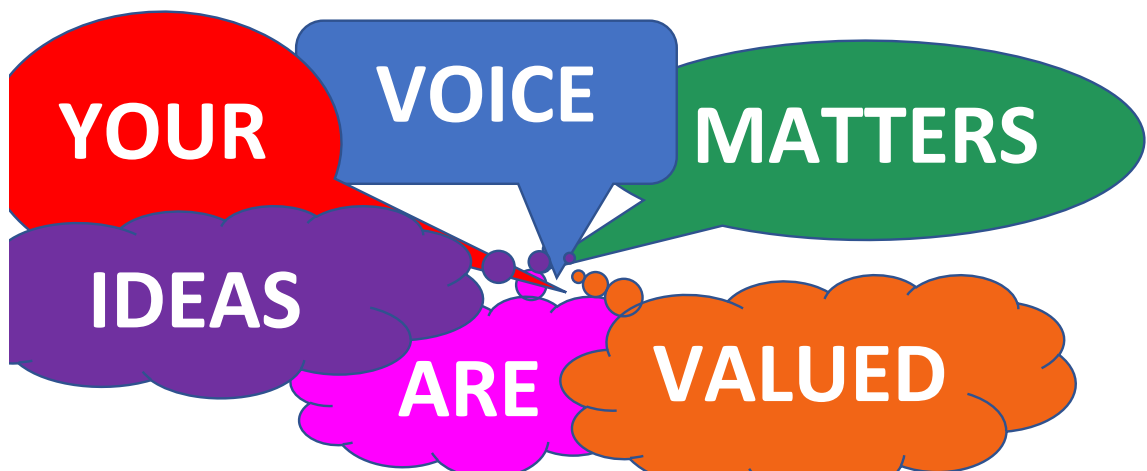
Saturday
March 26th
1:00PM

Session 2

Wednesday
March 30th
7:00PM

Session 3

Thursday
March 31st
6:00PM



Are you in need of healthy food?

The FeedMore WNY food pantry offers a variety of nutritious fresh and shelf-stable food items to those in need. The pantry is open to the West Side community, including D'Youville students.



Catholic Health | D'Youville | FeedMore WNY

Visitors to the FeedMore WNY food pantry may also be eligible to join the Food Farmacy! This unique program will provide you with free counseling with a Registered Dietitian. Plus, take part in regular health screenings, nutrition education and cooking demos.

How to get started:

Visit the food pantry representative on the second floor of the Health Professions Hub on the D'Youville campus (301 Connecticut St.)

When:

Open Tuesdays and Thursdays from 10 a.m. – 2 p.m.

Cost:

FREE!

Generously supported by



To learn more about this program, contact Katie Morris at (716) 829-7736 or kmorris@feedmorewny.org.

¿Estas interesado en comida saludable?

La FeedMore WNY despensa de comida ofrece una variedad de opciones nutricionales fresco y sano. La despensa está abierta a todos en la comunidad del Westside, incluyendo estudiantes de D'Youville.



Catholic Health | D'Youville | FeedMore WNY

¡Los que visitan la FeedMore WNY despensa de comida pueden ser elegible para unirse con el Food Farmacy! Este programa único puede proveer té con un consulto de una dietista registrada. Además, pueden participar en exámenes de salud, educación nutricional, y demostraciones de comida.

¿Como puedes comenzar?

Visita un representante en el segundo piso del Health Professions Hub en el campus de D'Youville

(301 Connecticut St.)


¿Cuándo?

Estamos abierto los martes y miércoles

10am – 2pm

¿Costo?

¡Gratis!

Generosamente apoyado por  United Healthcare

Pare saber más sobre este programa, contacta Katie Morris a su número de teléfono (716) 829-7736 o correo electrónico kmorris@feedmorewny.org.

Catholic Health Marketing/Promotional Materials

Applying a Trauma-Informed Lens




Applying
a **Trauma-
Informed
Lens**

**FREE
Webinar**

**APPLYING A
TRAUMA-INFORMED LENS**
*Building a Culture of Resilience
in the Professions of Care*

**September 2, 2022
2:00 pm - 3:30 pm**

 **Catholic Health**
The right way to care.

Laurie M. Belanger, LCSWR

Laurie Belanger has been providing services to children, adults, and families in Western NY



for over 20 years. She is passionate about serving the needs of families coping with multi-layered, complicated concerns. Laurie has a strong interest and background in trauma, sensory development, chronic pain, adoption,

mental health and learning differences. She is an approved EMDR Consultant through EMDRIA, and is professionally trained in TBRI® (Trust Based Relational Interventions) by the Karyn Purvis Institute of Child Development. Laurie currently provides therapy in her private practice setting in East Amherst, NY. Her passion for sharing trauma education has led her, over the last several years, to provide presentations and training. Laurie has worked with school districts, foster care/adoption agencies, churches, mental health providers and has presented at professional conferences for a diverse group of disciplines. She is dedicated to providing cross-discipline education to the community so that those outside of the trauma therapy field might have access to the most up-to-date, evidence-based knowledge to add to their own area of service. Laurie has also worked at Christian Counseling Ministries and is an active member of her local Presbyterian Church.

Sisters of Charity Hospital **Clinical Pastoral Education**

Clinical Pastoral Education
ACPE Accredited Center

Rev. Christopher Okoli
Director of CPE

Dr. Yvonne Valeris
Certified Educator

Rev. Amir Tawadrous
Certified Educator Candidate

Nancy Koteris
Administrative Assistant III

Sisters of Charity Hospital **Clinical Pastoral Education**

2157 Main Street, Buffalo, NY 14214
(716) 862-1374

Speaker Contact

lbelanger@willowintegrative.com
(716) 276-9520
grow-with-that.org

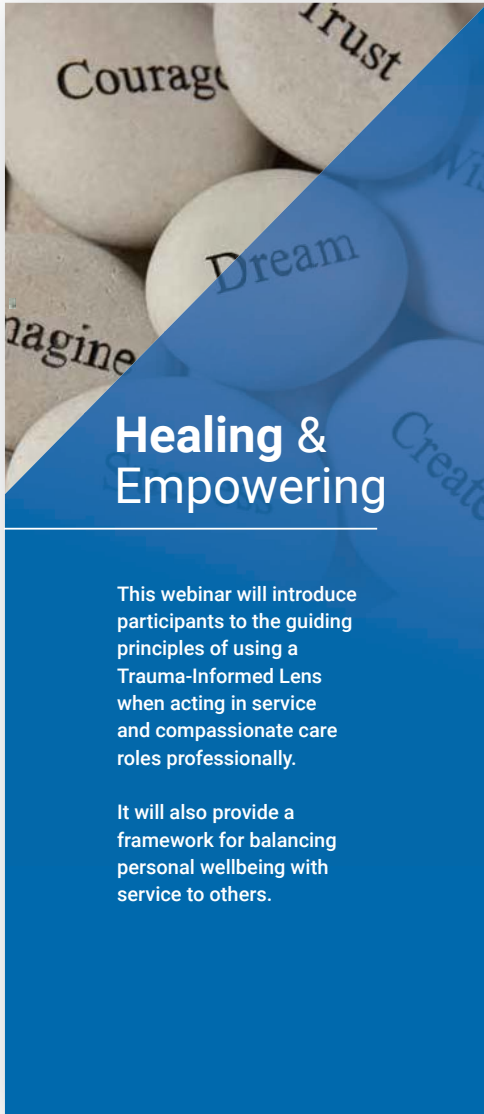


Contact
Nancy Koteris
to register for this
FREE WEBINAR
(716) 862-1374
nkoteris@chsbuffalo.org

Once registered, the
Webex link will be
sent to you.

 **Catholic Health**

23211 rev 8/9/22



Healing & Empowering

This webinar will introduce participants to the guiding principles of using a Trauma-Informed Lens when acting in service and compassionate care roles professionally.

It will also provide a framework for balancing personal wellbeing with service to others.

Applying a Trauma-Informed Lens

Free Webinar • September 2, 2022

Objectives

Join us in learning practical material that will bring *color* and *light* to difficult times and circumstances.

- Participants will learn about various forms of trauma and the different ways in which they can impact physical experience, the processing of thoughts, and the experience of emotion.
- Participants will be able to identify practical and resilience building strategies for reducing the often harmful effects of holding compassionate space and witnessing patient trauma on a daily basis.
- Participants will be able to describe, discuss, and implement independently, in their own unique settings, trauma-informed strategies for supporting their own skills for delivering care.



Register Today!

Call Nancy Koteras at

(716) 862-1374 or email

nkoteras@chsbuffalo.org

Once registered, the Webex link will be sent to you.





Mercy Comprehensive Care Center

Expert, compassionate medical care
for a full range of conditions and
for patients at every stage of life.

 **Catholic Health**
The right way to care.

Your first place for care – right in the neighborhood

At the Mercy Comprehensive Care Center, we are dedicated to improving the health of you and your family. We are a multispecialty practice that provides expert diagnosis, treatment and ongoing care for a range of health conditions. You'll find services including primary care, pediatric care, OB/GYN services, orthopedic services and more – all at a single site – at our state-of-the-art 21,000 square foot medical center in the heart of Buffalo's Old First Ward.

On-site laboratory and imaging services help provide fast, convenient diagnoses, and we can help arrange additional care from other providers when needed, including specialist and addiction services. Our advanced educational programs, like Heart Smart for Life, help promote wellness and prevent illness.

- Same-day appointments whenever possible
- Translation services to accommodate any language
- Telehealth visits are available
- Medicare, Medicaid and most insurances accepted. Financial assistance available.
- 24-hour answering service



 Catholic Health
Mercy Comprehensive Care Center
A department of Sisters of Charity Hospital

Mercy Comprehensive Care Center

397 Louisiana Street
Buffalo, New York 14204

(716) 847-6610

More than primary care

- Primary Care
- Pediatrics
- OB/GYN
- Orthopedics
- Podiatry
- Nutritional Counseling
- Community Programs
- Social Counseling
- Educational Programs
- Insurance Assistance

All services provided at the Mercy Comprehensive Care Center are departments of Sisters of Charity Hospital.

Our Mission

We are called to reveal the healing love of Jesus to all.

Our 2025 Vision

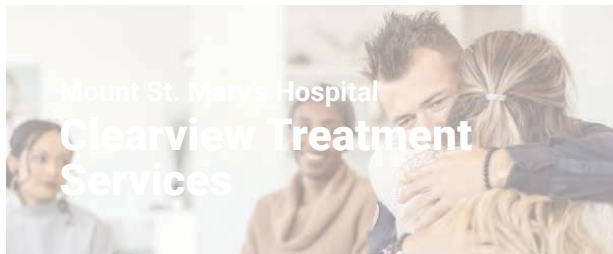
As your trusted partner, inspired by faith and committed to excellence, we lead the transformation of healthcare and create healthier communities.

 **Catholic Health**

21861 - REV 3/22/21

Catholic Health Marketing/Promotional Materials

Clearview Treatment Services



Clearview Treatment Services has been helping individuals with substance use disorders since 1986. Located in Mount St. Mary's Hospital in Lewiston, Clearview provides an inpatient rehabilitation program in a safe, comfortable environment. Our team takes a comprehensive approach to addiction management. We provide individualized, progressive care for individuals, including 24/7 nursing coverage, a medical director, a clinical psychologist, and a psychiatrist to address patient needs.

You don't have to overcome your addiction alone. Having the right type of support system around you is critical on your path to recovery. Our addiction management programs are tailored to the individual, with recommended treatment for your circumstances and the complexity of your condition. We respect the person living with addiction by treating patients with compassion and observing their privacy.

What to Expect from Clearview:

- Individualized care in a safe, comfortable short-term rehabilitative environment
- Individual and group counseling sessions focusing on medical and social needs, relapse prevention, addiction education, mental health and wellness, spirituality, infectious diseases, grief and loss, and self-help.
- Available therapies include Cognitive Behavioral Therapy (CBT) and Rational Emotive Behavior Therapy (REBT).
- Gender-specific treatment and living arrangements



Eligibility:

- 18 years of age or older with a severe alcohol/drug dependency issue

Please note: All potential patients undergo a medical and mental health assessment prior to admission. Clearview does not offer detox services.

Referrals:

- Referrals are accepted by an individual's physician, outpatient provider, detoxification unit, legal entity, and others involved in assisting those with substance use disorders. Clearview also accepts self-referrals.

Cost:

- Clearview Treatment Services accepts Medicaid, Medicare, and most private insurances.
- Individuals may also choose self-payment.

Length of Stay:

28 days

What happens after discharge?

Because all cases are different, the steps after discharge vary; some patients continue treatment in an outpatient setting in the community, while others will enter into additional residential treatment.

Contact us at:

**Clearview Treatment Services at
Mount St. Mary's Hospital**
5300 Military Road
Lewiston, NY 14092
(716) 298-2115



22032 - REV 4/15/21

Pregnant with your first baby?



**A lot's
gonna
change**

You've got this!
with a free personal nurse



What is Nurse-Family Partnership?

Nurse-Family Partnership is **free** for women who are pregnant with their first baby. When you enroll you will be connected to a registered nurse who will provide the support, advice and information you need to have a healthy pregnancy, a healthy baby and be a great mom.



How much does it cost?

Nurse-Family Partnership is **free** to eligible women.

Your nurse will support you to:

- Have a healthy pregnancy and a healthy baby.
- Become the best mom you can be.
- Learn and practice things that make you more confident as a mom, like breastfeeding, nutrition, child development, safe-sleep techniques and much more.
- Get referrals for healthcare, childcare, job training and other support services available in your community.
- Continue your education, develop job skills or follow your dreams for the future.

Who can enroll in Nurse-Family Partnership?

Any woman who:

- Is pregnant with her first child
- Is pregnant 28 weeks or less
- Meets income requirements
- Lives in an area where Nurse-Family Partnership is available

Can my baby's father participate?

The father, family members and friends are welcome to participate in the program, but as the mom, **you are the main focus!**





Nurse-Family
Partnership

Helping First-Time Parents Succeed



A lot's gonna change



You've got this!

with a free personal nurse

that can give you the support, advice and information
you need as a new mom, pregnant with your first baby.

Contact Us
CALL (716) 706-2482
TEXT (844) 637-6667
www.chsbuffalo.org

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For your free personal nurse

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www.chsbuffalo.org
For your free personal nurse



Breastfeeding Support Group

Every Tuesday from 11 am - 1 pm

Every Thursday from 6:30 pm - 8:30 pm

Offering Support from Pregnancy to Weaning

Get support at our Baby Café – live, online!

- Breastfeeding: planning, guidance and support
- Breast pumping support
- Information about breastfeeding and returning to work
- Opportunity to meet other mothers – share tips and socialize
- Support when you are ready to wean your child

Interested? Simply provide your name, email address, and phone number to jscarpen@chsbuffalo.org or log on using the below QR code.



Licensed & recognized by:





Our Mission

We are called to reveal the healing love of Jesus to all.

Our Vision

As a trusted partner, inspired by faith and committed to excellence, we lead the transformation of healthcare and create healthier communities.

Our Values

REVERENCE

We honor the inherent dignity and uniqueness of each person.

COMPASSION

We unconditionally demonstrate empathy, kindness, and acceptance.

INTEGRITY

We are honest, transparent, and accountable.

INNOVATION

We continually learn, find creative solutions, and embrace change.

COMMUNITY

We work together to build community and promote social justice in our organization and in society.

EXCELLENCE

We commit to achieve the highest standards of quality, safety, and service.



Mercy Hospital of Buffalo
565 Abbott Road
Buffalo, NY 14220
chs.buffalo.org