CHAUTAUQUA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chautauqua County Community Health Improvement Plan 2014-2017

November 15, 2013

This document was developed in partnership with local hospitals including Brooks Memorial Hospital, TLC Health Network, WCA Hospital, and Westfield Memorial Hospital, in addition to the Chautauqua County Department of Mental Hygiene, the Chautauqua County Health Network, and The Chautauqua Center. The P2 Collaborative of Western New York provided oversight and guidance of the planning and public engagement processes.

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Disclaimer: On October 16, 2013, TLC Health Network announced that Lakeshore Hospital will close January 31, 2014.

Overview of the Community Health Planning Process

In response to the New York State Department of Health's (NYSDOH) request for local health departments to collaborate with local hospitals on their respective Community Health Assessments and Community Service Plans, the Chautauqua County Community Health Planning Team (CCCHPT) created during the 2010-2013 CHA/CSP process reconvened to develop the 2014-2017 Community Health Improvement Plan. As requested by the state, this team included the local health department and all hospitals located in Chautauqua County. In addition, the rural health network, the federally qualified health center, and the local mental health department provided assistance with priority selection and planning.

Chautauqua County Community Health Planning Team

Brooks Memorial Hospital

Established in 1898, Brooks Memorial Hospital (BMH) provides a wide range of health care services to the communities surrounding Dunkirk and Fredonia, NY with an emphasis on quality and caring. Current offerings include Acute Care, Cardiac Rehabilitation, Cardiopulmonary, Diagnostic Imaging, Dialysis, Emergency Care, Gastroenterology, Laboratory Services, Obstetrics, Physical Therapy, Short Term Rehabilitation, Sleep Studies, Surgical Care, and Women's Imaging. Brooks Memorial Hospital is also a member of Lake Erie Regional Health System of New York.

Chautauqua County Department of Health and Human Services

The Chautauqua County Department of Health and Human Services (CCDHHS) protects and promotes the health, safety and self-reliance of Chautauqua County residents and provides essential human services, especially for those who are least able to help themselves. Divisions of the CCDHHS include: Administrative Services, Public Health, Family and Children Services, Temporary Assistance, Medical Assistance, Legal Affairs, and Youth Bureau. Addressing the social determinants of health is critical to improving the overall health and well-being of communities. In an effort to affect real change, the integrated department has taken on the task of integrating programs such as immunization, disease control, maternal child health, environmental health, early intervention, child, family and adult services, temporary assistance, and SNAP to name a few. This holistic approach to human need is a step in the right direction toward real, long -term solutions. The CCDHHS is making significant progress to increase efficiencies, reduce duplication, and positively impact the lives of County residents.

Chautauqua County Department of Mental Hygiene

The Chautauqua County Department of Mental Hygiene (CCDMH) is charged under Mental Hygiene Law with planning for, funding and overseeing community services to individuals with

mental health, addiction and/or developmental challenges. The Department of Mental Hygiene also operates an array of outpatient services including behavioral health clinics and health home services.

Chautauqua County Health Network

Chautauqua County Health Network (CCHN) is a state designated rural health network comprised of three hospital organizations, physicians, and more than 50 local health and community based organizations including skilled nursing, home care, hospice, county government, business, and human service agencies. CCHN also has two sister-organizations, the Integrated Delivery System (IDS) and Chautauqua Region Associated Medical Partners (AMP). First, IDS is an Independent Practice Association (IPA) comprised of 110 physician members, both primary care and specialties, along with the same three hospital organizations as CCHN. Second, AMP recently formed as an Accountable Care Organization that includes eight primary care physician groups (35 physicians), all three hospital organizations, three skilled nursing facilities, as well as beneficiary and community based agency representation. Our organizations are co-located which has enabled us to share staff and leverage our respective resources to sustain and improve the delivery of services locally.

TLC Health Network

TLC Health Network (TLC) is comprised of Lake Shore Health Care Center - a full service hospital in Irving - and various outpatient facilities throughout Chautauqua and Cattaraugus Counties. Combined, these facilities offer a wide range of services to the people of Western NY, including Acute Care, Behavioral Health, Cardiac Rehabilitation, Cardiopulmonary, Chemical Dependency Counseling, Diagnostic Imaging, Emergency Care, Gastroenterology, Home Health Care, Laboratory Services, Long Term Care, Physical Therapy, Primary Care, Short Term Rehabilitation, Surgical Care, Urgent Care, and Women's Imaging. TLC Health Network is also a member of Lake Erie Regional Health System of New York. **Disclaimer: On October 16, 2013, TLC Health Network announced that Lakeshore Hospital will close January 31, 2014.**

P^2 Collaborative of Western New York

P^2 Collaborative of Western New York (P^2 of WNY)is a Robert Wood Johnson Foundation Aligning Forces for Quality organization which works to improve the health of Western New Yorkers. Efforts focus on quality improvement, community health planning, and health engagement programs. For the CHIP process, P2 provided extensive facilitation, oversight and guidance to the CCCHPT.

The Chautauqua Center

The Chautauqua Center (TCC), a Federally Qualified Health Center, located in Dunkirk provides an array of services to the residents of Chautauqua County and its surrounding areas. Serving all individuals regardless of ability to pay or insured status, TCC provides family medicine,

gynecology, women's health, family planning, social and mental health, and support services. TCC believes and values the importance community collaborations with both health and non-health related organizations. Our mission is to deliver comprehensive, high quality patient-centered health and support services in the Chautauqua region. Our patient-centered service principles are access, treatment, education, and prevention delivered by friendly and professional clinic and administrative teams.

Women's Christian Association Hospital

The Woman's Christian Association Hospital (WCA) of Jamestown, NY is a not-for-profit acute care hospital which provides service to an economically challenged, rural population of approximately 160,000 people in Chautauqua County, Western Cattaraugus County, NY, and Northwestern Warren County, PA. WCA operates two inpatient facilities: WCA Hospital, a 277-bed full-service community hospital, and Jones Memorial Health Center, an 40-bed facility. Services provided include cardiology, cancer treatment, general surgery, orthopedic care, women's services, behavioral health, community preventative services, and emergency department care.

Westfield Memorial Hospital

Westfield Memorial Hospital (WMH) was founded in 1942 to meet the community need for a non-profit, acute care general hospital, and remains the principal resource for acute hospital and ambulatory care for Westfield, NY and the surrounding communities. Services include inpatient care, emergency room, ambulatory surgery, imaging, cardiac services, physical therapy, wound care, specialty care, and diabetes services. An affiliate of Saint Vincent Health System in Erie, PA, the hospital also offers direct access to highly specialized care, including the convenience of on-site physician specialists. With a modernized facility staffed by the area's finest physicians and medical professionals, Westfield Memorial Hospital is committed to providing high-quality patient care in a friendly and compassionate environment.

Selection of Prevention Agenda Priority Areas

Consideration of public input and secondary health data from the NYSDOH led the CCCHPT to select the following priorities, focus areas, and disparities:

1) Prevent Chronic Diseases
   Focus Area(s): Reduce Obesity in Children and Adults, and Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and community Settings
   Disparity: Low-income residents

2) Promote Healthy Women, Infants, and Children

Focus Area(s): Preconception and Reproductive Health, and Maternal and Infant Health (Not including TLC Health Network or Westfield Memorial Hospital)

3) Promote Mental Health and Prevent Substance Abuse
Focus Area(s): Strengthen Infrastructure Across Systems

Gathering Public Input

To gauge health issues in Chautauqua County the CCCHPT adopted a three-pronged approach, taking into consideration: input from community members, secondary data from NYSDOH and other health resources, and input from local content area experts. Community input was gathered through a primarily web-based survey and three community conversations.

Community Health Survey

The Chautauqua County Community Health Survey was open for responses from March 28, 2013 to June 26, 2013. The survey asked residents what issues they considered to be community problems, what health issues were most concerning, about their personal health, and requested demographic information. The survey also asked residents which medical services they leave the county for and why. The P^2 Collaborative of WNY provided technical assistance in designing the survey. Survey results were automatically analyzed by Survey Monkey programming. The CCCHPT was able to use filter functions on the website to look at trends in the data by specific population groups and identified behaviors.

The link for the survey was widely distributed through Facebook, the CCDHHS website, was featured in a press release to local newspapers, and sent electronically to a number of employee and community-based email distribution lists. All CCCHPT partners participated in electronic distribution of the survey. The web-based format successfully reached White, middle class, employed, and insured residents. Paper copies of the survey were made available throughout the community to reach special population groups, who were less likely to respond to the web-based survey.

In order to obtain input from hard to reach residents, the CCCHPT made efforts to target the following population groups:

- Chautauqua County's new federally qualified health center- The Chautauqua Center- has serves a primarily Hispanic patient population. Center staff assisted patients in filling out the surveys and also provided translation services.
- Paper copies of the survey were provided to the local Amish population at Cancer Services Program Clinics in Sherman and Clymer, and were also shared by employees with their Amish friends.

- Paper copies of the survey were provided to inmates of the Chautauqua County Jail to gain input from incarcerated residents. Jail staff assisted in this process by encouraging participation and providing assistance when necessary.
- Paper copies of the survey were available to low-income residents in CCDHHS Temporary Assistance Offices, the reproductive health clinics, the federally qualified health center, hospital emergency rooms, and mental health clinics.

From March 28 to June 2, 2013, 1,170 survey responses were collected: 1,027 responded electronically; 143 paper responses were collected. The majority of the respondents self-identified as Female (73.99%) and White/Caucasian (95.34%) and reported having some form of private health insurance (76.67%).

The top three family and/or community problems identified in the survey were jobs (79.20%), not enough money (52.39%), and transportation (34.19%). The top three health issues individuals were more concerned about were health insurance (41.32%), obesity or overweight (37.43%), and cancer (23.24%).

A copy of the Chautauqua County Community Health Survey is included in Appendix A for review.

Community Conversations

Community members' perceptions of health issues were also gathered at three "Community Conversations" sponsored by the P^2 Collaborative of WNY and the Chautauqua County Health Network. These conversations spanned Chautauqua County's geographic and cultural separations, covering the "North County" in Dunkirk, the "South County" in Jamestown, and the "West County" in Westfield. These diverse locations were able to capture the County's rural and urban populations. Community members were asked to give their perspective on community health and wellness issues and offer solutions in an open discussion facilitated by P^2 Collaborative representatives.

Specific dates, locations, and attendance for these Community Conversations were as follows:

- June 13, 2013 at WCA Hospital in Jamestown, NY (42 people present)
- June 20, 2013 at Dunkirk High School in Dunkirk, NY (10 people present)
- June 26, 2013 at Eason Hall in Westfield, NY (16 people present)

Although health issues and solutions differed by area, the following topics were discussed in at least two of the three meetings:

- Transportation
- Food accessibility

- Health literacy/education
- Poverty
- Lack of motivation
- Discrimination/cultural stigmatization
- Substance abuse

Proposed solutions discussed at the meetings included:

- Increasing the number and promotion of community health events
- Free health screenings
- Community weight loss challenges
- Mentoring programs
- Support groups
- Improve public transportation

Summaries of individual Community Conversations are available for review in Appendix B.

Stakeholder Meeting

After identifying potential health improvement strategies for the proposed collaborative priority areas, the CCCHPT reached out to local content area experts to ensure that these strategies were logical in the context of the community and current efforts. Professionals working in the fields of chronic disease prevention, mental health and substance abuse, and prenatal care were in attendance of a half-day meeting to observe outstanding statistics, and provide specific guidance for the Community Health Improvement Plan. Thirty people were in attendance, representing sixteen organizations and twenty-seven different programs.

Stakeholders confirmed the issues that were presented and provided guidance regarding items to include in the Community Health Improvement Plan. The following table provides a list of organizations and representatives who attended the September 13 Community Health Improvement Plan Stakeholder Meeting.

Table 1. Organizations and representatives present at CHIP Stakeholder Meeting

Attending Organizations	Representative
Brooks Memorial Hospital	Theresa Schrantz
Chautauqua Alcohol and Substance Abuse Council	Kathleen Colby
Chautauqua County Department of Health and Human Services	Julie Apperson
Chautauqua County Department of Health and Human Services	Angela Swartzman
Chautauqua County Department of Health and Human	Breeanne Agett

Services	
Chautauqua County Department of Health and Human Services, Cancer Services Program	Darlene Rowe
Chautauqua County Department of Health and Human Services, Early Intervention Program	Denise Nichols
Chautauqua County Department of Mental Hygiene	Briana Postle
Chautauqua County Department of Mental Hygiene	Pat Brinkman
Chautauqua County Health Network	Kerri Brown
Chautauqua County Health Network	Ann Abdella
Chautauqua County Health Network	Janet Forbes
Chautauqua Lake Child Care Center	Beth Starks
Chautauqua Opportunities Inc.	Tarra Johnson
Chautauqua Opportunities Inc.	Jen Irwin
Delphi Health Care Partners	Melissa Bock
Eastside YMCA	Max Martin
Jamestown Psychiatric	Sandra Dohl
Jamestown Treatment Court, 8th Judicial District	Cathy Newton
Lake Erie Regional Health System	Scott Butler
Lake Erie Regional Health System	Kimberly Maben
P2 of WNY	Marissa Slevar
The Chautauqua Center	Mike Pease
WCA Hospital	Toni DeAngelo
WCA Hospital	Linda Johnson
WCA Hospital	Andy O'Brien
WCA Hospital	Mary Bosek
Westfield Memorial Hospital	Patty Ballman
Westfield Memorial Hospital	Kim Greiner
YMCA of Jamestown	Meg Pickard

Organizations that were invited to the meeting, but were unable to attend are listed in Table 2.

Table 2. Organizations unable to attend CHIP Stakeholder Meeting

Invited Organizations
American Cancer Society
Chautauqua Mental Health Association
Cornell Cooperative Extension of Chautauqua County
Erie-2 Chautauqua Cattaraugus BOCES
Family Health Medical Services
The Resource Center
Tri-County Tobacco Free Programs

United Way of Southern Chautauqua County
WIC Program

Data and Information Used

The New York State Department of Health's Community Health Indicator Reports and Tracking Indicators for Public Health Priority Areas were extensively used to identify health issues in Chautauqua County. These figures compiled by New York State were pulled from many different data sources, including NYS Vital Statistics Data, NYS Expanded Behavioral Risk Factor Surveillance System (eBRFSS), Statewide Planning and Research Cooperative System (SPARCS) the US Census Bureau, and the Student Weight Status Category Reporting System (SWSCRS).

Additional behavioral and public input data was provided by the New York State Department of Health through the Community Transformation Grant, "Community Transformation in Small Communities Grant (CTG) Population Survey Preliminary Frequencies from Baseline Data (2013). A breakdown of ICD-9 codes regarding newborn drug-related discharges was provided by Trang Nguyen at the New York State Department of Health (2008-2010).

Demographic and socioeconomic data were gleaned from the U.S. Census Bureau website, and the NYS Education Department School Report Cards website. Table 3 provides a summary of data sources that were used to identify health issues in Chautauqua County. An exhaustive list of data sources used in the Community Health Assessment process is included in its Methodology section.

Table 3. Summary of data sources used in priority area selection

Data Summary Reports	Years	Types of Data	Website
Health Data			
NYS Community Health Indicator Reports	2008-2010, 2009-2011	Births, mortality and hospitalization rates for health statuses and conditions, behavioral data	http://www.health.ny.gov/statistics/chac/indicators/
NYS Indicators for Tracking Public Health Priority Areas, 2013-2017	Various 2005-2012	Health and socioeconomic data with breakdowns for health disparities by income and minority status	http://www.health.ny.gov/prevention_agenda/2013-2017/indicators/2013/chautauqua.htm

Community Transformation Grant (CTG) Population Survey Preliminary Frequencies from Baseline Data Collection	2013	Behavioral data regarding weight, nutrition, physical activity, and tobacco use; Public opinion data regarding nutrition, physical activity, and smoke exposure environments	N/A, provided directly by NYSDOH Community Transformation Grant staff; July 2013
Newborn drug-related discharge ICD-9 Codes	2008-2010	Breakdown of ICD-9 codes included in newborn drug-related discharge rates	N/A, provided directly by NYSDOH staff member Trang Nguyen; July 2013
Demographic Data			
US Census Bureau American Community Survey	2007-2011	General population and demographic figures, poverty, employment, education, etc.	http://www.census.gov/acs/www/
NYS State Education Department School Report Cards	2011-2012	Population and socioeconomic status by school district, school resource data	http://www.p12.nysed.gov/irs/reportcard/

Rationale for Selecting Priorities

In order to identify needs and prioritize the data, the CCCHPT looked at conditions for which Chautauqua County was significantly worse than New York State or categorized in the 4th quartile. Issues that affected large numbers of people, but were not necessarily different from state averages, such as obesity, were also flagged as important.

In addition to identifying overall burden of health issues and discrepancies when compared to New York State, the core group took into consideration needs identified in the community health survey and at the community conversations. Existing infrastructure, support, and funding were also considered in the selection process. The following framework describes how priority areas were selected.

To be selected, priority areas:

- Must include data that indicates great burden to Chautauqua County (high case numbers) or great exceedance over state averages
- Must have been identified as a need in the community health survey and at community conversations
- Must include relevant actionable steps for agencies involved
- Were bolstered by existing resources to support action items

Justifications for selecting priority areas are listed.

Agenda Priority Area: Prevent Chronic Disease

- Demonstrated burden for obesity across all ages, as well as high mortality rates for cardiovascular disease, stroke, and cancer
- Supported by health behavior data
- Identified both in survey and at community conversations
- All agencies are affected by and have a stake in chronic disease prevention and management
- Infrastructure, funding, and support in place through several grants in Chautauqua County (e.g. Community Transformation Grant, and Creating Healthy Places to Live, Work, and Play)

Prevention Agenda Priority Area: Promote Healthy Women, Infants, and Children

- Demonstrated discrepancies from state averages for early prenatal care, maternal health, birth spacing, breastfeeding rates, and newborn drug-related hospital discharges
- Identified both in survey and at community conversations

- Both Brooks Memorial Hospital and WCA Hospital provide labor and delivery services and CCDHHS provide community programming in this area. TLC Health Network and Westfield Memorial Hospital were excluded from this priority area action plan because they do not provide labor and delivery services.
- CCDHHS was recently awarded Maternal and Infant Community Health Collaborative funds from NYSDOH to work in this priority area, in conjunction with local hospitals, community agencies, and prenatal care providers.

Prevention Agenda Priority Area: Promote Mental Health and Prevent Substance Abuse

- While there is not a great deal of mental health and substance abuse data available through the NYSDOH, this issue was identified when observing that newborn drug-related discharge rates were more than double the state average. Anecdotal evidence from professionals in the field supplemented the need identified for this priority area.
- Identified both in survey and at community conversations
- TLC Health Network and WCA Hospital provide mental health and chemical dependency services.
- Collaboration with the Chautauqua County Department of Mental Hygiene will help to bolster this initiative.

CCCHPT Community Health Improvement Plan 2014-2017

Prevention Agenda Priority Area: Prevent Chronic Diseases

CCCHPT Partners Included: BMH, CCDHHS, CCHN, TCC, TLC, WCA, WMH
Disparity: Low-income residents

Focus Area: Reduce Obesity in Children and Adults		
NYS Overarching Objective 1.0.1: By December 31, 2017 reduce the percentage of public school children reported to the Student Weight Status Category Reporting System who are obese by 5% to 12.8% (Baseline: 17.8%; Target: 12.8%; Years: 2008-2010; Source: NYS Student Weight Status Category Reporting System) NYS Overarching Objective 1.0.2: By December 31, 2017, reduce the percentage of adults ages 18 years or older who are obese by 5% to 22.3% (Baseline 27.3%; Target: 22.3%; Years: 2008-2009; Source: NYS eBRFSS)		
NYS Goal 1.1: Create community environments that promote and support healthy food and beverage choices and physical activity.		
Chautauqua County Objective CD 1.1. By December 31, 2017 decrease the percentage of adults ages 18 years and older who consume at least one soda or sugary drink per day by 5%		
Tracking Indicators: (Baseline: 25%; Target: 20%; Year: 2013; Source: Community Transformation Grant Population Survey Preliminary Frequencies from Baseline Data Collection)		
Activities/Interventions	*Date*	*Partner(s) Responsible*
Educate county residents about healthy beverage choices through media campaign (radio, television, social media), utilizing Community Transformation Grant resources. Special emphasis will be placed on low-income target school districts of Dunkirk, Jamestown, and Silver Creek.	1/14-9/14	CCDHHS
Provide presentations regarding healthy beverage choices to organizations throughout Chautauqua County and technical assistance for healthy beverage policy development (Tracking Indicator: number of new policies developed; Goal: 14 buildings by September 2014)	1/14-9/14	CCDHHS
Provide presentations to appropriate staff/boards representing hospitals and County buildings	3/14	CCDHHS
Pass healthy beverage policy at each hospital and at Chautauqua County buildings (Tracking Indicator: number of policies passed; Goal: 4 policies)	3/14-9/14	BMH, CCDHHS, TLC, WCA, WMH
Work with local media outlets to highlight new policies (Tracking Indicator: number of earned media hits (radio, television, newspaper); Goal: 4 media hits)	3/14-9/14	CCDHHS

Carry out specifications of healthy beverage policies	9/14-1/15	BMH, CCDHHS, TLC, WCA, WMH
Agency representatives will inspect vending/sales to ensure standards set in policy are being met (Tracking Indicator: policies met or not met)	6/15, 12/15, 6/16, 12/16, 6/17, 12/17	BMH, CCDHHS, TLC, WCA, WMH
Track sales data to identify increase or decrease in sales; if decrease is detected, work with vendors to identify new healthy products that will sell (Tracking Indicator: Sales figures before change, sales figures after change; Goal: no decrease in sales)	6/15, 12/15, 6/16, 12/16, 6/17, 12/17	BMH, CCDHHS, TLC, WCA, WMH
Work with Community Transformation Grant Leadership Team and CCCHPT to identify opportunities to expand policy development, and opportunities for sustainability	8/14-12/14	BMH, CCDHHS, TLC, WCA, WMH
Continue to work with community organizations to develop healthy beverage policies; expand to other areas in county	9/14-9/17	CCDHHS
Chautauqua County CD Objective 1.2: By December 31, 2017 increase availability of fresh and local produce; increase % of adults eating 5 or more fruits or vegetables per day by 5%.		
Tracking indicators: (Baseline 24.9%, Target: 29.9%; Years: 2008-2009; Source: NYS Expanded Behavioral Risk Factor Surveillance System)		
Activities/Interventions	*Date*	*Partner(s) Responsible*
Collaborate with Chautauqua Health Action Team and Cornell Cooperative Extension of Chautauqua County to identify ways to expand local food system (Farm to School, Farm to Table, Local Foods Coalition, Food Hub efforts)	1/14-12/17	BMH, CCDHHS CCHN, TLC, WCA, WMH
Plan hospital gardens, start seeds (Tracking Indicator: plans developed, seeds started)	2/14-3/14	BMH, CCHN, WCA
Along with designated patients, plant starters (Tracking Indicator: seeds planted)	4/14-5/14	BMH, CCHN, WCA
Maintain and care for gardens; educate patients on how to care for gardens (Tracking Indicators: number of patients who help maintain gardens)	4/14-9/14	BMH, CCHN, WCA
Offer produce from gardens and produce from external farmers for sale to Chautauqua County residents, use produce in hospital meals	6/14-10/14	BMH, CCHN, WCA
Refer low-income patients and residents to local farmers; markets that accept SNAP benefits, WIC Vegetables and Fruits Checks, and Senior Farmers' Market Nutrition Program	1/14-12/14	BMH, CCDHHS CCHN, TCC, TLC, WCA, WMH

Coupons (Tracking Indicators: Number of WIC, SNAP, and Senior vouchers or dollars spent at markets)		
Donate produce from garden to low-income residents (ex/cancer treatment patients, Meals on Wheels, local soup kitchens)	6/14-10/14	BMH, WCA
Evaluate impact and success of healthy foods work through feedback from patients, employees, and visitors (satisfaction surveys, anecdotal evidence)	11/14-2/15	BMH, CCDHHS CCHN, TLC, WCA, WMH
Replicate steps if indicated, identify new opportunities to expand program to improve access for low-income patients and residents; establish next steps	3/15-12/17	BMH, CCDHHS CCHN, TLC, WCA, WMH
Chautauqua County Objective CD 1.3. By December 31, 2017, community residents in at least 6 municipalities in Chautauqua County will have access to safe and accessible streets for walking and biking.(Complete Streets)		
Tracking Indicators: (Baseline: 1 municipality; Target: 6 municipalities; Year: 2013; Source: Community Transformation Grant Staff)		
Activities/Interventions	*Date*	*Partner(s) Responsible*
Collaborate with NYSDOH Community Transformation Grant staff to achieve grant goals and objectives	1/14-9/14	CCDHHS
Collaborate with CCHN Creating Healthy Places to Live, Work, and Play staff	1/14-12/15	CCDHHS, CCHN
Locate additional funding sources to continue with Complete Streets work initiated by Creating Healthy Places to Live, Work, and Play, and Community Transformation Grants.	10/14-12/15	CCDHHS, CCHN
CTG staff conducts training sessions in various municipalities across Chautauqua County.	1/14-1/16	CCDHHS
Build relationships with municipalities interested in establishing Complete Streets policies.	1/14-1/16	CCDHHS
Share model practices with planning departments, departments of transportation, and public works departments.	1/14-1/16	CCDHHS
Engage community to develop grassroots support for complete streets.	1/14-1/16	CCDHHS
Work to uphold Complete Streets policies as road maintenance projects are scheduled.	1/14-12/17	CCDHHS
Chautauqua County Objective CD 1.4. By December 31, 2017, increase by 100% the number of child care centers and child care homes that provide developmentally appropriate (quantity and quality) physical activity for young children in high needs areas in Chautauqua County.		
Tracking Indicators: (Baseline: 15 child care centers and homes; Target: 30 child care centers and homes ; Year: 2013 (October); Source: Community Transformation Grant Staff)		
Activities/Interventions	*Date*	*Partner(s) Responsible*

Continue to recruit child care homes and centers to participate in physical activity trainings.	1/14-9/14	CCDHHS, Chautauqua Child Care Council
Continue to provide trainings. (Tracking Indicator: number of centers/homes trained, number of classrooms and students in centers)	1/14-9/14	Chautauqua Child Care Council
Work with Chautauqua Child Care Council and NYSDOH CTG staff to locate additional sources of funding to maintain Physical Activity Specialist.	6/14-12/14	CCDHHS, Chautauqua Child Care Council, NYSDOH
Expand reach of program, targeting areas outside of high needs districts to conduct trainings (if funding is available).	10/14-10/16	CCDHHS, Chautauqua Child Care Council
Identify next steps.	10/14-10/16	CCDHHS, Chautauqua Child Care Council, NYSDOH
Chautauqua County Objective CD 1.5. By December 31, 2017, 5 school districts in Chautauqua County will participate in a regional food procurement initiative working to consolidate food procurement, standardize menu planning, leverage buying power, and improve the nutritional quality of the school lunch program.		
Tracking Indicators: (Baseline: 0 school districts; Target: 5 school districts ; Year: 2013; Source: Community Transformation Grant Staff)		
Activities/Interventions	*Date*	*Partner(s) Responsible*
Work with NYSDOH, Broome County Health Department, and Cattaraugus County Health Department staff to further regional food procurement initiative.	1/14-9/14	CCDHHS
Collaborate with Erie-2 Chautauqua-Cattaraugus BOCES to develop a plan to initiate regional food procurement initiative.	1/14-9/14	CCDHHS
Contract with registered dietitian to improve nutritional quality of collaborative food bid.	1/14-9/14	CCDHHS
Identify next steps	8/14-10/14	CCDHHS
Locate funding source to support advancement of regional food procurement process.	9/14-1/15	CCDHHS, NYSDOH CTG staff
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in both Clinical and Community Settings		
NYS Goal 3.2: Promote use of evidence-based care to manage chronic diseases.		
Chautauqua County Objective CD 2.1. By December 31, 2017 reduce cardiovascular disease mortality rate by 5% in Chautauqua County.		
Tracking Indicators: (Baseline: 378.6 deaths per 100,000 residents; Target: 359.67 deaths per		

100,000; Year: 2009-2011; Source: NYS Vital Statistics Mortality Data)		
Activities/Interventions	*Date*	*Partner(s) Responsible*
Establish work group to coordinate *Million Hearts*™ Initiative activities.	1/14	BMH, CCDHHS, CCHN, WCA, WMH, health insurance companies, health care providers
Identify upcoming training opportunities from IPRO for the *Million Hearts*™ Initiative's hypertension management program.	1/14-3/14	CCHN, P2
Reach out to health care and community providers to educate them about the IPRO Initiative, identify and train master trainers, implement the program, and evaluate results. Target health care organizations that serve Medicaid population to focus on low-income residents.	3/14-6/15	CCHN, P2
Develop plan to disseminate *Million Hearts*™ ABCS (aspirin when appropriate, blood pressure control, cholesterol management, and smoking cessation) messaging to community.	3/14-6/14	BMH, CCHN, CCDHHS, WCA, WMH, health insurance companies
Align *Million Hearts*™ initiative benchmarks for success across Chautauqua Integrated Delivery Network.	5/14-5/15	CCHN, Identified provider practices, WCA, BMH, WMH, TLC
Pilot NCQA Heart/Stroke Recognition Program among 10 primary care physicians.	5/14-5/15	CCHN, Identified provider practices
Research effective methods to encourage cholesterol management improvement among county residents.	5/14-6/14	BMH, CCDHHS, CCHN, WCA, WMH, health insurance companies, health care providers
Explore feasibility of participating in regional coalition to address cardiovascular disease prevention and management.	1/14-12/16	BMH, CCDHHS, CCHN, WCA, WMH
Identify next steps.	7/15	BMH, CCDHHS, CCHN, WCA, WMH
Chautauqua County Objective CD 2.2: By December 31, 2017, increase the number of Chautauqua County adults who have been diagnosed with pre-diabetes that have participated in the National Diabetes Prevention Program by 300%.		
Tracking Indicators: Target: 93 participants completed program; Baseline: 31 participants completed program; Year: 2013; Source: Kerry Mihalko, RD, CDE and Kim Greiner, RD, CDE (DPP Lifestyle Coaches)		

Activities/Interventions	*Date*	*Partner(s) Responsible*
Identify funding streams to expand National Diabetes Program in Chautauqua County	9/13-1/14	CCHN
Obtain funding to train 7 new National Diabetes Prevention Program Lifestyle Coaches in Chautauqua County	9/13-1/14	CCHN
7 employers in Chautauqua County will have staff person trained to offer DPP to employees and community at large (specific efforts will be made to recruit Spanish-speaking Lifestyle Coach)	2/14-6/14	BMH, CCDHHS, CCHN, Cummins, TCC, TLC, WCA, WMH
Target primary care practices with high Medicaid populations to encourage referrals to NDPP for persons diagnosed with pre-diabetes (Tracking Indicators: Number of high Medicaid practices referring patients, number of Medicaid patients referred)	6/14-6/15	BMH, CCDHHS, CCHN, Cummins, TCC, TLC, WCA, WMH
Target faith-based groups and outreach organizations with high populations of Hispanic or African Americans who would benefit from DPP.	6/14-6/15	BMH, CCDHHS, CCHN, Cummins, TCC, TLC, WCA, WMH
Initiate at least 6 DPP programs for employees and community members (including lessons and follow-up sessions) (Tracking Indicators: number of programs initiated, number of participants)	6/15	BMH, CCHN, CCDHHS, Cummins, TCC, TLC, WCA, WMH
Collaborate to identify methods to increase sustainability of DPP in Chautauqua County	6/14-6/16	BMH, CCHN, CCDHHS, Cummins, TCC, TLC, WCA, WMH
Complete at least 6 DPP programs in Chautauqua County (Tracking Indicators: number of participants who completed program, pounds lost by participants individually and collectively, minutes of moderate to vigorous physical activity conducted each week by participants, participants' changes in A1C)	6/16	BMH, CCHN, CCDHHS, Cummins, TCC, TLC, WCA, WMH
Identify next steps	1/16-7/16	BMH, CCHN, CCDHHS, Cummins, TLC, TCC, WCA, WMH

Additional chronic disease prevention efforts currently underway:

- **With CCDHHS Community Transformation Grant (CTG) funds, Chautauqua Opportunities, Inc.'s Chautauqua Child Care Council is working to expand the Child**

and Adult Care Food Program to child care centers and homes and legally exempt providers (through local mandate) to improve nutrition in early child care settings.

- **The CTG School Coordinator is working with Jamestown Public Schools and Silver Creek Central School Districts to integrate physical activity into elementary classrooms.**
- **The CTG School Coordinator is working with Jamestown Public Schools to increase the number of children who walk or bike to or at school through Safe Routes to School activities.**
- **The CTG School Coordinator is working with Jamestown Public Schools and Silver Creek Central School District to expand school tobacco-free policies to school events that occur off of school grounds (e.g. field trips, formal dances, ball games, etc.).**
- **The CTG Community Coordinator and Tri-County Tobacco Free Programs are working to increase the availability of smoke-free low-income multi-unit family housing, through the development of smoke-free policies.**

Prevention Agenda Priority Area: Promote Healthy Women, Infants and Children

CCCHPT Partners Included: BMH, CCDHHS, CCHN, TCC, TLC, WCA, WMH

Partners: BMH, CCDHHS, WCA

Focus Area: Preconception and Reproductive Health		
Goal 1: Increase utilization of preventive health services among women of reproductive age to improve wellness, pregnancy outcomes and reduce recurrence of adverse birth outcomes. (NYS Action plan Goal 7)		
Chautauqua County Objective HWIC 1.1: By December 31, 2017 increase the percentage of pregnant women who access prenatal care during the first trimester by at least 10%.		
Tracking Indicators: Percentage of births with early (1st trimester) prenatal care. (Target 78.8%; Baseline: 68.8%; Year 2008-2010; Source: NYS Vital Statistics Data)		
Activities/Interventions	*Date*	*Partner(s) Responsible*
Hold Maternal and Infant Community Health Collaborative (MICHC) coalition meeting; partners participate in coalition	1/14-2/14	BMH, CCDHHS, MICHC partners, WCA
MICHC Coalition develops list of pregnancy resources to provide to pregnant mothers	3/14-4/14	BMH, CCDHHS, MICHC partners, WCA
MICHC distributes resource list to appropriate local agencies	4/14	BMH, CCDHHS, MICHC partners, WCA
MICHC Program works with CCDHHS Reproductive Health Clinics to develop process for referring women to prenatal care providers including Delphi (WCA's prenatal care clinic), including follow-up by clinic nurses and community health workers (Tracking indicator: Process developed)	5/14	BMH, CCDHHS, MICHC partners, WCA
MICHC Coalition reaches out to other practices, community agencies to share referral process (ex/college health centers, school nurses, school-based health centers, women's health services centers, etc.)	6/14-7/14	BMH, CCDHHS, MICHC partners, WCA
MICHC Coalition develops survey to identify reasons for late prenatal care among mothers	7/14	BMH, CCDHHS, MICHC partners, WCA
Community health workers and/or maternity nurses offer survey to new mothers in hospitals after delivery	8/14-12/14	BMH, CCDHHS, MICHC partners, WCA
MICHC Coalition reviews survey results, identifies barriers to early prenatal care	1/15	BMH, CCDHHS, MICHC partners, WCA
MCH Coalition develops plan to overcome barriers to early	2/15-	BMH, CCDHHS,

prenatal care	3/15	MICHC partners, WCA
Develop strategy for reaching out to pregnant women	3/15-5/15	BMH, CCDHHS, MICHC partners, WCA
Implement plans to overcome barriers to prenatal care, strategy to reach out to pregnant women	5/15-5/16	BMH, CCDHHS, MICHC partners, WCA
Evaluate process (Tracking Indicator: percentage of births with prenatal care during the first trimester)	6/16	BMH, CCDHHS, MICHC partners, WCA
Identify next steps, update plan of action	7/15-12/17	BMH, CCDHHS, MICHC partners, WCA
Chautauqua County Objective HWIC 1.2: By December 31, 2017 decrease the newborn drug-related discharge rate per 10,000 newborn discharges by at least 10%.		
Tracking Indicators: (Target: 156.9 per 10,000 ; Baseline; 174.3 per 10,000; Year 2009-2011; SPARCS, NYSDOH Bureau of Biometrics and Health Statistics)		
Activities/Interventions	*Date*	*Partner(s) Responsible*
Maternal and Infant Community Health Collaborative Coalition establishes workgroup to address newborn drug-related discharge rates	3/14	BMH, CCDHHS, MICHC partners, WCA
Convene or survey OB/GYN practices to explore feasibility of conducting standard urine-based substance abuse screenings during prenatal care (Tracking Indicator: number of practices who attend or respond to survey)	4/14-6/14	BMH, CCDHHS, MICHC partners, WCA
If urine-based substance abuse screenings determined not feasible, explore feasibility of incorporating substance abuse or mental health screening tools into prenatal clinic procedures	7/14-8/14	BMH, CCDHHS, MICHC partners, WCA
Develop process for identified screening strategy (Tracking Indicator: process developed)	9/14-10/14	BMH, CCDHHS, MICHC partners, WCA
Develop guidance for health practitioners to address positive screens (ex/guidance and referral flow chart) (Tracking Indicator: guidance developed)	11/14-12/14	BMH, CCDHHS, MICHC partners, WCA
Create resource guide for OB/GYN practices to share with mothers identified as substance abusers (Tracking Indicator: resource guide created)	1/15-3/15	BMH, CCDHHS, Child Protective Services, MICHC partners, WCA
Work with OB/GYN practices to implement process for identified screening strategy	4/15	BMH, CCDHHS, MICHC partners,

		WCA
MICHC community health workers share resource guide with pregnant and new mothers, assist mothers with reminders for and/or transportation to necessary appointments	4/15-12/17	CCDHHS
Monitor progress, problems with screening and referral process	4/15-10/15	BMH, CCDHHS, MICHC partners, WCA
Make changes to screening and referral process as indicated	11/15-12/15	BMH, CCDHHS, MICHC partners, WCA
Explore evidence-based programs that will help pregnant women or new mothers stay drug-free	1/16-4/16	BMH, CCDHHS, MICHC partners, WCA
Locate funding source to carry out evidence-based programming	4/16-12/16	BMH, CCDHHS, MICHC partners, WCA
Monitor changes in newborn drug-related discharge rates	1/16-12/17	BMH, CCDHHS, MICHC partners, WCA
Chautauqua County HWIC Objective 1.3: By December 31, 2017 improve birth spacing by at least 10%		
Tracking Indicators: Percentage of live births that occur within 24 months of a previous pregnancy. (Target 15.1%; Baseline: 25.1%; Year 2008-2010; Source: NYS Vital Statistics Data)		
Activities/Interventions	*Date*	*Partner(s) Responsible*
Hold MICHC coalition meeting; partners participate in coalition	1/15-2/15	BMH, CCDHHS, MICHC partners, WCA
MICHC Coalition designs survey to assess reasons why women do not seek out birth control method after delivery	3/14-4/14	BMH, CCDHHS, MICHC partners, WCA
MICHC Coalition works with WIC program to distribute survey, collect responses (Tracking Indicator: number of surveys completed)	4/14-7/14	BMH, CCDHHS, MICHC partners, WCA
MICHC Coalition uses survey results to develop plans to improve birth spacing	8/14-9/14	BMH, CCDHHS, MICHC partners, WCA
MICHC Coalition works with OB/GYN practitioners to develop a process for educating mothers about healthy birth spacing in clinical settings	9/14-11/14	BMH, CCDHHS, MICHC partners, WCA
MICHC Coalition works with hospital maternity wards to add birth control method education to discharge packet	11/14	BMH, CCDHHS, MICHC partners,

information, provide direct education to new mothers		WCA
Community health workers provide peer education to moms about importance of leaving hospital with birth control method	9/14-12/17	CCDHHS
Monitor birth spacing to track progress	1/15-12/17	CCDHHS
Focus Area: Maternal and Infant Health		
Goal 1: Increase proportion of NYS babies who are breastfed. (NYS Action plan Goal 2)		
Chautauqua County HWIC Objective 2.2: By December 31, 2017 increase the percentage of WIC mothers breastfeeding at 6 months by 10% to 24.5%		
Tracking Indicators: Percentage of WIC mothers breastfeeding at 6 months (Target: 24.5%; Baseline: 14.5%; Year 2008-2010; Source NYS Pediatric Nutrition Surveillance System)		
Activities/Interventions	*Date*	*Partner(s) Responsible*
MICHC Coalition develops survey to learn reasons why mothers are not breastfeeding at 6 months	2/14	BMH, CCDHHS, MICHC partners, WCA
Identify opportunities to recruit new lactation consultant for WCA Hospital.	1/14-12/14	CCDHHS, MICHC partners, WCA
Explore feasibility of developing “no-formula handout” policies at local hospitals.	1/14-9/14	BMH, CCDHHS, WCA
Work with MICHC Coalition to identify additional methods to improve breastfeeding initiation at hospitals.	1/14-12/16	BMH, CCDHHS, WCA
Survey WIC moms to assess reasons for not breastfeeding at 6 months	3/14-6/14	BMH, CCDHHS, MICHC partners, WCA, WIC
Review survey results	7/14	BMH, CCDHHS, MICHC partners, WCA
Educate pediatricians about available lactation support services	8/14	BMH, CCDHHS, MICHC partners, WCA
Explore feasibility of establishing Baby Cafés at Brooks Memorial Hospital and WCA Hospital	2/14-6/14	BMH, CCDHHS, MICHC partners, WCA
If indicated, establish billing plan to ensure sustainability of program	7/14	BMH, CCDHHS, MICHC partners, WCA
Locate funding source to create appropriate and comfortable spaces in hospitals and to cover start-up costs associated with program	8/14-12/14	BMH, CCDHHS, MICHC partners, WCA

Work with maternity staff to develop process to cross-train maternity nurses to provide lactation guidance at "Baby Café" drop-in center located at the hospitals	4/15	BMH, CCDHHS, MICHC partners, WCA
Establish lactation support hotline/textline, "The Milk-Line" for new mothers to call in or text and ask questions to trained personnel	6/15-8/15	BMH, CCDHHS, MICHC partners, WCA
Establish Baby Cafés	12/15	BMH, WCA
Monitor utilization of Baby Cafés and The Milk-Line	3/16-12/17	BMH, CCDHHS, MICHC partners, WCA
Explore possibility of offering incentive raffles to mothers breastfeeding at 6 months to provide positive reinforcement, garner media, and encourage community support for breastfeeding.	12/14-12/16	BMH, CCDHHS, MICHC partners, WCA
Monitor breastfeeding rates at 6 months to track progress	12/15, 12/16, 12/17	BMH, CCDHHS, MICHC partners, WCA

Additional healthy women, infants, and children efforts currently underway:

- **MICHC grant program staff will work to decrease smoking rates in pregnant women by referring moms who smoke to evidence-based tobacco cessation programs.**
- **MICHC staff will hire community health workers to provide peer education to moms from the point when she finds out she is pregnant, through the child's first year of age. Community health workers will assist moms in navigating health and social systems to ensure good health outcomes.**
- **CCDHHS Reproductive Health Clinics provide men and women of reproductive health age with pregnancy prevention resources (including various birth control methods: condoms, oral contraceptives, IUDs, contraceptive shots, etc.), education, pregnancy testing, and STI/HIV testing and counseling.**
- **CCDHHS Lead Poisoning Prevention and Lead Primary Prevention Programs work to identify and reduce lead hazards in homes of children with elevated blood lead levels or homes of children in high-risk neighborhoods.**
- **CCDHHS Early Intervention and Preschool Special Education Programs work with family of children ages 0-5 with developmental disabilities to ensure they receive appropriate care.**

Prevention Agenda Priority Area: Promote Mental Health and Prevent Substance Abuse

CCCHPT Partners Included: BMH, CCDHHS, CCDMH, CCHN, TCC, TLC, WCA, WMH

Focus Area: Strengthen Infrastructure Across Systems		
Goal 1: Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment and recovery. (NYS Action plan Goal 3.1)		
NYS Objective 1.2: Support efforts to integrate MEB disorder screening and treatment into primary care.		
Chautauqua County MHSA Objective 1.1: Support efforts to integrate MEB disorder and substance abuse screenings and referral to treatment in primary care, clinic, and emergency room settings throughout Chautauqua County.		
Tracking Indicators: (number of health care settings screening patients for mental health and substance abuse, baseline to be established)		
Activities/Interventions	*Date*	*Partner(s) Responsible*
Recruit mental health, primary care, substance abuse, and community partners to form mental health and substance abuse work group, or identify existing work group/coalition to adopt this task.	1/14	BMH, CCDHHS, CCHN, TLC, WCA, WMH, CCDMH, Chautauqua County Mental Health Association
Research the incidence of street drug overdose to determine capacity to deliver effective detox and step down services.	1/14-4/14	BMH, CCDHHS, CCHN, TLC, WCA, WMH, CCDMH, Chautauqua County Mental Health Association
Research MH/SA screening tools currently being used in health care settings in Chautauqua County; identify baseline for tracking indicators	3/14	BMH, CCDHHS, CCHN, TLC, WCA, WMH
Assist Chautauqua County Department of Mental Hygiene in developing connections with health care practices to expand reach of Early Identification and Recognition Program; Inform physicians and support staff at annual meetings, provide CCDMH with contact information for affiliated physicians (Tracking Indicator: number of practices that work with CCDMH; baseline: 3 practices)	3/14-3/15	BMH, CCDHHS, CCHN, TLC, WCA, WMH, CCDMH
Survey health care providers to determine willingness to implement a screening tool, understand current mechanisms for providing or referring mental health/substance abuse care, and barriers (Tracking Indicator: number of practices that respond to survey)	5/14	BMH, CCDHHS, CCHN, TLC, WCA, WMH, CCDMH
Research reimbursement options for integrating screening	6/14-	BMH, CCDHHS,

or mental health care into practice	9/14	CCDMH, CCHN, TCC, TLC, WCA, WMH
Convene primary care and mental health/substance abuse providers to identify best evidence-based screening tool or practice to ensure patients are receiving appropriate care	8/14	BMH, CCDHHS, CCHN, TLC, WCA, WMH, CCDMH
Identify care settings in hospitals where patients should be screened (e.g. emergency rooms, inpatient services)	9/14	BMH, TLC, WCA, WMH
Develop list of nearby mental health/substance abuse resources for PCPs to share with patients (Tracking Indicator: list developed)	9/14-12/14	BMH, CCDHHS, TLC, WCA, WMH, CCDMH
Identify organization that can provide interviewer training for selected screening tools; if necessary, identify funding source to pay for trainings	9/14	CCDHHS, CCDMH, CCHN
Train appropriate staff at hospitals and primary care settings to use screening tools properly	1/15-6/15	BMH, CCDHHS, CCDMH, TCC, TLC, WCA, WMH, identified agency, primary care practices
Begin implementation of screening tool	2/15-7/15	BMH, CCDHHS, TCC, TLC, WCA, WMH, primary care practices
Track number of practices using screening tool, number of staff people trained to screen, number of patients screened	2/15-2/16	BMH, CCDHHS, TLC, WCA, WMH
Identify issues with screen	2/16-6/16	BMH, CCDHHS, CCDMH, TCC, TLC, WCA, WMH, primary care practices
Work with team of primary care and mental health/substance abuse providers to identify any next steps	7/16-12/17	BMH, CCDHHS, CCDMH, TCC, TLC, WCA, WMH, primary care practices

Description of Evidence-Based Interventions

The strategies chosen to address the selected Prevention Agenda priority areas are a combination of existing and new strategies for Chautauqua County. Some strategies specify evidence-based programs, policies, or environmental changes. In many cases, additional research and planning was deemed necessary before moving forward. Other strategies reflect concepts that make sense for our community, but are not necessarily proven methods. The evidence-based strategies that were selected are described below.

Reducing Access to Sugary Drinks

According to the CDC, sugary drinks are the largest source of added sugar in the diets of children in the United States. This behavior is linked to childhood obesity, and on average, 80% of youth consume sugar loaded beverages every day. Efforts to reduce access to sugary drinks, and increase access to healthier beverages in community settings are promising practices to reduce the burden of obesity. Policy-level work focusing on this initiative will lend to sustainability and long-term change. (Overweight and Obesity: A Growing Problem, 2013)

Million Hearts Program

Million Hearts is a national initiative headed by the US Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMMS) that aims to prevent one million heart attacks and strokes by 2017. The initiative plans to do this by:

- Improving access to effective care
- Improving the quality of care for the ABCS
- Focusing clinical attention on the prevention of heart attack and stroke
- Activating the public to lead a heart-healthy lifestyle
- Improving the prescription and adherence to appropriate medications for the ABCS

This program encourages public health workers and clinical care providers to adopt approaches proven effective by the Community Guide including the use of health information technology, a focus on the ABCS model, and using team-based care innovations. (Million Hearts Initiative Overview)

National Diabetes Prevention Program

The National Diabetes Prevention Program (NDPP) is an evidence-based lifestyle change program for preventing Type 2 diabetes. Intended for individuals who have been diagnosed with pre-diabetes, the program helps people make modest nutrition and physical activity behavior changes to lose 5%-7% of their body weight, cutting their risk of developing type 2 diabetes in half. The program spans a year, with lifestyle coaching that includes 16 core sessions (usually one per week) and 6 post-core sessions (1 per month). The NDPP is led by the CDC. (National Diabetes Prevention Program, 2013)

Access to Professional Support for Breastfeeding

The CCCHPT proposes to explore opportunities to develop breastfeeding drop-in centers and a phone/text helpline at local hospitals that provide labor and delivery services. The purpose for this initiative is to increase access to breastfeeding support professionals and encourage mothers to continue breastfeeding. The CDC Guide to Support Breastfeeding Mothers and Babies outlines access to professional support for breastfeeding as a recommended strategy. The report outlines various studies that have shown that continued communication with and support from trained professionals have resulted in increased numbers of women breastfeeding babies longer. (The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies, 2013)

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

The CCCHPT proposes to identify evidence-based mental health and substance abuse screening tools to adopt and implement in local hospitals and health care practices. The Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an integrated and comprehensive public health approach to delivery of early intervention and treatment services for people with substance abuse disorders, as well as individuals who are at risk. Hospital emergency rooms, primary care practices, health clinics, and other community settings provide opportunities to identify at-risk substance users and offer intervention services before more serious consequences occur. This tool assesses the severity of substance abuse and identifies appropriate levels of treatment, provides a brief intervention that aims to increase awareness and motivate behavior change, and provides referral to appropriate treatment when necessary. (Screening, Brief Intervention, and Referral to Treatment (SBIRT), 2012)

Maintaining Engagement

By committing to collaborate on the initiatives described above, the Chautauqua County Community Health Planning Team (CCCHPT) will maintain close contact over the next four years. CCCHPT and partners county-wide understand that to make real, long-term change, we must work together. This fact, in combination with the reality of budget cuts and staffing shortages, fosters collaboration in Chautauqua County.

In addition to intense topic-specific collaboration involved as described above, CCCHPT partners will meet biannually to review the CHIP, assess progress, and make appropriate amendments to these plans. Each partner will report out on respective tracking indicators at biannual meetings. The CCCHPT and the CCDHHS intend for the CHIP and respective Community Service Plans to be dynamic documents and catalysts for health improvement.

The Chautauqua County Department of Health and Human Services will coordinate periodic meetings. The tentative meeting schedule for the CCCHPT for 2014-2017 is as follows:

- January 2014
- July 2014
- January 2015
- July 2015
- January 2016
- July 2016
- January 2017
- July 2017

Plans for Distribution

The Chautauqua County Department of Health and Human Services, in partnership with the Chautauqua County Community Health Planning Team, will make the 2014-2017 Community

Health Assessment and Community Health Improvement Plan available to the community through a number of means.
These include:

- Posting the CHA and CHIP documents on the County website
- Posting the CHA and respective CSPs on hospital websites (BMH, TLC Health Network, WCA, WMH)
- Developing a press release and distributing to all local media
- Posting links to the CHA, CHIP, and CSPs on CCDHHS Facebook and Twitter pages
- Emailing links to CHA and CHIP to all Chautauqua County Government employees
- Sharing documents and links to documents with community partners at various coalition and workgroup meetings
- Forwarding links to CHA, CHIP, and CSPs to various community email lists (e.g. faith-based organizations, local physicians, youth-serving organizations, wellness coordinators at worksites, school administrators, etc.)
- Develop and distribute educational brochure that aligns with NYSDOH's "Make New York the Healthiest State" brochure that will inform county residents of current and proposed efforts to improve community health.

The CCDHHS and CCCHPT will additionally respond to any earned media requests generated from this outreach.

Works Cited

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Appendix A: Chautauqua County Community Health Survey

Chautauqua County Community Health Survey

Community and Health Needs

The Chautauqua County Department of Health and Human Services, the Chautauqua County Health Network, Lake Erie Regional Health System, The Chautauqua Center, WCA Hospital, and Westfield Memorial Hospital are gathering information to help with public health planning for the next four years.

1. Of the following issues/concerns, which three issues does your family face, or do you consider to be community problems? Please select 3 issues or concerns.

- □ Transportation
- □ Jobs
- □ Education
- □ Housing
- □ No support system (family or friends to help when needed)
- □ Not enough money
- □ Access to dental services
- □ Access to doctors
- □ Other _____

2. What health issues are you most concerned about? Please select 3 health issues.

- □ Can't get in to see a doctor/can't get an appointment
- □ Health insurance
- □ Don't have the money to go to a doctor
- □ Tobacco/cigarettes/cigars
- □ Physical activity
- □ Nutrition
- □ Obesity or overweight
- □ Diabetes (sugar, high blood sugar)
- □ Asthma (difficulty breathing)
- □ Cancer
- □ HIV/AIDS
- □ Sexually transmitted diseases (Chlamydia, gonorrhea, syphilis, HPV, herpes, genital warts, etc.)
- □ Immunizations (vaccines, flu shots, healthy baby shots)
- □ Injury (falls, motor vehicle accidents, etc.)
- □ Alcohol and drug abuse
- □ Dental care

- □ High blood pressure
- □ Heart disease
- □ Cholesterol (clogged arteries)
- □ Arthritis
- □ Unplanned pregnancy
- □ Mental health (depression, panic attacks, nerves)
- □ Other _____

3. Do you want to share more about any of the issues listed above, or do you have suggestions for how we can help find solutions for these problems? Please describe issues or offer suggestions below.

Your Personal Health

4. How often do you use tobacco products?
- □ Daily
- □ Weekly
- □ Sparingly
- □ Never

5. How would you describe your mood on most days over the past month?
- □ Happy, positive, or optimistic
- □ Neutral or content
- □ Sad, blue, or depressed
- □ Worried, tense, or anxious
- □ I don't know

6. How often do you participate in physical activity or exercise for 30 minutes or more?
- □ 6-7 times per week
- □ 3-5 times per week
- □ 1-2 times per week
- □ Try to add physical activity where possible (taking the stairs, etc.)
- □ No physical activity beyond daily regular activities

7. Which, if any, of the following would help you become more active? Select all that apply.
- □ Transportation to the park or gym

- □ Walking or exercise groups
- □ Workshops or classes about exercise
- □ Safe place to walk or exercise
- □ Individual instruction or personal trainer
- □ Information about programs in your community
- □ Discounts for exercise programs or gym memberships
- □ Low-cost sneakers, sweatsuits, or other equipment
- □ A friend to exercise with
- □ Activities you can do with your children
- □ Other _____

8. What keeps you from eating healthy food every day? Select all that apply.
   - □ Time it takes to prepare
   - □ Cost
   - □ Not sold at a store near me
   - □ Do not like to eat healthy food
   - □ Family does not like to eat healthy food
   - □ Do not know how to cook or prepare healthy foods
   - □ Other _____

9. In the future, what might help you make healthy changes in your life? Select all that apply.
   - □ Access to free workshops or classes in your community on exercise, diet, stress reduction, chronic disease management, and/or quitting 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 or 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
   - □ Having the desire to get healthier
   - □ Local hospitals and businesses offering free health screenings (blood pressure, diabetes, etc.)
   - □ More recreational/sports opportunities that are appropriate to your age and skill level
   - □ Taking more time to talk with health care professionals (doctors, nurses, dieticians, counselors, etc.)
   - □ Transportation
   - □ An incentive such as a gift card, prize for participation, or discounted service
   - □ Wanting my family to be healthier

□ Other _____

10. Your health insurance is:
    - □ Private insurance from your or your spouse's workplace
    - □ Medicaid
    - □ Medicare
    - □ Purchased by you directly
    - □ Child Health Plus
    - □ I do not have health insurance
    - □ Other _____

11. How often do you visit the following providers for care? Check one box per line.

	More than once per year	Once per year	Every other year	Less than every other year	This type of care is not available to me	I do not go to this kind of provider
Your family doctor	☐	☐	☐	☐	☐	☐
An urgent or immediate care clinic	☐	☐	☐	☐	☐	☐
Emergency room	☐	☐	☐	☐	☐	☐
Clinic or health center	☐	☐	☐	☐	☐	☐
Your dentist	☐	☐	☐	☐	☐	☐

12. Please list the top 3 medical services you are most likely to leave Chautauqua County for, and why you leave the county for these services.

Demographics

Please tell us a little about yourself. All of the information that you share with us will be used to help us during our health planning, and will be completely confidential.

13. What is your ZIP code? _____

14. What is your Sex?
    - □ Male

- □ Female

15. Your age range:
    - □ Less than 18
    - □ 18-29
    - □ 30-39
    - □ 40-49
    - □ 50-59
    - □ 60 or older

16. What is your race?
    - □ White or Caucasian
    - □ Black or African American
    - □ American Indian or Alaska Native
    - □ Asian or Pacific Islander
    - □ Other (please specify) _____
17. Do you consider your ethnicity to be Hispanic or Latino?
    - □ Yes
    - □ No

18. What is your height in inches? _____

19. What is your weight in pounds? _____

20. How many children live in your home, including yourself, that are younger than 18 years old? _____

21. How many adults live in your home, including yourself, between the ages of 18 and 64? _____

22. How many seniors live in your home, including yourself, that are 65 years old and older? _____

THANK YOU!

You are just about done. Please share any of your final thoughts below and return this survey.

23. What makes you proud of your community?

24. Your responses will be very helpful to our planning for the next few years. If you have any other comments about health issues or health needs in the community, please add them below. Thank you!

Appendix B: Community Conversation Summaries

Jamestown Region Community Conversation: WCA Hospital
June 13, 2013
Attendance: 62

The first questions posed to the community members gathered at the WCA Hospital in Jamestown were **"What are some health issues that stand out as important to you or your community? What keeps people from being healthier?"** Some notable responses from the small group discussions were:

- Discrimination
- Lack of providers
- Violence
- Lack of walkable/bikable communities
- Lack of health literacy
- Lack of fitness programs (or promotion of)

The small groups combined into a larger group, shared their ideas, and ultimately decided on a few priorities that the community agreed were the most important health issues. These areas included:

- **Lack of motivation**
- **Lack of education pertaining to healthy lifestyles**
- **Transportation**
- **Lack of access to healthy foods**
- **Poverty**

From these discussions, the next question was posed: "**What do you think could be done to improve on the health issues and factors that you've identified?"** From this, the community members brainstormed ideas for improvements regarding the aforementioned priorities of the Jamestown community. Some ideas were as follows:

- Encourage collaboration of city, county, and other institutions and organizations to work together and share resources
- Enhance promotion of already existing services, maybe using social media
- Increase number of community events
- Create more affordable wellness and fitness programs, have them be interactive and fun
- Provide healthy cooking classes
- Make transportation available to recreational activities and programs
- Increase health and physical education in schools
- Education children about healthy lifestyles early: Early intervention
- Improve community design: more paths, community gardens, street policies
- Get support for public transportation
- Create neighborhood health clinics

Dunkirk Region Community Conversation: Dunkirk High School
June 20, 2013
Attendance: 10

The first questions posed to the community members gathered at the WCA Hospital in Jamestown were **"What are some health issues that stand out as important to you or your community? What keeps people from being healthier?"** Some notable responses from the small group discussions were:

- Poverty
- Mental health and stress
- Parenting skills
- Transportation
- Substance Abuse
- Food options

The small groups combined into a larger group, shared their ideas, and ultimately decided on a few priorities that the community agreed were the most important health issues. These areas included:

- **Lack of sensitivity and cultural competency training (stigmas)**
- **Unhealthy behaviors (fast food, physical inactivity, smoking, etc.)**
- **Lack of education around health issues**
- **Limited resources and support services**

From these discussions, the next question was posed: "**What do you think could be done to improve on the health issues and factors that you've identified?"** From this, the community members brainstormed ideas for improvements regarding the aforementioned priorities of the Jamestown community. Some ideas were as follows:

- Provide sensitivity trainings for physicians and community members
- Community mobilization
- Asset inventory: resource collaboration, linking services
- Annual meeting for service providers
- Promote awareness of existing services (ex. newspaper column)
- Competition program (weight loss, other healthy behaviors)

Westfield Region Community Conversation: Eason Hall
June 26, 2013
Attendance: 16

The first questions posed to the community members gathered at the WCA Hospital in Jamestown were **"What are some health issues that stand out as important to you or your community? What keeps people from being healthier?"** Some notable responses from the small group discussions were:

- Lack of insurance/affordable care
- Lack of patient engagement
- Chronic diseases: Obesity, Diabetes
- Tobacco use
- Lack of education

The small groups combined into a larger group, shared their ideas, and ultimately decided on a few priorities that the community agreed were the most important health issues. These areas included:

- **Family support and stability**
- **Lack of motivation (obesity, overweight)**
- **Substance abuse and mental health**
- **Living in rural community (transportation, employment)**

From these discussions, the next question was posed: "**What do you think could be done to improve on the health issues and factors that you've identified?"** From this, the community members brainstormed ideas for improvements regarding the aforementioned priorities of the Jamestown community. Some ideas were as follows:

- Educate parents
- Family approach to issues
- Mentoring program for kids
- More free/low-cost youth recreation
- More support groups and safe areas for drug users (ex. NA)
- Education programs: exercise, nutrition, parenting
- Community sponsored walking clubs, worksite wellness
- Weight loss challenge
- Free health screenings and education at community events
- Promoting wellness within community organizations (YWCA, library, churches, grocery stores, etc.)
- Promote services that already exist (ex. Office of Aging)