

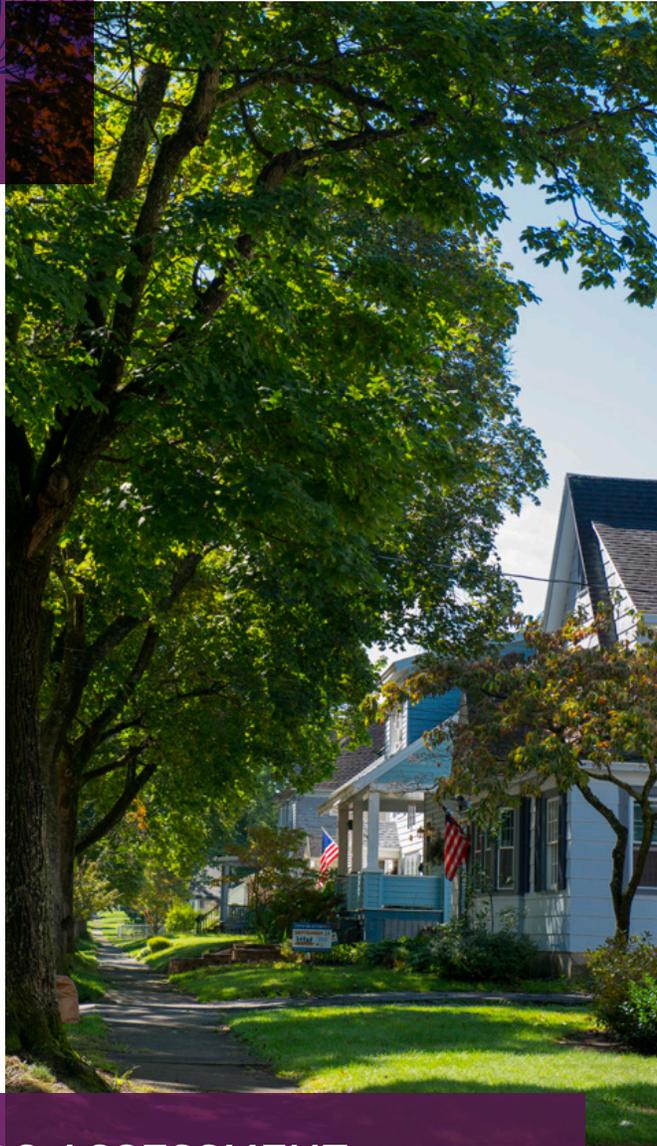


**Community Health Needs Assessment
Community Health Strategic Plan**
Chautauqua, Erie, McKean, and Venango Counties

June 30, 2019

Enhancing the Health of Our Communities

*Chautauqua, Erie, McKean,
and Venango Counties*



**COMMUNITY HEALTH NEEDS ASSESSMENT
UPDATE COVERING**

**UPMC CHAUTAUQUA
UPMC HAMOT**

**UPMC KANE
UPMC NORTHWEST**

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2016-2019 REGIONAL PROGRESS REPORT



UPMC is committed to improving the health and wellbeing of its communities in Chautauqua, Erie, McKean, and Venango counties. Working with community partners and engaging system-wide resources, UPMC hospitals are making measurable progress on each of their health initiatives.

EXPANDING WORLD-CLASS CARE WITH NEW FACILITIES AND IMPROVED CAPABILITIES

UPMC's investment in its buildings and services reflects our continued commitment to our patients, our employees, and our community.

- **Patient Care Tower at UPMC Hamot:** The largest project in the hospital's 135-year history, the new Patient Care Tower will transform the landscape of health care in Erie and will accommodate increasing patient volumes and demand for services.
- **Hospital expansion at UPMC Chautauqua:** This \$20 million project offers a new women's and maternity care center, behavioral health units, and increases local jobs.
- **Express Care at UPMC Kane:** UPMC Kane opened a new Express Care facility to meet the need for greater access to primary and specialty care. The hospital further expanded access with extended hours and a walk-in program.
- **Telemedicine at UPMC Northwest:** The hospital is using state-of-the-art telehealth technology to bring nationally ranked, world-class specialty care to the local community. These virtual visits connect local residents with a range of specialists and save travel time and costs.

UPMC Northwest Teleconsult Center has provided more than 4,000 visits since 2012.



HELPING TO DETECT AND MANAGE CHRONIC DISEASE

UPMC promotes screening events to educate the community and help patients with chronic diseases better manage their conditions.

- **Encouraging preventive screenings:** UPMC Hamot's Primary Care providers are ordering screenings suggested by evidence-based guidelines and following up with patients to improve screening rates, with a targeted focus on mammography, diabetes, and colon cancer.
- **Detecting lung cancer:** UPMC Northwest is helping to improve lung cancer detection by increasing the number of certified radiology technicians, expanding scanning capabilities with a second CT scanner and a new MRI/CT suite, and adding appointment availability for a cardiothoracic surgeon from UPMC Hamot.
- **Supporting active self-management of diabetes:** UPMC Northwest connects patients with a diabetes educator for one-on-one consultations to help manage their condition and set goals. In addition, UPMC Chautauqua offers a 16-week Diabetes Prevention Program for prediabetics.
- **Helping to make physical fitness easier for older adults:** UPMC Kane launched the Silver and Fit Program in its community. Silver and Fit is a national exercise program tailored to seniors to help improve cardiac wellness and promote healthy aging.

UPMC Chautauqua is a leader in worksite wellness — earning the Healthiest Large Employer Award from *Buffalo Business First* in 2014 and 2016.



In 2016, UPMC Hamot became the first accredited kidney transplant program in the region.



FOCUSING ON MOTHERS AND INFANTS

UPMC is enhancing efforts to educate and support pregnant women and new mothers. Efforts include:

- **Women's Recovery Center at Magee-Womens, UPMC Hamot:** The hospital opened an outpatient program that offers substance use disorder treatment for women with families and expectant mothers who also need prenatal care. Treatment combines opioid withdrawal medications, counseling, peer support, and routine prenatal check-ups.
- **Outreach to immigrant and refugee women:** UPMC Hamot is improving outreach to refugees and immigrants who have settled in Erie through a childbirth education program for non-native English speakers, which includes materials in Spanish, Somali, and Swahili.
- **Keystone 10 Initiative:** UPMC Northwest supports exclusive breastfeeding, has added a breastfeeding support class, and encourages uninterrupted skin-to-skin contact immediately after birth.



DELIVERING THE RIGHT SERVICES AND SUPPORT

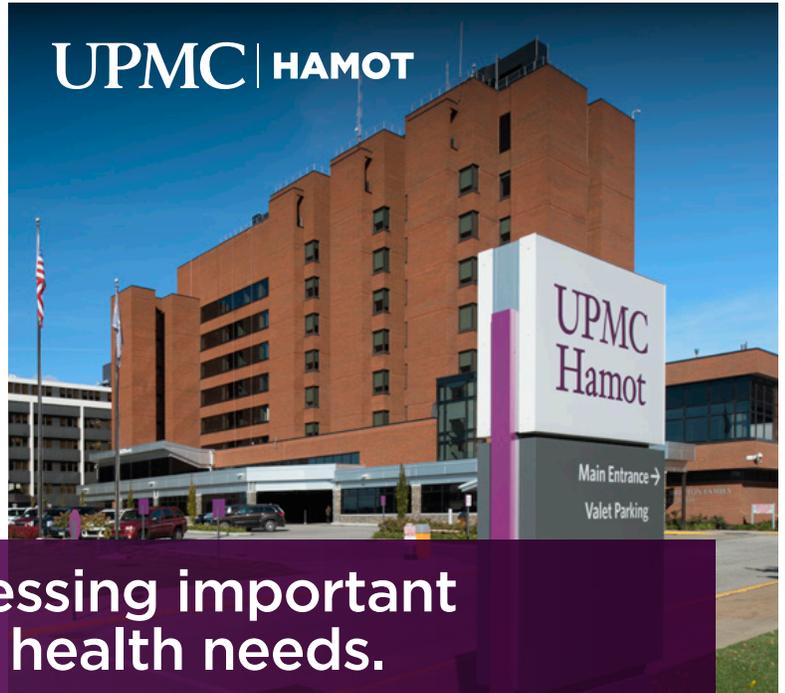
UPMC's array of services is expanding to better meet the growing needs of its communities. Efforts include:

- **Broadening access to behavioral health services:** UPMC Safe Harbor obtained three new licenses, which allow it to improve access to mental health resources for people in Erie County.
- **Teaching neighbors how to respond to a mental health crisis:** UPMC Chautauqua, along with county-wide community partners, hosted Mental Health First Aid trainings, which helped attendees develop key skills to assist anyone who is experiencing a mental health crisis.
- **Improving education to increase end-of-life care awareness:** UPMC Hamot partnered with local assisted-living facilities to host "Being Mortal" educational programming and to engage people in discussions about terminal illness and treatment decisions.

GROWING A MORE DIVERSE WORKFORCE WITH THE EAGLE'S NEST PROGRAM

UPMC Hamot helped to create The Eagle's Nest Program, which helps provide Erie's young people with entry-level opportunities at UPMC Hamot. Many Eagle's Nest graduates who work at UPMC Hamot have been promoted or are pursuing higher education in fields like nursing and forensic science.

UPMC's community benefits contributions to the UPMC Chautauqua, UPMC Hamot, UPMC Kane, and UPMC Northwest communities total more than **\$49 million** each year.



UPMC is addressing important community health needs.

- Access to Primary and Specialty Care
- Behavioral Health
- Cancer
- Diabetes
- End-of-Life Care
- Heart Disease
- Maternal and Infant Health
- Obesity
- Preventive Screenings
- Respiratory Diseases



I. EXECUTIVE SUMMARY

UPMC's mission is to serve our community by providing outstanding patient care and to shape tomorrow's health system through clinical and technological innovation, research, and education.

UPMC Plays a Major Role in Its Community:

UPMC is one of the world's leading Integrated Delivery and Financing Systems ("IDFS"), combining a major Health Services Division with 40 hospitals and more than 700 clinical locations, with a 3.4 million-member Insurance Services Division. One of the largest nonprofit health systems in the United States, UPMC is headquartered in Pittsburgh, Pennsylvania, and serves patients seeking highly specialized medical care primarily from communities across Pennsylvania, as well as throughout the nation and around the world. UPMC is also the largest medical insurer in western Pennsylvania, and is the largest insurer of Medical Assistance, Medicare Advantage, Children's Health Insurance, and Behavioral Health populations in the region.

Committed to its mission of service, UPMC provides approximately \$1 billion a year in benefits to the communities it serves, and delivers more care to the region's poor and underserved than any other health system in the state.

UPMC's commitment to service is seen in the following ways:

- **Establishing a healthy culture in the communities we serve:** UPMC enhances health and wellness through more than 3,000 community-focused programs.
- **Caring for the vulnerable:** In Fiscal Year 2017, UPMC subsidized \$303 million in charity care and coverage for unreimbursed costs of care provided to Medicaid beneficiaries.
- **Providing state-of-the-art, life-saving care to the community:** In partnership with the University of Pittsburgh, UPMC makes significant investments in translational science, technology, research, and education designed to improve clinical quality, promote patient-centered care, and benefit the overall health of residents of our communities.

UPMC's Community Benefit Commitment	
FY2018	\$1.2 billion
FY2017	\$960 million
FY2016	\$912 million

- **Contributing to a thriving future for the state:** UPMC fosters economic prosperity through direct investment and new product development, which improves the health of communities large and small. The largest nongovernmental employer in Pennsylvania, UPMC supports more than one in four hospital jobs in the commonwealth and has a \$36 billion economic impact in the region each year.
 - » UPMC invested \$400 million in education and research in 2017, primarily at the University of Pittsburgh, which ranks #5 in National Institutes of Health (NIH) dollars.
 - » UPMC sponsors 97 percent of all hospital-funded research in western Pennsylvania.

Assessing the Significant Community Health Needs for the Four-County Region:

In Fiscal Year 2019, UPMC’s four licensed hospitals located in and serving Erie, McKean, and Venango counties in Pennsylvania, and Chautauqua County in New York, conducted a joint Community Health Needs Assessment (CHNA) in keeping with requirements described in section 501(r) of the Internal Revenue Code. Building on the initial CHNAs conducted in Fiscal Years 2013 and 2016, the Fiscal Year 2019 joint CHNA provided an opportunity for the hospitals to re-engage with community stakeholders in a rigorous, structured process guided by public health experts.

UPMC Licensed Hospitals in the Four-County Region	
UPMC Chautauqua	Chautauqua County, New York
UPMC Hamot	Erie County, Pennsylvania
UPMC Kane	McKean County, Pennsylvania
UPMC Northwest	Venango County, Pennsylvania

The collaborating hospitals in this CHNA function as a regional hub that delivers an array of specialized programs and services to the residents of the region. UPMC Chautauqua, located in southwestern New York, offers an extensive range of inpatient and outpatient acute and rehabilitation services to meet the health care needs of a large rural population. UPMC Hamot serves the entire region as an acute-care teaching hospital and regional referral center. Located in Erie, Pennsylvania, the hospital delivers a full suite of quality medical services, including highly specialized medical and surgical treatment, a Level III neonatal intensive care unit, and the region’s only Level II Trauma Center. In McKean County, UPMC Kane provides quality medical services to area residents, who may otherwise have to travel long distances for care. It provides access to medical, surgical, rehabilitation, and transitional care, as well as specialized services. UPMC Northwest, located in Seneca, Pennsylvania, is the only hospital in Venango County, and offers area residents access to cutting-edge medical services not typically found at a local community hospital.

For the purpose of this joint CHNA, these collaborating UPMC hospitals define their community to be Erie, McKean, and Venango counties in Pennsylvania, and Chautauqua County in New York. By combining efforts and resources, this joint assessment identifies important local health issues, while supporting a coordinated, system-wide community health strategy that extends across the region. Working together, UPMC’s hospitals are committed to advancing health for residents in the community.

Input from Community Stakeholders and Public Health Experts:

UPMC partnered with experts at the University of Pittsburgh Graduate School of Public Health (Pitt Public Health) to conduct the CHNA using a best-practice methodology. The assessment blended analysis of documented public health data and socioeconomic factors with a structured community input survey process that solicited feedback from community advisory panels composed of leaders and organizations that represent patient constituencies within the community — including medically underserved, low-income, and minority populations.

CHNA Findings: Significant Community Health Needs for the Four-County Region:

The residents of the four-county region have a wide range of health concerns. The Fiscal Year 2019 joint CHNA identified four significant health needs of importance to the communities served by UPMC Chautauqua, UPMC Hamot, UPMC Kane, and UPMC Northwest.

	Significant Health Needs	Health Issues	Importance to the Community
1	Chronic Disease Management	Heart Disease and Stroke, Respiratory Disease, Diabetes, Cancer	More than 60 percent of deaths in the community are attributable to chronic disease.
2	Behavioral Health	Opioid and Substance Abuse, Access to Behavioral Health Services	Behavioral health conditions are among the most common conditions in the nation. They have a far-reaching impact on the community. Individuals with a behavioral health condition are at greater risk for developing a wide range of physical health problems.
3	Access to Care and Navigating Resources	Specialty Care, Primary Care, Palliative and End-of-Life Care	Access to care and navigating resources have important implications for the health of the community in a variety of ways, including preventing disease and disability, detecting and treating illnesses or conditions, managing chronic disease, reducing preventable hospitalization, and increasing quality of life.
4	Prevention and Community-Wide Healthy Living	Community Prevention and Wellness Initiatives, Interpersonal Safety, Health-Related Social Needs	Preventive care efforts, such as preventive screenings, can help identify diseases early, improve management of diseases, and reduce costs.

Amplifying UPMC’s Impact Across the Four-County Region:

In 2019, the Board of Directors for each UPMC licensed hospital adopted plans to address the significant health needs identified in the Fiscal Year 2019 joint CHNA, and to measure and track associated improvements. This report documents progress toward addressing significant health needs identified from prior CHNAs, as well as delineates hospital-specific implementation plans that will address community health needs over the Fiscal Year 2019-2022 period. These plans build upon the goals established in Fiscal Year 2016, recognizing that significant health needs will generally require more than two to three years to show meaningful improvement.

While tailored to each hospital, the implementation plans:

- **Focus on a Few High-Urgency Issues and Follow-Through:** UPMC hospitals in the four-county region are concentrating on a limited number of health issues that will address the significant health needs in the community.
- **Support a Wide Range of Chronic Disease Prevention and Care Initiatives:** More than 60 percent of deaths in the community are attributable to chronic disease.
- **Enhance and Expand Efforts to Address Behavioral Health Needs:** Rated high in importance by community survey participants, behavioral health conditions have a growing impact on the community.
- **Promote Navigating Available Resources:** Established health care programs in the region are often untapped due, in part, to social and logistical challenges faced among populations.
- **Leverage Community Partnerships:** An ongoing objective of the CHNA effort is to help align community programs and resources with community health needs. UPMC hospitals are collaborating successfully with local organizations to improve community health. The hospitals are also leveraging resources and synergies within the UPMC system, which include comprehensive programs and resources targeted at areas including behavioral health, mothers and infants, and children and adolescents.
- **Emphasize Populations Most in Need:** Where applicable, implementation plans specify programs and outreach for population segments that include women and infants, children and adolescents, seniors, medically underserved, low-income, and minority populations.

The following chart illustrates how each UPMC hospital will contribute to addressing the significant health needs in the four-county region. Additionally, detailed hospital-specific implementation plans are provided in Section IV of this report.

2019 Significant Health Needs in Chautauqua, Erie, McKean, and Venango Counties												
UPMC Hospitals in Chautauqua, Erie, McKean, and Venango Counties	Chronic Disease Management			Behavioral Health		Access to Care and Navigating Resources			Prevention and Community-Wide Healthy Living			
	Heart Disease and Stroke	Respiratory Diseases	Diabetes	Cancer	Opioid and Substance Abuse	Access to Behavioral Health	Primary Care	Specialty Care	Palliative and End-of-Life Care	Community Prevention and Wellness	Interpersonal Safety	Health-Related Social Needs
	UPMC Chautauqua	✓		✓	✓	✓	✓		✓		✓	
UPMC Hamot					✓	✓	✓		✓	✓	✓	✓
UPMC Kane							✓	✓		✓		
UPMC Northwest		✓	✓			✓		✓		✓		

II. Overview and Methods Used to Conduct the Community Health Needs Assessment

CHNA Goals and Process Overview:

In Fiscal Year 2019, UPMC's four licensed hospitals in Chautauqua, Erie, McKean, and Venango counties collaborated to conduct a joint CHNA, in keeping with IRS 501(r) guidelines. Through the assessment process, UPMC's hospitals identified the four-county region's significant health needs, prioritized those health needs, established action plans, and identified resources to address those needs. The 2019 document builds upon prior assessments and implementation plans developed in Fiscal Years 2013 and 2016. UPMC approached the CHNA requirement as an opportunity to evaluate and assess needs through a formalized, rigorous, and structured process to ensure that health improvement efforts and resources are aligned with the most significant community health needs. Goals of the CHNA were to:

- Better understand community health care needs.
- Develop a roadmap to direct resources where services are most needed, and impact is most beneficial.
- Collaborate with community partners, where together, positive impact can be achieved.
- Improve the community's health and achieve measurable results.

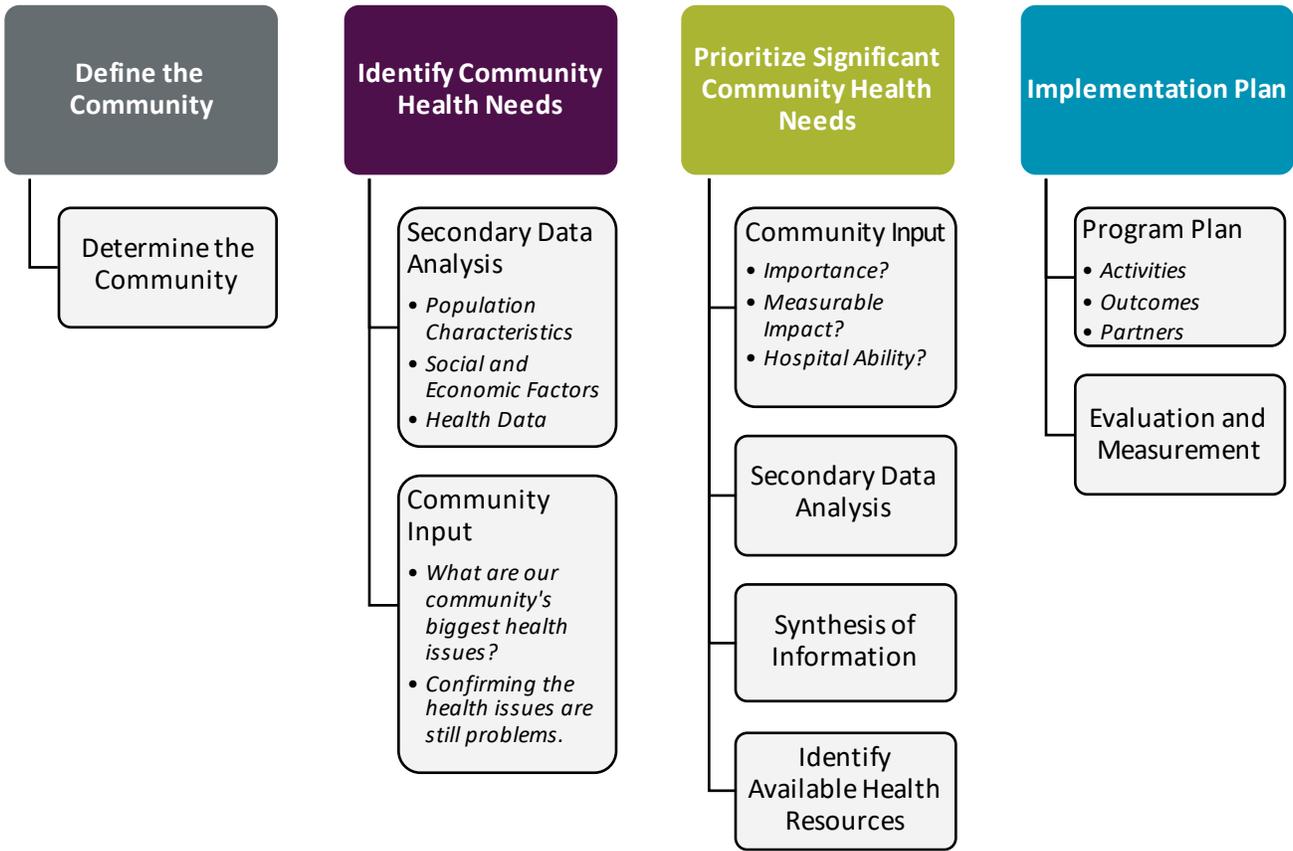
The CHNA incorporated analysis of public health data and input from individuals representing the broad interests of the community — including those with special knowledge and expertise in public health, and community stakeholders representing members of medically underserved, low-income, and minority populations. The overall health of the community is a shared responsibility among many stakeholders and entities, including government agencies, health care providers, nongovernmental organizations, and community members themselves. While the IRS CHNA requirements apply specifically to nonprofit hospital organizations, collaboration with community partners is essential for implementing and achieving effective community health improvement.

Collaborated with Experts in Public Health:

To conduct the CHNA in a manner that reflects best practices, UPMC partnered with the University of Pittsburgh Graduate School of Public Health (Pitt Public Health). Pitt Public Health's mission is to provide leadership in health promotion, disease prevention, and the elimination of health disparities in populations. Aligning with assessments conducted in 2013 and 2016, Pitt Public Health faculty and researchers' expertise supported a structured process for obtaining community input on health care needs and perceived priorities, an in-depth review and summary of publicly available health data, and the establishment of criteria for evaluating and measuring progress.

Framework for Conducting the CHNA:

The Community Health Improvement Process developed by the Institute of Medicine served as a guiding framework in assessing the health needs of the UPMC hospital communities. The hospitals adapted this model to guide the development of their CHNA.



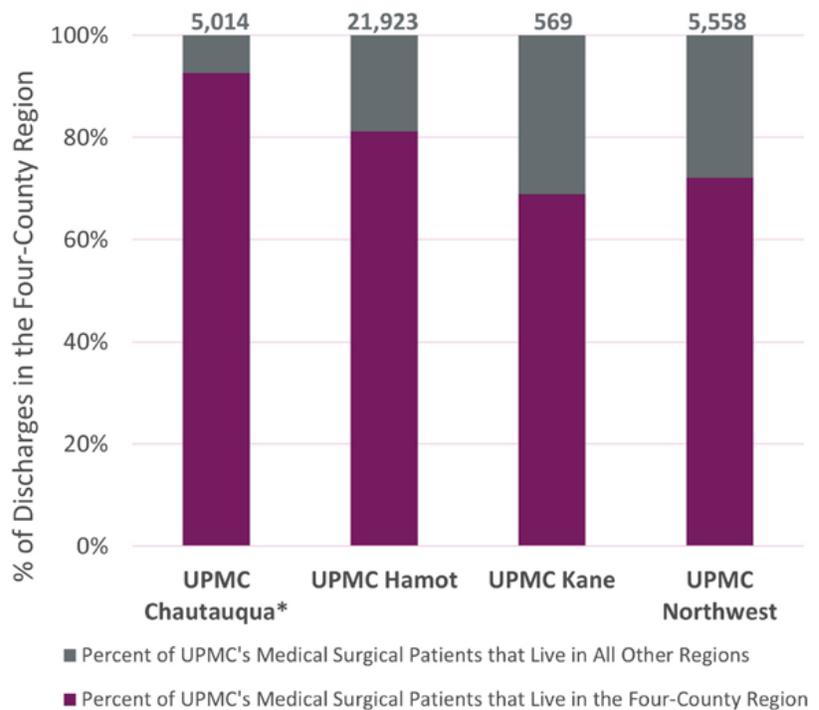
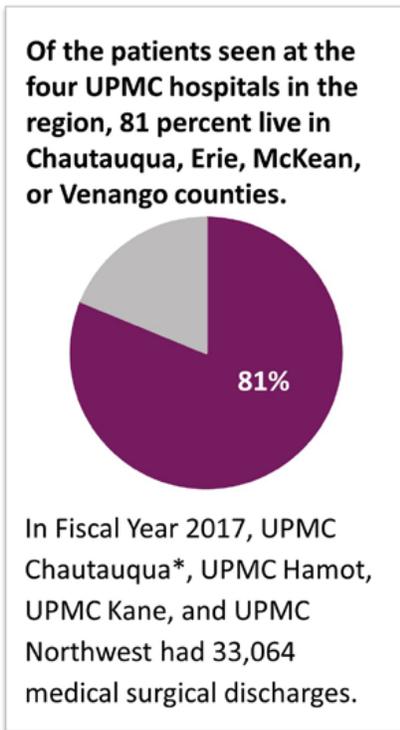
Definition of the Community: Chautauqua, Erie, McKean, and Venango Counties:

For the purpose of this joint CHNA, all four of the collaborating UPMC hospital facilities define their community to be the four-county region. With 81 percent of patients treated at UPMC Chautauqua, UPMC Hamot, UPMC Kane, or UPMC Northwest residing in Chautauqua, Erie, McKean, or Venango counties, these four hospitals primarily serve residents of this geographic region. By concentrating on Chautauqua, Erie, McKean, and Venango counties, UPMC can consider the needs of the great majority of its patients, and do so in a way that allows accurate measurement using available secondary data sources.

While the four-county region represents the basic geographic definition of each of these hospitals, this CHNA also considered characteristics of the broader area, such as state data, as well as specific populations within the defined community — such as minorities, low-income individuals, and those with distinct health needs.

By combining efforts and resources, UPMC Chautauqua, UPMC Hamot, UPMC Kane, and UPMC Northwest are focusing on important local health issues, while supporting a coordinated community health strategy across the region and system-wide.

Most Patients Treated at UPMC Chautauqua, UPMC Hamot, UPMC Kane, and UPMC Northwest Live in the Four-County Region: Chautauqua, Erie, McKean, and Venango Counties

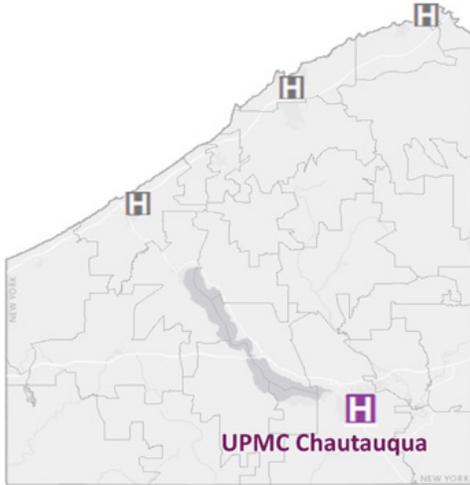


Sources: Pennsylvania Health Care Cost Containment Council, Fiscal Year 2017; NY SPARCS (Statewide Planning and Research Cooperative System)
*UPMC Chautauqua data is for Calendar Year 2016

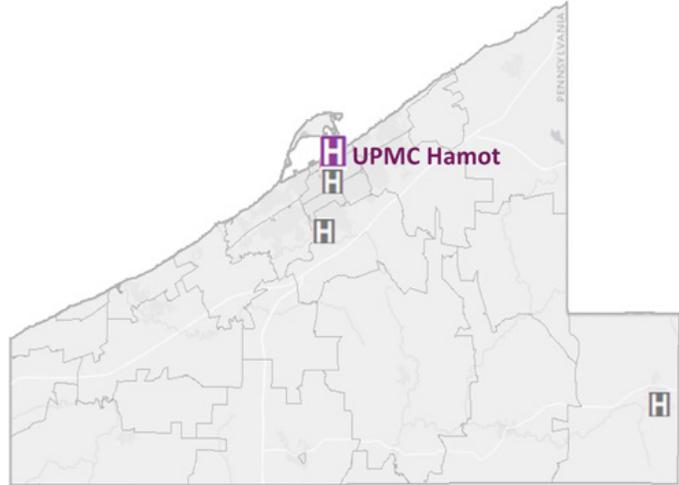
Identifying UPMC's System-wide Resources Available to Address the Region's Significant Health Needs

UPMC's hospitals are supported by a comprehensive network of additional health care resources in the area, including 75 UPMC outpatient offices within Chautauqua, Erie, McKean, and Venango counties. Facilities include Urgent Care Centers, Centers for Rehabilitation Services, Imaging Centers, and pediatric, primary, and specialty care doctors' offices.

Chautauqua County

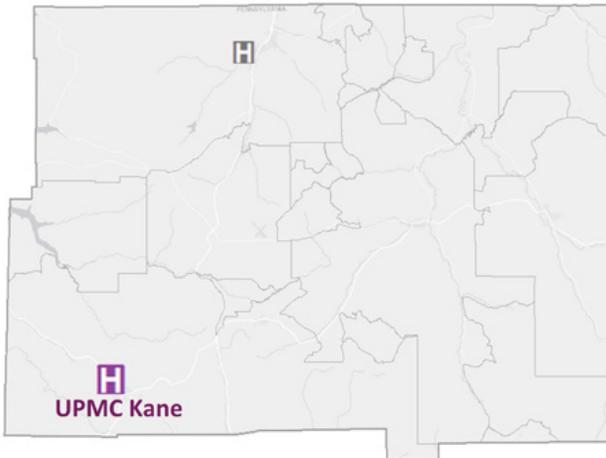


Erie County

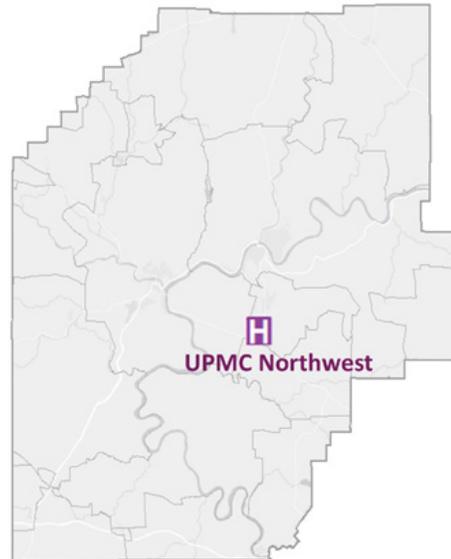


-  UPMC Hospitals
-  Other Hospitals

McKean County



Venango County



Identifying and Prioritizing Significant Health Needs:

Secondary Data Analysis and Sources:

UPMC conducted an in-depth analysis of publicly available data in partnership with Pitt Public Health. Secondary data, including population demographics, mortality, morbidity, health behaviors, clinical care, socioeconomic, and health status data, were used to identify, prioritize, and confirm significant community health needs. A full list of secondary data sources used are listed in **Appendix A**. Community-level data (usually county-level) were compared to the state, nation, and *Healthy People 2020* benchmarks to help identify key health issues. This information may be found in **Appendix B**.

Population characteristics, socioeconomic, and health status data were also examined. When available, data specific to low-income individuals, underserved minorities, and uninsured populations were examined. In addition, the analysis considered federal designations of Health Professional Shortage Areas (HPSAs) — defined as “designated as having a shortage of primary medical care providers”, Medically Underserved Areas (MUAs) — which may consist of a whole county or a group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts, and Medically Underserved Populations (MUPs) — which are specific sub-groups of people living in a defined geographic area with a shortage of primary care health services.

Community Input:

Community input on the perceived health needs and priorities of the region was used to complement analysis of publicly available data. To identify and prioritize health needs of the communities served, the CHNA solicited and took into account input from persons who represent the broad interests of the community, including those with special knowledge of or expertise in public health.

The Fiscal Year 2019 CHNA builds on the assessment processes applied in Fiscal Years 2013 and 2016, engaging community advisory panels to provide structured input on health needs present in each hospital’s surrounding community. In May-June 2018, Pitt Public Health surveyed community leaders and stakeholders specific to each hospital’s local community, as well as a system-wide panel of regional stakeholders. A total of 2,074 community participants from 22 UPMC hospital communities were surveyed.

Participants included:

- Leaders or members of medically underserved, low-income, minority populations, and populations with chronic disease.
- Representatives from public health departments or governmental agencies serving community health.
- Medical staff leaders who have a unique perspective and view of the community.
- Other stakeholders in community health such as consumer advocates, nonprofit and community-based organizations, local school districts, government organizations, and health care providers. See **Appendix C** for a complete list and description of community participants.

Additional community engagement:

As part of New York State’s Prevention Agenda, in May through July of 2016, UPMC Chautauqua collaborated with the Chautauqua County Department of Health and Human Services, Division of Public Health (CCDHHS) and other Chautauqua County hospitals to solicit survey input from 1,353 Chautauqua County residents. They held four community conversations that engaged approximately 200 individuals. They also conducted a stakeholder meeting, which was attended by 19 organizations, to discuss health improvement plans and obtain feedback. The community input was used to develop the Chautauqua County 2016-2018 Community Health Assessment and Improvement Plan and Community Service Plan. (See **Appendix E**).

Chautauqua, Erie, McKean, and Venango County Survey Participation Statistics

168

Community stakeholders invited to participate across Community Health Needs Surveys

74%

Of participants surveyed, represented medically underserved, low-income, or minority populations

The full community input survey process consisted of multiple stages over the past three CHNA cycles; UPMC Chautauqua joined the system-wide process for the first time in 2019:

CHNA Year	Activity	Description
2013	Brainstorming on Health Problems	Each hospital's community advisory panel met to gather input on the question, "What are our community's biggest health care problems?" Brainstorming resulted in the development of a 50-item list of health problems.
2013	Rating and Sorting Health Problems to Identify Significant Health Needs	Community members participated in the rating and sorting process to prioritize the 50 health problems. Each participant sorted the list into overarching themes, and then rated the problems using a 1 to 5 Likert scale, according to the following criteria: <ul style="list-style-type: none"> How important is the problem to our community? What is the likelihood of being able to make a measurable impact on the problem? Does the hospital have the ability to address this problem?
2013	Concept Mapping	Multi-dimensional scaling was applied to the sorting data to examine similarities between the 50 community health problems. Hierarchical clustering was used to group the sorting data into common thematic areas and to establish a final cluster map, which provided a visual representation of the data.
2016	Confirming Health Issues	Community advisory panels were surveyed about the continuing importance of the identified health issues. Advisory panel members participated in an online Qualtrics survey that solicited feedback on new health issues as well as reaffirming whether previously identified issues continue to be a problem in the community.
2019	Confirming and Expanding Health Issues	In partnership with Pitt Public Health, UPMC refined the community survey to incorporate emerging areas of exploration within the public health field (e.g., health-related social needs). Using a Qualtrics survey, community leaders provided feedback on: <ul style="list-style-type: none"> The continued importance of the 2016 health issues. Relative importance, ability to impact, and hospital ability to address an expanded list of health issues. Determination of population segments with the greatest health needs (e.g., seniors, children and adolescents, mothers and infants, general community, or other).

Synthesis of Information and Development of Implementation Plan:

The secondary data analyses and results from the community input survey process were aggregated, evaluated, and synthesized with the assistance of public health experts from Pitt Public Health. Through this effort, UPMC hospital leadership identified a set of significant health needs and their composite health issues that are critical, addressable, and have high levels of urgency in the community. The process then matched those needs to:

- **Best-practice methods for addressing these needs.**
- **Existing hospital community health programs and resources.**
- **Programs and partners elsewhere in the community that can be supported and leveraged.**
- **Enhanced data collection concerning programs.**
- **A system of assessment and reassessment measurements to gauge progress over regular intervals.**

Outcomes and Evaluation of Hospital Implementation Plans:

UPMC engaged with researchers from Pitt Public Health to develop evaluation metrics to measure and track progress related to this implementation plan. The metrics vary by hospital, according to health outcomes, current hospital efforts, and hospital resources.

The implementation plan was developed with the expectation that future progress would be reviewed by the hospital, as well as potentially by public health agencies. Therefore, two types of outcomes are considered:

- **Process Outcomes (directly relating to hospital/partner delivery of services):** Process outcomes indicate efforts hospitals and community partners can undertake to increase delivery of a service designed to change a health impact indicator. These mostly involve increases (or better targeting) in programming, outreach, publicity, or related efforts. Process outcomes can be measured by increases in investment (dollars or personnel), outreach (media messages, public service announcements), service units delivered (classes, screenings), people attending or completing programs, and number of sites for delivery of programs.
- **Health Impact Outcomes (applies to changes in population health for which the hospital's efforts are only indirectly responsible):** Health impact outcomes are changes in population health related to a broad array of factors, of which hospital and community partner efforts are only one contributing part. These outcomes include reductions in the prevalence of disease, risk factors, and health behaviors associated with disease. Benchmarks for progress in population indicators are available from *Healthy People 2020* and Robert Wood Johnson Foundation county health rankings.

III. Results of the Community Health Needs Assessment and In-Depth Community Profile

Characteristics of the Community:

Chautauqua County, located in western New York, has a total population of 134,905. Erie, McKean, and Venango counties are located in northwestern Pennsylvania. Erie County has a total population of 280,566, McKean County has a total population of 43,450, and Venango County has a total population of 54,984.

Sizable Elderly Population with High Social Needs: A notable characteristic of the community is the large and increasing percentage of elderly residents (65 years and older). All counties in the region have an elderly population that is larger than national benchmarks. Chautauqua, Erie, McKean, and Venango counties have large elderly populations (17 percent, 15 percent, 17 percent, and 18 percent, respectively), compared to the nation (13 percent).

Reflective of the higher proportion of elderly, the percentage of Medicare recipients was higher in the counties in the region than the nation (See **Appendix B**).

Chautauqua, Erie, McKean, and Venango Counties Have a Sizable Elderly Population

Age Distribution - 2010							
	Chautauqua County	Erie County	McKean County	Venango County	New York	Pennsylvania	United States
Median Age	40.9	38.6	41.5	44.3	38.0	40.1	37.2
% Children (<18)	21.8	22.7	21.1	21.5	22.3	22.0	24.0
% 18-64	61.6	62.7	61.9	60.5	64.2	62.6	63.0
% 20-49	36.7	38.6	37.7	34.5	42.0	39.0	41.0
% 50-64	21.0	20.4	21.0	23.6	19.2	20.6	19.0
% 65+	16.6	14.6	17.0	18.0	13.5	15.4	13.0
% 65-74	8.3	7.2	8.5	9.4	7.0	7.8	7.0
% 75-84	5.7	4.8	5.9	6.3	4.5	5.4	4.3
% 85+	2.6	2.4	2.6	2.3	2.0	2.4	1.8
% Elderly Living Alone	12.6	11.3	12.9	12.0	10.5	11.4	9.4

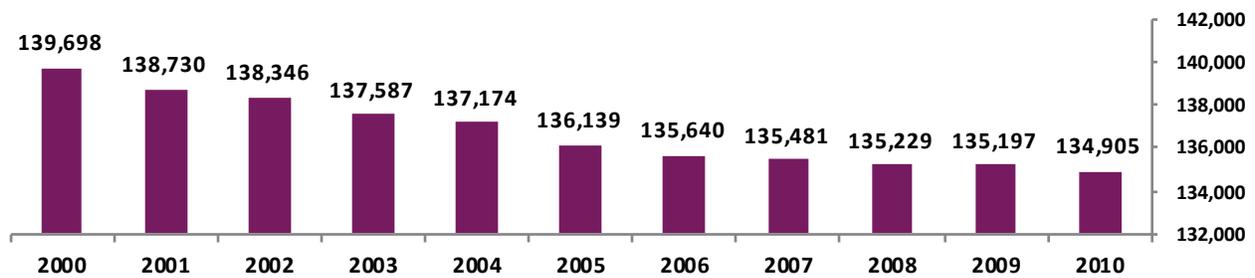
Source: U.S. Census

Aging Population in Chautauqua, Erie, McKean, and Venango Counties is Increasing: Across the region, the total population per county either remained stable or decreased, while the elderly population (age 85 and over) increased (see figures below).

- **Chautauqua County:** The total population decreased by 3 percent from 2000 to 2010. However, the county’s most elderly population (age 85 and over) increased by 13 percent during the same period.
- **Erie County:** The total population has seen little change from 2000 to 2010. However, the county’s most elderly population (age 85 and over) increased by 37 percent during the same period.
- **McKean County:** The total population decreased by 5 percent from 2000 to 2010. However, the county’s most elderly population (age 85 and over) increased by 8 percent during the same period.
- **Venango County:** The total population decreased by 5 percent from 2000 to 2010. However, the county’s most elderly population (age 85 and over) increased by 20 percent during the same period.

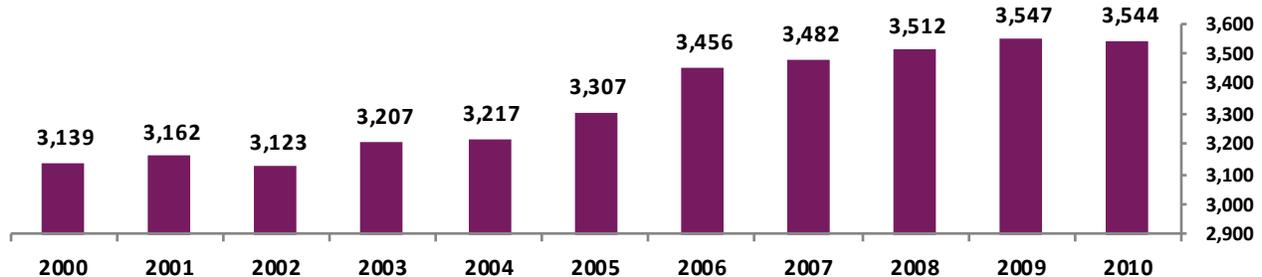
Chautauqua County’s total population has seen a 3 percent decrease from 2000 to 2010.

Chautauqua County Total Population Trend



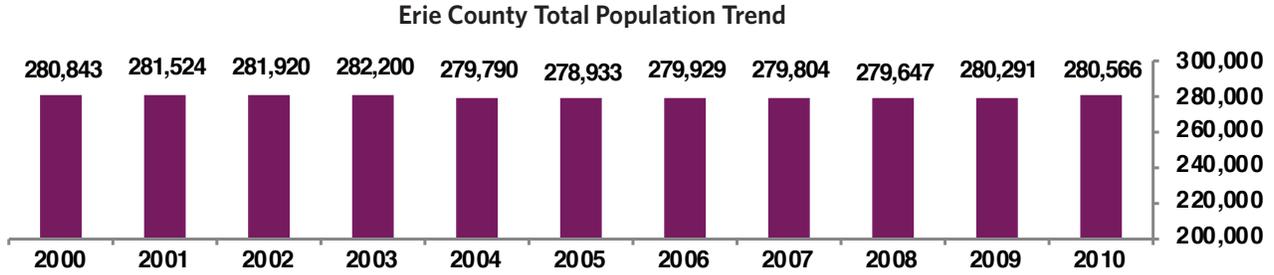
However, the most elderly population in Chautauqua County (age 85 and over) has seen a 13 percent increase from 2000 to 2010.

Chautauqua County Elderly (85+) Population Trend

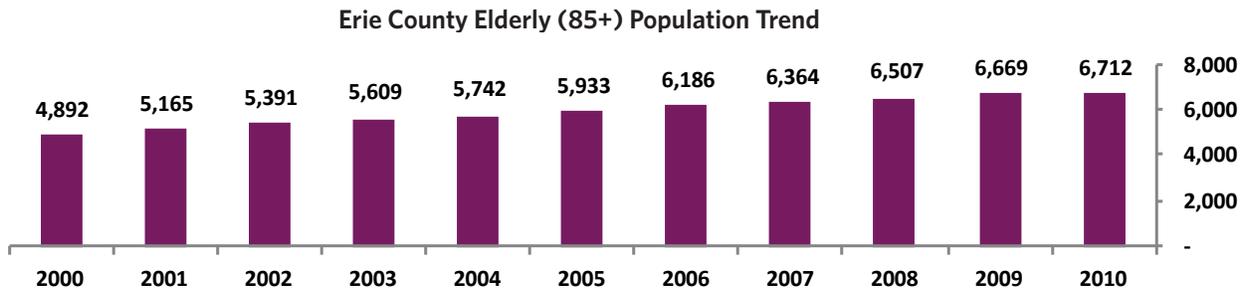


Source: U.S. Census

Erie County's total population has seen little change from 2000 to 2010.

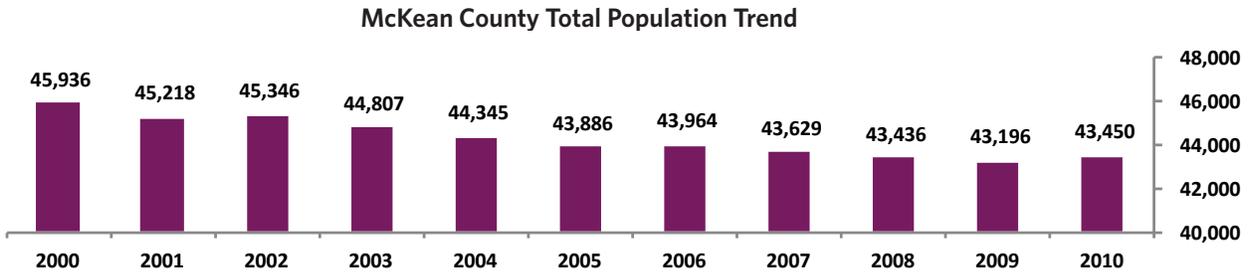


However, the most elderly population in Erie County (age 85 and over) has seen a 37 percent increase from 2000 to 2010.

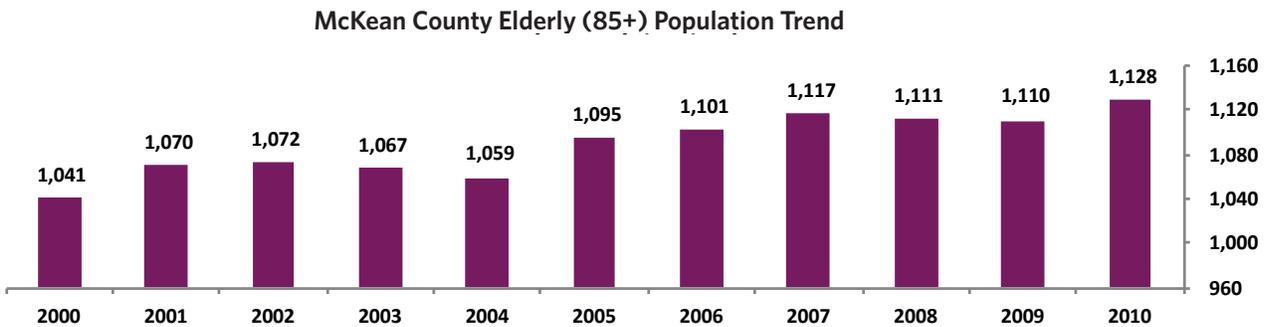


Source: U.S. Census

McKean County's total population has seen a 5 percent decrease from 2000 to 2010.



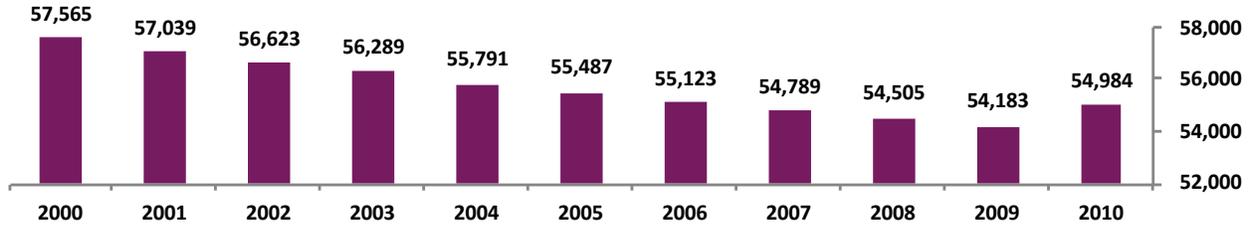
However, the most elderly population in McKean County (age 85 and over) has seen an 8 percent increase from 2000 to 2010.



Source: U.S. Census

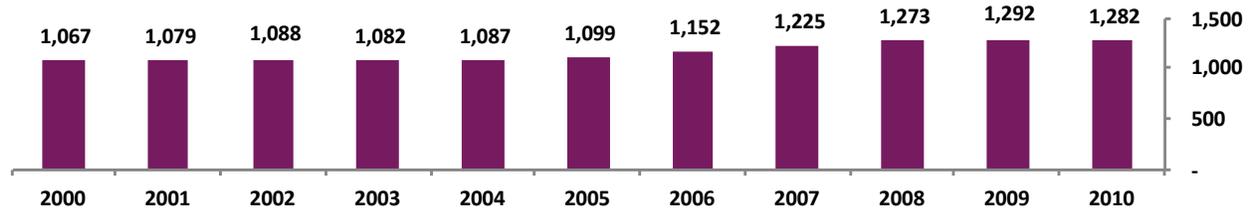
Venango County's total population has seen a 5 percent decrease from 2000 to 2010.

Venango County Total Population Trend



However, the most elderly population in Venango County (age 85 and over) has seen a 20 percent increase from 2000 to 2010.

Venango County Elderly (85+) Population Trend



Source: U.S. Census

Socioeconomic challenges in Chautauqua, Erie, McKean, and Venango counties: The overall population of the community faces some economic challenges when compared to state and national benchmarks.

Chautauqua County tends to have:

- A lower median household income
- More people living in poverty

Erie County tends to have:

- A lower median household income
- More people living in poverty
- More recipients of the income-based Medicaid health insurance program (see Appendix B)

McKean County tends to have:

- A lower median household income

Venango County tends to have:

- A lower median household income
- More people living in poverty

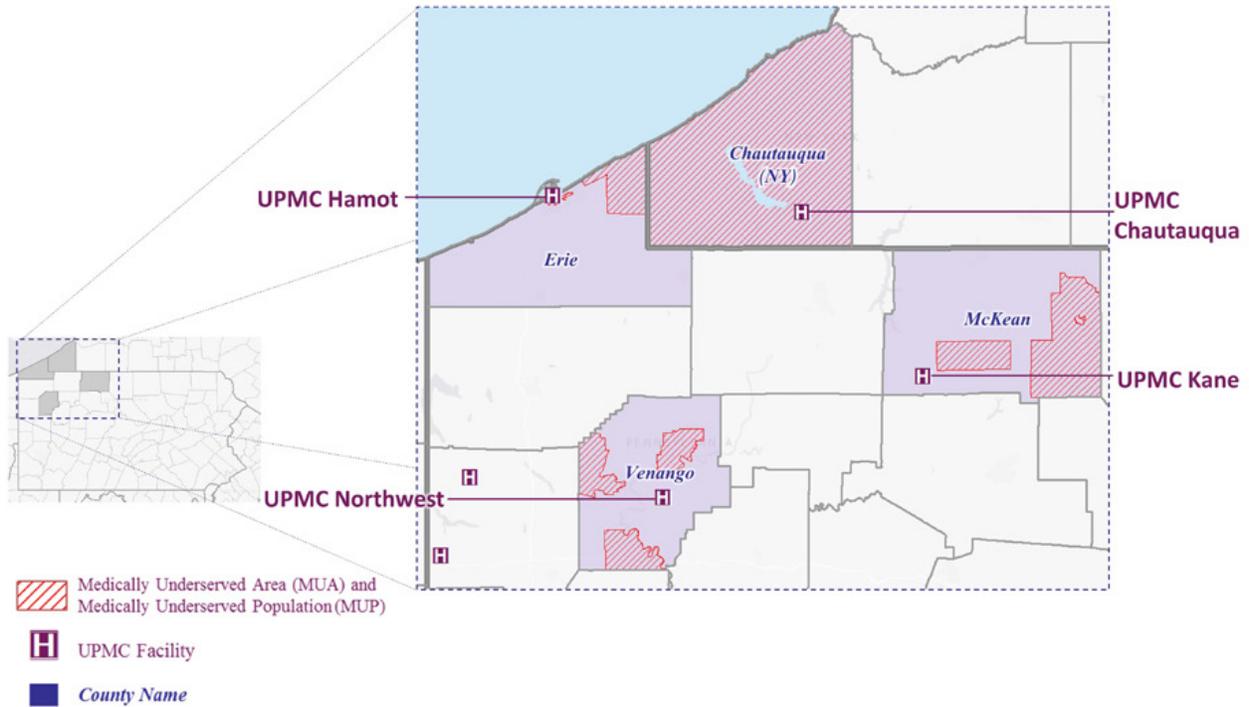
Social and Economic Population Demographics							
	Chautauqua County	Erie County	McKean County	Venango County	New York	Pennsylvania	United States
Median Age	40.9	38.6	41.5	44.3	38.0	40.1	37.2
Median Household Income	\$40,443	\$42,519	\$39,717	\$40,734	\$54,148	\$49,288	\$50,046
% of People in Poverty	17.1	17.4	15.0	15.8	14.9	13.4	15.3
% with No High School Diploma (among those 25+)	12.5	9.8	10.6	12.3	15.1	11.6	14.4
% Unemployed (among those 16+ in labor force)	10.4	9.4	10.6	8.5	9.9	9.6	10.8
Racial Groups							
% White	92.6	88.2	95.9	97.1	65.7	81.9	72.4
% African-American	2.4	7.2	2.4	1.0	15.9	10.8	12.6
% Other Race	5.0	4.6	1.7	1.9	18.4	7.3	15.0

Source: U.S. Census

Medically Underserved Areas and Populations in the Community: In Chautauqua, Erie, McKean, and Venango counties, there are some neighborhoods and populations that are more likely to experience health disparities. The map below indicates neighborhoods and populations in the counties that are federally designated by the Health Resources & Services Administration (HRSA) as Medically Underserved Areas (MUAs) or Medically Underserved Populations (MUPs).

The following factors are considered in the determination of MUAs and MUPs:

- A high percentage of individuals living below the poverty level
- A high percentage of individuals over age 65
- High infant mortality
- Lower primary care provider to population ratios



Percent Population that Lives in a HRSA-Designated Medically Underserved Area (MUA) Across the Region:

- ~100 percent of the Chautauqua County population lives in a HRSA-designated Medically Underserved Area (MUA).
- ~9.9 percent of the Erie County population lives in a HRSA-designated Medically Underserved Area (MUA).
- ~10.8 percent of the McKean County population lives in a HRSA-designated Medically Underserved Area (MUA).
- ~9.3 percent of the Venango County population lives in a HRSA-designated Medically Underserved Area (MUA).

Findings: Significant Health Needs for the Community:

Synthesizing data from the community input process and secondary data analyses for Chautauqua, Erie, McKean, and Venango counties yielded four significant health needs for the community:

- Chronic Disease Management
- Behavioral Health
- Access to Care and Navigating Resources
- Prevention and Community-Wide Healthy Living

Significant Health Needs for the Community

Chronic disease management rated highly in importance and hospitals' ability to address the need.	Behavioral health rated as highly important for the region, with an emphasis on combating opioid and substance use.
Access to care and navigating resources was rated highly in the hospitals' ability to address and likelihood of making a significant impact.	Prevention and community-wide healthy living was perceived as particularly important for the general population.

These four significant health needs were identified based on data from the community input process, earlier concept mapping efforts conducted with community participants, public health literature, and consultation with public health experts. Each need represents an area that is correlated with, and often drives, health outcomes, including mortality, quality of life, risk of hospitalization, and disease burden. All four significant health needs rated as a high priority on importance and perceived ability for hospitals to address the issue across the community leader surveys administered in Chautauqua, Erie, McKean, and Venango counties (scored above 3.90 on a scale of 1 to 5). For UPMC's Chautauqua, Erie, McKean, and Venango County hospitals, the assessment also identified 12 composite health topics within the overarching health priorities.

Chautauqua, Erie, McKean, Venango County Significant Health Needs			
Chronic Disease Management	Behavioral Health	Access to Care and Navigating Resources	Prevention and Community-Wide Healthy Living
<ul style="list-style-type: none"> • Heart Disease and Stroke • Respiratory Diseases • Diabetes • Cancer 	<ul style="list-style-type: none"> • Opioid and Substance Abuse • Access to Behavioral Health Services 	<ul style="list-style-type: none"> • Primary Care • Specialty Care • Palliative and End-of-Life Care 	<ul style="list-style-type: none"> • Community Prevention and Wellness Initiatives • Interpersonal Safety • Health-Related Social Needs

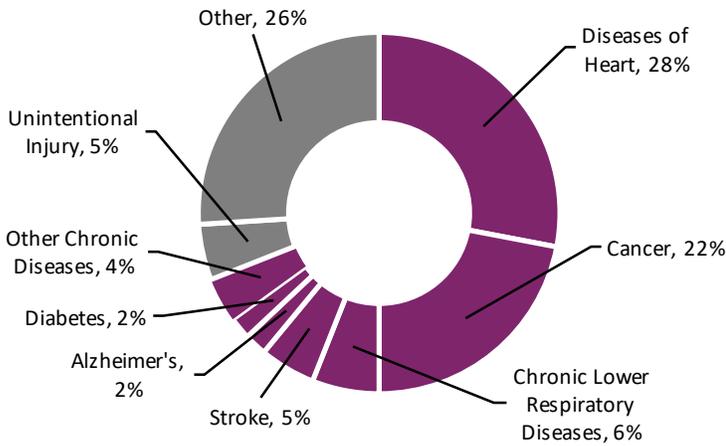
Chronic Disease Management — Importance to the Community:

Chronic diseases represent the leading causes of death nationally and in the community.

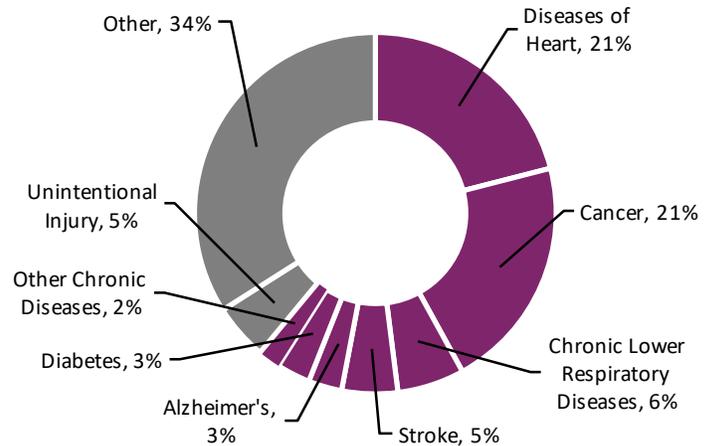
In each of the four counties, more than 60 percent of deaths are attributable to chronic disease. Chronic diseases have implications for the health and wellness and costs of care for community members. Seniors are particularly vulnerable as age is correlated with increased likelihood of developing chronic disease.

Chronic Disease is a Leading Cause of Death

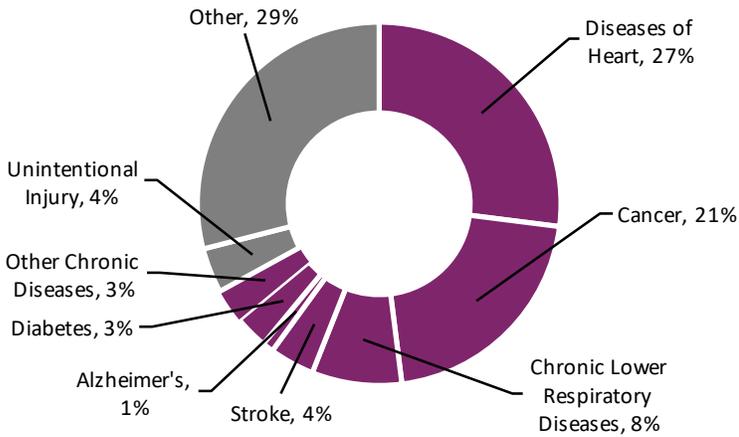
Chautauqua County: Chronic disease accounts for 68.3 percent of all deaths



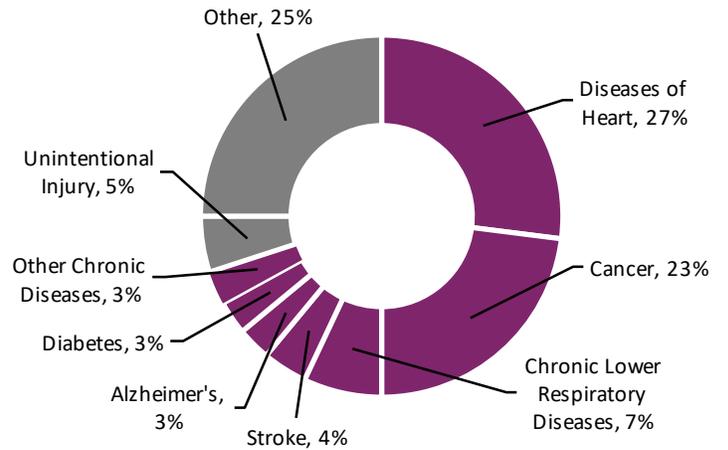
Erie County: Chronic disease accounts for 61.5 percent of all deaths



McKean County: Chronic disease accounts for 65.8 percent of all deaths



Venango County: Chronic disease accounts for 69.7 percent of all deaths



Other conditions Chronic disease

Sources: Pennsylvania Department of Health, 2016; U.S. Centers for Disease Control and Prevention, 2016

Chronic diseases have important implications for the health and wellness of the community.

Managing chronic diseases is becoming more complex as an increasing number of individuals suffer from multiple chronic conditions or comorbidities.

Chronic Disease	Significance
Obesity	Many populations continue to see steady increases in obesity rates. Obesity is a serious health concern because it is associated with the development of other chronic diseases, including diabetes, heart disease, stroke, and cancer. Nearly 1 in 5 children in grades 7-12 (19.1%) in Pennsylvania are obese, and 18.5% of middle and high school students in the state of New York are obese.
Heart Disease	Heart disease is the leading cause of death nationally, in Pennsylvania, and in New York. Heart disease is responsible for nearly 1 in every 4 national deaths.
Stroke	Stroke is the fifth leading cause of death for Americans and is responsible for 1 out of every 20 deaths.
Respiratory Disease	Chronic lower respiratory diseases are the fourth leading cause of death both nationally and in New York, and the fifth leading cause of death in Pennsylvania.
Diabetes	Diabetes is among the top 10 causes of death nationally, in Pennsylvania, and in New York. In both Pennsylvania and New York, more than 1 in 10 adults suffer from diabetes.
Cancer	More than 1.5 million people are diagnosed with cancer each year in the United States. Cancer is the second leading cause of death nationally, in Pennsylvania, and in New York.

Risks for chronic diseases vary across population segments in the community, with differences demonstrated for some medically underserved, low-income, and minority populations.

Public health data suggests that lower education and lower income are often associated with increased prevalence of certain chronic diseases. For example:

- In Chautauqua County in 2008-2009, 13 percent of adults with a high school education or less reported ever having a heart attack, angina, or stroke, compared to 5 percent with a college degree or more.
- In Erie County in 2016-2017, 16 percent of adults with a high school education have ever been told they have diabetes, compared to 9 percent of adults with a college degree.
- In McKean County in 2014-2016, 17 percent of adults who earn less than \$25,000 have ever been told they have diabetes, compared to 7 percent of adults who earn an income of \$50,000 or more.
- In Venango County in 2014-2016, 18 percent of adults who earn less than \$25,000 have ever been told they have diabetes, compared to 8 percent of adults who earn an income of \$50,000 or more.

Behavioral Health — Importance to the Community:

Access to behavioral health services — including assistance to combat opioid and substance use disorders — has significant community health implications.

Behavioral health disorders include a spectrum of conditions such as anxiety, depression, and bipolar disorder, as well as substance use disorders such as opioid addiction or alcohol abuse. Behavioral health conditions are among the most common health conditions in the nation.

Public health research has shown that individuals with a behavioral health condition are at greater risk of developing a wide range of physical health problems (e.g., chronic diseases).

Behavioral health issues are widespread across the population nationally and in the region.



Source: U.S. Centers for Disease Control and Prevention (CDC)

Across the region, many adults reported experiencing poor mental in the past month.

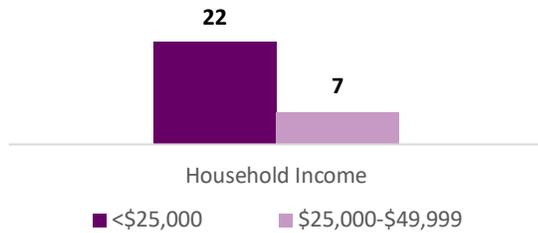
- In Chautauqua County in 2013-2014, 14 percent of adults reported experiencing poor mental health 14 or more days in the past month.
- In Erie County in 2016-2017, 42 percent of adults reported experiencing poor mental health one or more days in the past month.
- In McKean County in 2014-2016, 40 percent of adults reported experiencing poor mental health one or more days in the past month.
- In Venango County in 2014-2016, 36 percent of adults reported experiencing poor mental health one or more days in the past month.

Behavioral health needs occur at higher rates for some medically underserved, low-income, and minority sub-populations in the community.

Residents in the region with lower levels of income are more likely to report higher levels of mental health distress.

Poor Mental Health 14+ Days in the Past Month by Household Income (Percent)

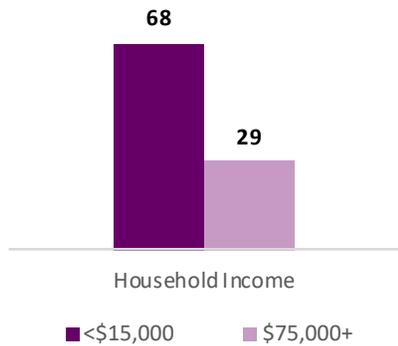
Chautauqua County



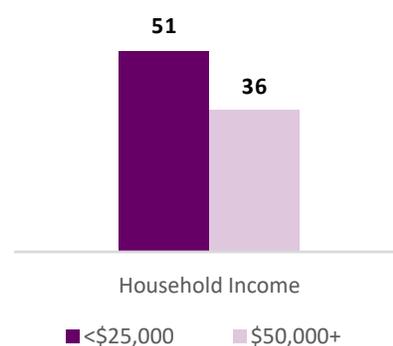
Source: New York State Department of Health, 2008-2009

Mental Health Not Good 1+ Day in the Past Month by Household Income (Percent)

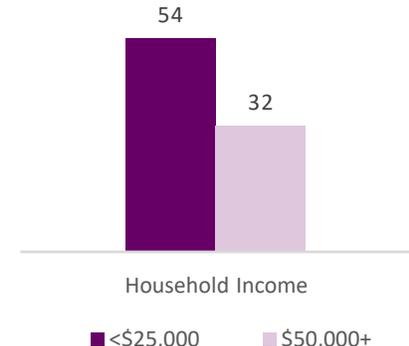
Erie County



McKean County



Venango County



Sources: Pennsylvania Department of Health, 2014-2016; Erie County Health Survey, 2016-2017

Opioid and substance use disorders are an epidemic of growing concern in Pennsylvania, New York, and the United States.

Nationally in 2016, approximately 20.1 million people 12 years or older had a substance use disorder (SUD) associated with alcohol or illicit drug use in the past year. Both Pennsylvania and New York have been affected by the opioid epidemic. In 2016, Pennsylvania was one of five states with the highest rates of death due to drug overdoses and New York state was one of several states noted as having significant increases in overdose deaths from 2015 to 2016.

	Erie County	McKean County	Venango County	Pennsylvania	Chautauqua County	New York
Drug overdose mortality rate per 100,000 population	24	20	23	28	20	15

Source: Robert Wood Johnson County Health Rankings & Roadmaps, 2018

Access to Care and Navigating Resources — Importance to the Community:

Access to health services and navigating the health care system contribute to positive health outcomes.

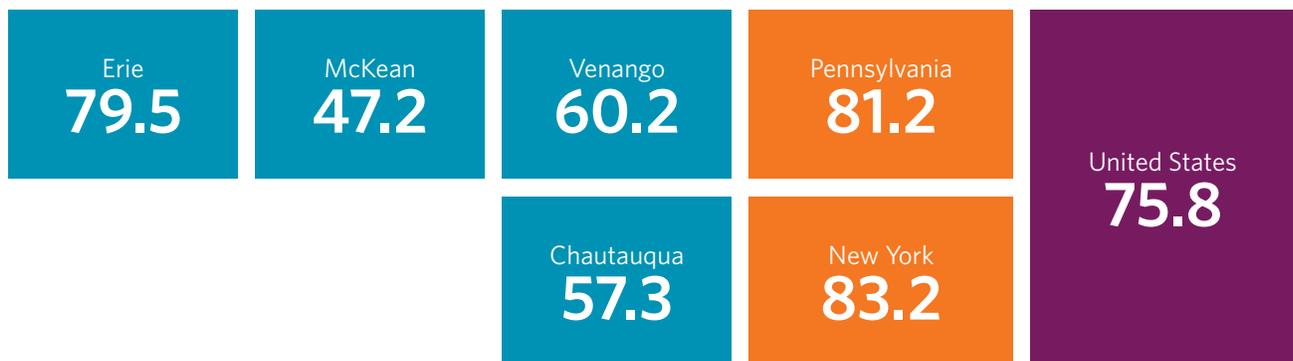
Access to care and navigating resources have important implications for the health of the community in a variety of ways, including: preventing disease and disability, detecting and treating illnesses or conditions, managing chronic disease, reducing preventable hospitalization, and increasing quality of life.

Primary care services can play a key role in facilitating access. Those without access to usual sources of primary care, such as a primary care physician, are less likely to receive preventive services, such as recommended screenings.

Primary care physician supply in the community is lower than state benchmarks. Within the region, there are areas and sub-populations that may exhibit impeded access. Chautauqua, Erie, McKean, and Venango counties contain a number of Health Professional Shortage Area (HPSA) designations, defined as geographic areas or population groups that indicate health provider shortages.

Across the region, there are fewer primary care physicians per 100,000 population compared to state benchmarks. McKean County has the lowest primary care physician supply per 100,000 population compared to the other counties in the region.

Primary care physicians per 100,000 population



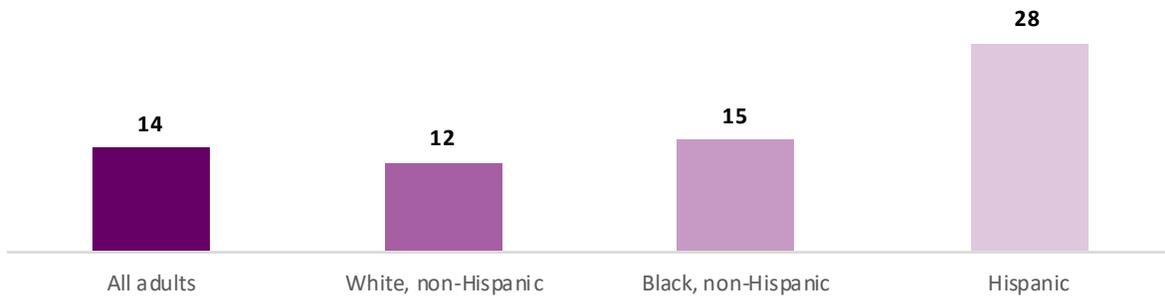
Source: Robert Wood Johnson County Health Rankings & Roadmaps, 2018

Similarly, access to specialty care is an important part of disease care and management, but patients may encounter challenges accessing services.

Available and ready access to primary care services has implications for medically underserved, low-income, and minority populations.

In Pennsylvania in 2016, more Hispanics (28 percent) and African Americans (15 percent) reported not having a primary care provider compared to White, non-Hispanics (12 percent).

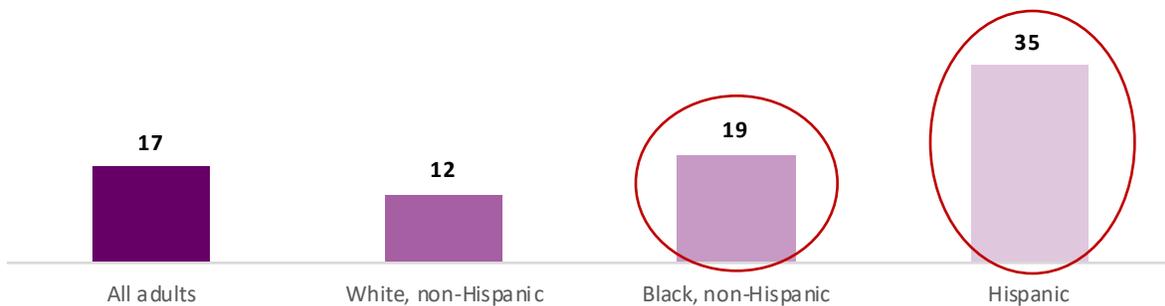
PA Adults That Report Not Having A Personal Health Care Provider In 2016 (Percent) By Race/Ethnicity



Source: Pennsylvania Department of Health, 2016

In the state of New York in 2008-2009, more Hispanics (35 percent) and African Americans (19 percent) reported not having a regular health care provider compared to White, non-Hispanics (12 percent).

NY Adults That Report Not Having A Personal Health Care Provider In 2008-2009 (Percent) By Race/Ethnicity



Source: New York State Department of Health, 2008-2009

Generally, across the region, residents with less education were more likely to report not having a personal health care provider.

- In Chautauqua County in 2008-2009, 17 percent of residents with less than or equal to a high school education reported not having a regular health care provider, compared to 8 percent with a college degree or more.
- In Erie County in 2016-2017, 12 percent of residents with a high school education reported not having a personal health care provider, compared with 8 percent of residents with a college degree.
- In Venango County in 2014-2016, 14 percent of residents with less than or equal to a high school education reported not having a personal health care provider, compared with 8 percent of residents with a college degree.

Navigating resources, including palliative and end-of-life care can present barriers to patients in need.

Even with an adequate supply of providers, navigating the health care system can be challenging for some patients and families. A key element demonstrated to assist in care coordination includes palliative and end-of-life care.

Navigating Resources Element	Significance
Palliative and end-of-life care services	Access to palliative and end-of-life care services provides important options for patients and families. Palliative and end-of-life care provide physical, emotional, social, and spiritual support.

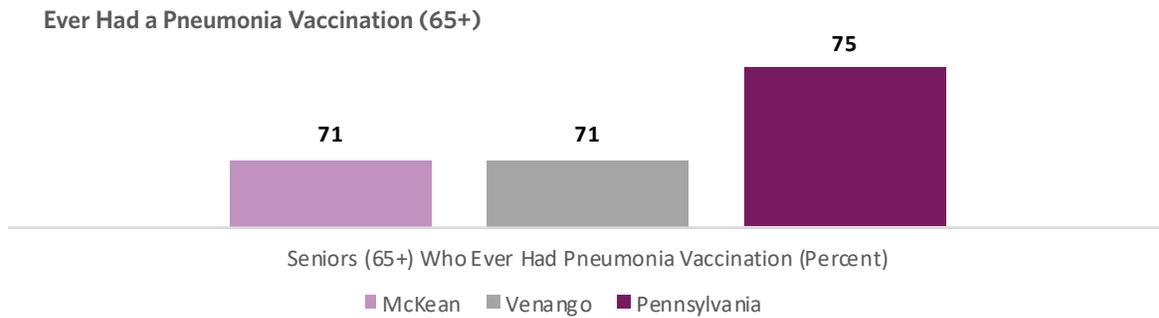
Prevention and Wellness Initiatives — Importance to the Community:

Preventive care efforts are effective tools to improve community health.

Preventive care efforts, such as preventive screenings, can help identify diseases early, improve management of diseases, and reduce costs.

Medically underserved, low-income, and minority populations may be less likely to access or receive preventive care.

County data indicates that seniors may experience barriers in accessing preventive services. Fewer seniors aged 65+ in McKean and Venango counties reported having a pneumonia vaccination compared to the state.



Source: Pennsylvania Department of Health, 2014-2016

Health-related social needs (lack of affordable housing, food insecurity, and unemployment) are associated with negative health outcomes.

Health-related social needs (HRSN) are the economic and social conditions that impact health, including housing instability, food insecurity, and unemployment. Academic research and government agencies continue to study the impact of health-related social needs on health outcomes. Research shows a strong association between health-related social needs and the incidence and severity of disease, life expectancy, and overall wellbeing.

Interpersonal safety (accidental/unintentional injury, violence) is a leading cause of death in the state.

Interpersonal safety includes intimate partner violence, elder abuse, child maltreatment, and accidental injury. Accidental, or unintentional injury, which includes gun violence, is the third leading cause of death nationally, in Pennsylvania, and in New York.

UPMC Is Working to Address Significant Health Needs:

UPMC hospitals in Chautauqua, Erie, McKean, and Venango counties are dedicated to addressing significant health needs in the community.

UPMC hospitals continue to build an extensive suite of programs and services to address the four significant health needs of chronic disease management, behavioral health, access to care and navigating resources, and prevention and community-wide healthy living. UPMC hospitals leverage community-based partnerships and system-wide resources to support residents in need.

Chronic Disease Management

UPMC hospitals in the region are working to increase awareness, prevention, and management of chronic diseases in the community. The hospitals continue to employ and expand a broad array of tactics, including community education and outreach, preventive screenings, and use of telehealth technology to address chronic disease management in the community.

Behavioral Health

UPMC hospitals in the region continue to enhance efforts to address behavioral health needs in the community through a wide variety of channels and services. Efforts include expanding access to behavioral health specialties through better integration of medical and behavioral health care and programs to increase awareness and support residents impacted by substance use disorders.

Access to Care and Navigating Resources

Collaborating with local community organizations, as well as pioneering innovative care models, UPMC hospitals in the region are working to extend access to primary and specialty care and to offer palliative and end-of-life services to those in need.

Prevention and Community-Wide Healthy Living

UPMC hospitals in the region partner with local organizations to enhance and develop programs that promote a healthy and safe environment for the community.

2019 Significant Health Needs in Chautauqua, Erie, McKean, and Venango Counties

UPMC Hospitals
in Chautauqua,
Erie, McKean, and
Venango Counties

	Chronic Disease Management				Behavioral Health	Access to Care and Navigating Resources			Prevention and Community-Wide Healthy Living			
	Heart Disease and Stroke	Respiratory Diseases	Diabetes	Cancer	Opioid and Substance Abuse	Access to Behavioral Health	Primary Care	Specialty Care	Palliative and End-of-Life Care	Community Prevention and Wellness	Interpersonal Safety	Health-Related Social Needs
UPMC Chautauqua	✓		✓	✓	✓	✓		✓		✓		
UPMC Hamot					✓	✓	✓		✓	✓	✓	✓
UPMC Kane							✓	✓		✓		
UPMC Northwest		✓	✓			✓		✓		✓		

IV. UPMC Hospitals Are Improving Community Health

2016-2019 Progress Reports and 2019-2022 Implementation Plans by Hospital

Charting Progress: Reflecting on the Impact UPMC Has Had Over the Past Three Years:

UPMC Chautauqua, UPMC Hamot, UPMC Kane, and UPMC Northwest have worked to continuously improve community health since the last CHNA cycle. The following reports showcase the extensive range of innovative programs and initiatives these hospitals have put in place to promote community health and wellbeing.

Moving Forward: Continuing to Promote Health and Wellbeing in the Community:

To address the significant community health needs identified through the 2019 CHNA process, each hospital developed an implementation plan. The hospital plan relies on collaboration and partnership with many of the same organizations and stakeholders that participated in the assessment process. In addition, the plan considers input from:

- Community-based organizations
- Government organizations
- Non-government organizations
- UPMC hospital and Health Plan leadership
- Public health experts that include Pitt Public Health

The following section contains a description of each hospital, its 2016 CHNA priorities, a progress report documenting initiatives taken to respond to those priorities over the 2016 to 2019 time period, and the hospital's CHNA priorities and implementation plan for 2019 to 2022.

UPMC Chautauqua	Page 32
UPMC Hamot	Page 46
UPMC Kane	Page 61
UPMC Northwest	Page 69

Community Health Improvement Progress and Plans

*2016 – 2019 Progress Reports and
2019 – 2022 Implementation Plans*



UPMC | CHAUTAUQUA

Caring for the Community

UPMC Chautauqua is southwestern New York’s largest not-for-profit health care provider. The hospital offers an extensive range of inpatient and outpatient acute and rehabilitation services that aim to meet the health care needs of a large rural population. As a result of its merger with UPMC in 2016, the hospital will invest \$90 million dollars, which will lead to long-term sustainability. It will also make capital investments to enhance convenient access to local health care resources, while expanding accessibility to top-rated, specialty services.

UPMC Chautauqua maintains a historically strong connection with its rural community. Established in 1885, the hospital began its service to the Jamestown area as a one-room hospital in a boarding house for young, working women. From these humble beginnings to the present, UPMC Chautauqua has never wavered from its mission of improving the health and wellbeing of those we are so privileged to serve — the very purpose for which this hospital was founded. As the oldest hospital in southwestern New York, UPMC Chautauqua has a proud heritage of providing excellent care and devoted service to its community.

	VITAL STATISTICS FISCAL YEAR 2018		JOBS AND STRENGTHENING THE LOCAL ECONOMY	
	Licensed Beds	317	Employees	954
	Hospital Patients	8,109	Community Benefits Contributions	\$11 million
	Emergency Dept. Visits	37,139	Free and Reduced Cost Care	\$10 million
	Total Surgeries	4,214	Total Economic Impact of Hospital Operations	\$213 million

Addressing the Community’s Significant Health Needs

When the Fiscal Year 2016 CHNA was conducted, UPMC Chautauqua affirmed the following significant health needs:

- Prevent Chronic Disease
- Promote Healthy Women, Infants, and Children
- Promote Mental Health and Prevent Substance Use Disorder



GOAL

Improve community health and reduce health disparities by increasing emphasis on prevention and management

STRATEGY

The hospital is taking a comprehensive approach to help manage chronic disease and reduce obesity

ACTIONS:

- ✓ Increase access to high quality chronic disease preventive care and management in both clinical and community settings.
- ✓ Offer a range of health education and awareness events throughout the community.
- ✓ Promote healthy eating and increase access to fresh, local produce.



PROGRAMS:

Cardiovascular Disease

- Heart health education and awareness
- WCA Strike Out Heart Disease
- Cardiovascular screenings
- WCA Employee Worksite Wellness
- Tobacco cessation education
- Chautauqua County Quits
- National Stroke Center

Diabetes

- Diabetes Prevention Program
- WCA Farmers Market Express
- WCA Raised Garden Project
- Rethink Your Drink campaign
- Community Foot Screening
- Living Healthy
- National Diabetes Prevention Program
- Promote walking routes, paths, and seasonal activities

Cancer

- Patient Navigation Cancer Resource Program
- Breast Health Nurse Navigator
- October Breast Cancer Awareness Month
- Shades of Pink breast screening program
- One-to-one tobacco cessation counseling
- Great American Smokeout Blitz
- Community Prostate Screening
- CEO Gold Accreditation 2015-2017
- 80% by 2018 Colorectal Cancer Awareness and Screening Program
- Lily's Hope
- Look Good Feel Better Program
- Distress Screening Tool
- Nutrition classes

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (EST. ANNUAL TOTALS)



75 Individuals
Counseled about
Smoking Cessation



100 Individuals
Completed Chronic
Self-Management
Classes



500 Individuals
Reached through
Hands-Only CPR
Training

PROGRAM HIGHLIGHTS:*Promoting Evidence-Based Care to Help Manage Chronic Disease*

The hospital, in collaboration with the county health department and community health coalitions, offers a wide range of community programs to help prevent and manage chronic diseases. Notable achievements include:

- **Heart Disease:** The hospital provides heart health education and awareness activities to schools, outreach organizations, churches, and local industries. Through these events, the hospital educates community members about heart attack and stroke symptoms and offers hands-only CPR training. In 2018, these efforts reached 1,349 community members.
- **Diabetes:** The hospital is increasing awareness and self-management of diabetes by providing access to a Certified Diabetes Educator, offering a 16-week Diabetes Prevention Program for prediabetics, hosting Living Healthy and National Diabetes Prevention Program trainings, and encouraging people to reduce their consumption of sugary beverages through the Rethink Your Drink campaign.
- **Cancer:** The hospital is supporting cancer patients through various programs, such as the Patient Navigation Breast Program, which linked more than 8,000 patients to needed breast cancer care services through breast navigators, and “Lily’s Hope,” which provides wigs for approximately 300 women who are losing their hair due to cancer treatments.

*Creating Healthy Schools and Communities*

With a grant from the New York State Department of Health (NYSDOH), the hospital is collaborating with 78 members of the Community Health Action and Community Planning Teams to help reduce obesity-related chronic disease. To help support policy changes that encourage healthier eating and physical activity within six high-needs school districts, the hospital is:

- Distributing more than 3,000 pieces of messaging to the community regarding nutrition, physical activity, and sodium reduction.
- Participating in Community Conversations within the schools and the community to discuss the high health needs.
- Participating in the Statewide Million Hearts/CHQ 250 pledge with 40 other community organizations. The hospital is working to save 250 lives in Chautauqua County from heart attack or stroke by demonstrating proper blood pressure technique and hands-only CPR at community events, and educating community members about prevention and the early warning signs and symptoms of heart attack and stroke.

Leading by Example

Since 1984, UPMC Chautauqua has been the leader of worksite wellness in Chautauqua County. Studies show that a healthy workforce benefits the organization by improving morale, and reducing turnover and absenteeism, while containing health care costs. Efforts over the last three years include:

- **Encouraging Employees to Exercise:** The hospital offers a wide range of programs to promote health and wellness and enable employees to engage in physical activity during the workday, including WCA Walking at Work, Working Out at Work, fitness discounts for UPMC Chautauqua employees, and onsite exercise rooms. In 2017, the hospital's three employee exercise rooms logged 700 visits.
- **Educating Employees about Healthy Habits:** In collaboration with Nutrition Services, the hospital provides healthy options and nutrition information in cafeterias. The hospital is also teaching employees about the benefits of choosing low-fat/cholesterol items; promoting healthy snacks during meetings; removing the fryer from its cafeteria and replacing it with Grab N Go less than 500 calorie meals; and engaging employees in less than 500 calorie entrée recipe contests.
- **Earning Awards for Worksite Wellness:** In 2014 and 2016, the hospital was chosen first place winner in the large business category for the Healthiest Employers award given by *Buffalo Business First*. For the fifth year, the hospital earned CEO Gold Standard re-accreditation from Johnson and Johnson and the American Cancer Society for efforts in promoting and providing preventive and diagnostic cancer services to its employees.
- **Promoting Access to Healthy Foods:** The hospital takes a multi-pronged approach to promote healthy food options to staff and community members. Over the last three years, the hospital has:
 - » Implemented healthy vending policies.
 - » Offered entrees in the cafeteria that are healthier and lower in saturated fat.
 - » Offered farmer's markets on site during the growing season.
 - » Promoted access to locally-grown foods, including promotion of the Chautauqua Grown website.

**COMMUNITY PARTNERS:**

New York State Department of Health, Community Health Action Team, Community Health Planning Team, Chautauqua County Health Department, American Cancer Society, TLC Health Network, Westfield Memorial Hospital, Brooks Memorial Hospital, The Chautauqua Center

GOAL

Promote healthy lifestyle behaviors during and after pregnancy

STRATEGY

The hospital plays a central role in promoting healthy pregnancies in the community

ACTIONS:

- ✓ Offer prenatal education to reduce premature births.
- ✓ Participate in state wide hospital breastfeeding initiatives to increase the proportion of babies who are breastfed.
- ✓ Increase the number of lactation professionals available to help breastfeeding mothers.
- ✓ Increase access to long-acting reversible contraceptives (LARCs).



PROGRAMS:

- Baby & Me Tobacco Free Program
- Great Beginnings NY
- Childbirth classes
- Prenatal Clinic
- Maternal and Infant Health Coalition
- Women’s and Maternity Care Center

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (EST. ANNUAL TOTALS)



30 Prenatal Education Classes



508 Participants



250 Prenatal Clinic Deliveries

PROGRAM HIGHLIGHTS:

Educating Expectant Parents about Healthy Behaviors during and after Pregnancy

- **Community Baby Showers:** Approximately 50 women attend annual gatherings of mothers from the community, including women from the New York State Department of Health (NYSDOH) Community Health Worker and Nurse Family Partnership. The event covers a wide range of topics, including: child development/play, breastfeeding, immunizations, healthy homes, birth control, and fetal alcohol syndrome/substance use disorder. Education is also provided on smoking cessation, car seat safety, and safe sleep practices.
- **Referrals for Support:** 95 percent of new moms are referred to the NYSDOH Community Health Worker Program and Nurse Family Partnership from Chautauqua OB/GYN.
- **Tobacco Cessation:** 77 moms were counseled on tobacco cessation during pregnancy, and 25 remained tobacco free after delivery.
- **Recognition for Efforts:** Honorable mention in the Health Association of New York’s 2016 Community Improvement Publication for submission of Access to Prenatal Care in Chautauqua County.

Promoting Breastfeeding Initiatives

The hospital adopted policies and practices that support breastfeeding moms. Accomplishments include:

- Seeing 381 new moms at the hospital since January 2016, and educating them about breastfeeding. 256 of these mothers initiated breastfeeding.
- Hosting three free Blackwell Chapel Baby Café community seminars, which educated more than 300 community members about substance use disorder and exposure during and after pregnancy.
- Training two employees for certification in Lactation Consulting with funding awarded by Chautauqua County Health Department's Creating Breastfeeding Resources in Chautauqua County.



Reducing Rates of Unplanned Pregnancies

The hospital is helping to increase access to long-acting reversible contraceptives (LARCs) by providing these options post-delivery or through prenatal clinics. The hospital is convening perinatal experts to guide plans to make LARCs more readily accessible, which will help reduce instances of unplanned pregnancies among teenagers and women with substance use disorders.

Enhancing Facilities

In September 2017, the hospital began construction of a new Women's and Maternity Care Center. This state-of-the-art facility will consolidate current obstetrics and prenatal delivery systems, enabling the hospital to serve growing families in its community for years to come. Enhancements include:

- Four labor and delivery suites.
- 12 post-partum private rooms, where patients can heal.

COMMUNITY PARTNERS:

Chautauqua County Health Department, New York State Community Health Worker Program and Nurse Family Partnership, TLC Health Network, Westfield Memorial Hospital

GOAL

Prevent substance use disorder and other mental, emotional, and behavioral disorders

STRATEGY

The hospital is leveraging available resources to enhance behavioral health services

ACTIONS:

- ✓ Prevent suicides among youth and adults.
- ✓ Host community Mental Health First Aid Trainings to identify and assist individuals experiencing a mental health crisis or who are in the early stages of chronic mental health problems.
- ✓ Prevent underage drinking, non-medical use of prescription pain relievers by youth, and excessive alcohol consumption by adults.



PROGRAMS:

- Mental Health First Aid Trainings
- Adolescent and Adult Mental Health Inpatient Units
- UPMC Chautauqua Behavioral Health

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (EST. ANNUAL TOTALS)

 **77** People Trained in Mental Health First Aid

 **2** New Inpatient Behavioral Health Units

 **19,046** Behavioral Health Outpatient Visits

PROGRAM HIGHLIGHTS:

Developing Key Skills to Respond to a Mental Health Crisis

The hospital, along with county-wide community partners, hosts Mental Health First Aid trainings, a course offered to the public that focuses on developing key skills for people to assist and respond to anyone who is experiencing a mental health crisis. Through these collaborative, community-wide trainings:

- 77 participants have learned to recognize the signs of mental illness.

Mental Health First Aid 

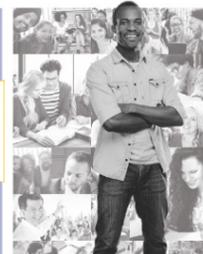
Join the movement.

Sometimes first aid isn't a bandage or CPR. Sometimes, first aid is YOU.

Who: Open to the Public
Where: Jones Memorial Health Center Auditorium
 51 Glasgow Ave., Jamestown
When: August 3, 2018
Time: 8am-5:30pm

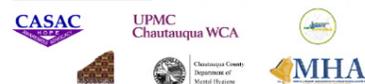
A person you know could be experiencing a mental health or substance use problem. Learn an action plan to help.

You are more likely to encounter someone in an emotional or mental crisis than someone having a heart attack. Learn how to help a friend, family member, coworker or neighbor in need. Get trained in Mental Health First Aid.



To register, please contact Victoria Patti, MHA, LMHW
 Phone: 716-753-4519 Email: vpatti@co.chautauqua.ny.us

Take a course. Save a life. Strengthen your community.



Reducing Prescription Drug Use by Youth and Adults

The hospital is working to help prevent non-medical use of prescription pain relievers by youth and adults. Efforts include:

- Helping to identify issues leading to miscommunications between physicians and emergency room staff, and to develop a plan to educate local physicians about how to inform patients about safe disposal of medications and reduce access to opiates.
- Collaborating with community partners to identify appropriate environmental and policy-level strategies to reduce access to and increase awareness of prescription drug abuse in Chautauqua County.
- Identifying opportunities to incorporate Screening, Brief Intervention, and Referral to Treatment (SBIRT) within emergency department settings.

Enhancing Services with New Facilities

The hospital also remains committed to providing a full range of behavioral health services, including:

- **Adolescent and Adult Mental Health Inpatient Units:** In September 2017, the hospital began construction of new inpatient mental health units. The hospital is enhancing its ability to meet the community's behavioral health needs with the addition of 10 inpatient adolescent mental health rooms and 20 inpatient adult mental health rooms.
- **Long-Term Residential Program:** In 2017, the hospital was awarded \$700,000 to open a 20-bed long-term residential program on the Jones Memorial campus. Renovations are currently underway. This program offers three levels of care: stabilization, rehabilitation, and community reintegration. This redesign of long-term care allows for individuals who may relapse while in treatment to remain in the residence, rather than change locations. This model of care offers the ability to adapt treatment plans and programming around a patient, increasing support and services as needed.
- **UPMC Chautauqua Behavioral Health:** In July 2017, behavioral health services relocated to a new, spacious outpatient center where it continues to provide counseling for mental health and substance use disorder care. Services include: psychiatric assessment, medication management, ancillary withdrawal services, individual and family therapy, support groups, and relapse prevention.
- **Outpatient Chemical Dependency Program (OPCD):** Over the last three years, the hospital has focused on expanding access to Medication Supported Recovery, and in October 2017, OPCD was awarded \$1.5 million over three years to expand access to Medication Assisted Therapy (MAT) through a grant from the Substance Abuse and Mental Health Services Administration. The hospital's OPCD program leverages telemedicine to reach more people needing these services.

COMMUNITY PARTNERS:

Western New York Chemical Dependency Consortium, CASAC, Chautauqua HOPE Coalition, The Community Alliance for Suicide Prevention, Chautauqua County Department of Mental Hygiene, Chautauqua Tapestry Expansion Initiative

UPMC CHAUTAUQUA IS ADDRESSING HIGH PRIORITY HEALTH ISSUES:

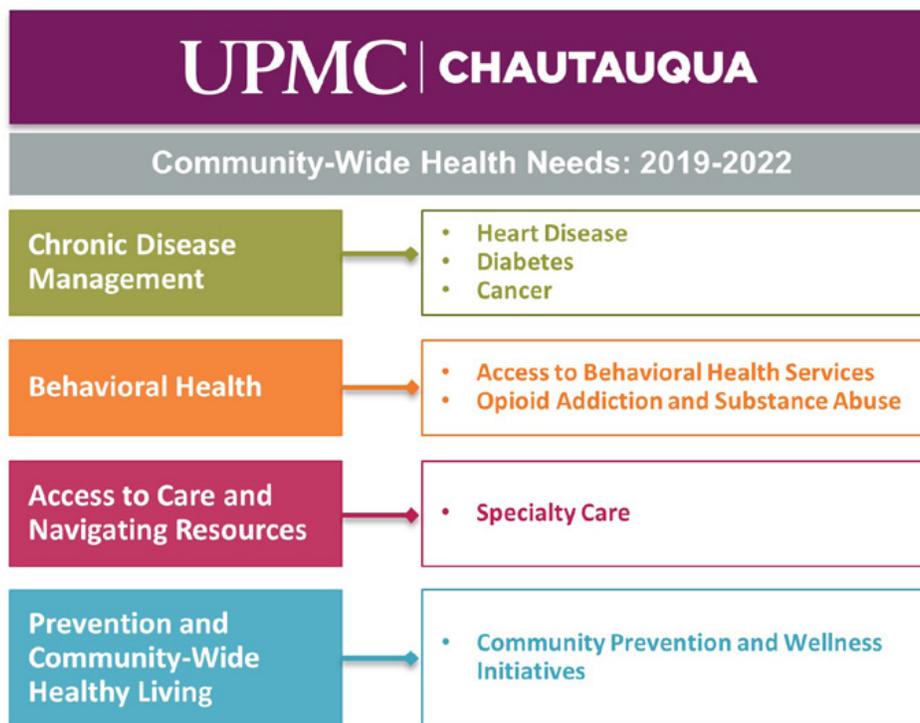
Adoption of the Implementation Plan

On February 11, 2019, the UPMC Chautauqua Board of Directors adopted an implementation plan to address the significant health needs identified:

- **Chronic Disease Management**
- **Behavioral Health**
- **Access to Care and Navigating Resources**
- **Prevention and Community-Wide Healthy Living**

UPMC Chautauqua Is Leveraging UPMC and Community Resources

By providing a comprehensive suite of programs, UPMC Chautauqua plays an important role in addressing the community health needs that were identified in the recent Community Health Needs Assessment. The hospital will support the priority areas with internal resources, through grants, and by strengthening collaborations with numerous community partners.



Addressing Chronic Disease Management

UPMC Chautauqua is addressing chronic disease management through an extensive suite of interventions targeting heart disease, cancer, and diabetes. Efforts include: education, screenings, and a wide variety of community outreach initiatives.

CHRONIC DISEASE MANAGEMENT			
	Heart Disease	Diabetes	Cancer
Intended Actions	Increase access to high quality chronic disease preventive care and management in both clinical and community settings <ul style="list-style-type: none"> Offer a range of health education and awareness events throughout the community 		
Programs	<ul style="list-style-type: none"> Heart health education and awareness UPMC Chautauqua Strike Out Heart Disease Cardiovascular screenings Tobacco cessation education National Stroke Center Cardiac Nurse Navigator initiative 	<ul style="list-style-type: none"> Diabetes Prevention Program UPMC Chautauqua Farmers Market Express UPMC Chautauqua Raised Garden Project Rethink Your Drink campaign Grab and Go Healthy Food Initiative under 500 calories Community Foot Screening Living Healthy National Diabetes Prevention Program 	Access, Care Coordination, Education, and Support Services: <ul style="list-style-type: none"> Add new infusion center Patient Navigation Cancer Resource Program Breast Health Nurse Navigator Shades of Pink Breast Cancer Support for breast and other women’s cancers One-to-one tobacco cessation counseling CEO Gold Accreditation Lily’s Hope Look Good Feel Better Distress Screening Tool Nutrition classes Screening Initiatives: <ul style="list-style-type: none"> Shades of Pink breast screening program Colorectal cancer awareness screening program Representative located in UPMC Chautauqua Wellness to conduct outreach and recruitment for cancer screenings Community Outreach Initiatives: <ul style="list-style-type: none"> Great American Smokeout Blitz October Breast Cancer Awareness Month
Target Population	General community, medically underserved/low income/minority populations		
Anticipated Impact Three-Year Goal	Increase awareness, prevention, and management of chronic disease in the community		
Planned Collaborations	New York State Department of Health, Community Health Action Team, Community Health Planning Team, Chautauqua County Health Department, American Cancer Society, TLC Health Network, Westfield Memorial Hospital, Brooks Memorial Hospital, The Chautauqua Center, Chautauqua County Office of the Aging, Steuben, Cattaraugus, Alleghany and Chautauqua Cancer Services Program		

Addressing Behavioral Health

UPMC Chautauqua will enhance and create comprehensive services to meet the community’s needs relating to behavioral health and substance use. The hospital will continue to develop and maintain multiple channels and community-based partnerships to ensure residents have access to behavioral health services. Efforts include: community-based Medication-Assisted Therapy (MAT), inpatient units, and community outreach initiatives.

BEHAVIORAL HEALTH		
	Access to Behavioral Health Services	Opioid Addiction and Substance Abuse
Intended Actions	Take a comprehensive approach to address behavioral health <ul style="list-style-type: none"> ▪ Help prevent suicides among youth and adults ▪ Host community Mental Health First Aid Trainings to identify and assist individuals experiencing a mental health crisis or in the early stages of chronic mental health problems ▪ Continue to enhance and expand mental health programming for the community 	Create programming to stem addiction <ul style="list-style-type: none"> ▪ Help prevent underage drinking, non-medical use of prescription pain relievers by youth, and excessive alcohol consumption by adults ▪ Continue to offer treatment and support for individuals with substance use disorder
Programs	<ul style="list-style-type: none"> ▪ Mental Health First Aid Trainings ▪ Adolescent and Adult Mental Health Inpatient Units ▪ UPMC Chautauqua Behavioral Health ▪ Long-Term Residential Program 	<ul style="list-style-type: none"> ▪ Outpatient Chemical Dependency Program (OPCD) ▪ Targeted prevention efforts to help reduce drug and substance use by youth and adults ▪ Medication-Assisted Therapy treatment sites ▪ Offer telehealth channels between medication dependency sites
Target Population	General community	General community
Anticipated Impact Three-Year Goal	Increase awareness of and access to behavioral health resources	Improve awareness of and access to services to support those suffering from addiction
Planned Collaborations	Western New York Chemical Dependency Consortium, CASAC, Chautauqua HOPE Coalition, The Community Alliance for Suicide Prevention, Chautauqua County Department of Mental Hygiene, Chautauqua Tapestry Expansion Initiative	

Addressing Access to Care and Navigating Resources

UPMC Chautauqua will continue to address access and navigating resources in the community through a variety of channels. Dedicated efforts include: recruiting physicians and providing access to UPMC’s world-renowned specialists through telehealth, which offers residents access to the best quality care close to home.

ACCESS TO CARE AND NAVIGATING RESOURCES

Specialty Care	
Intended Actions	Increase access to specialty care <ul style="list-style-type: none"> Examine multiple methods to expand specialty care services in the community
Programs	<ul style="list-style-type: none"> Physician recruitment Conduct evaluation to determine viability of telehealth offerings within the community Work to build family residency program
Target Population	General community
Anticipated Impact Three-Year Goal	Improve access to specialty care
Planned Collaborations	New York State Dept. of Health, UPMC Chautauqua Medical Staff, Family Graduate Medical Education Office of UPMC

Addressing Prevention and Community-Wide Healthy Living

UPMC Chautauqua is addressing prevention and community-wide healthy living by building a robust platform of community-based efforts to educate and promote healthy lifestyles. UPMC Chautauqua is leading this initiative by example, taking a comprehensive approach to support employee wellness at work.

PREVENTION AND COMMUNITY-WIDE HEALTHY LIVING

Community Prevention and Wellness Initiatives	
Intended Actions	The hospital is taking a comprehensive, community-oriented approach to improve the health and wellness of residents in the community. Efforts include: targeted initiatives to support employees and mothers and infants. <ul style="list-style-type: none"> Promote healthy eating and increase access to fresh, local produce Offer prenatal education to reduce premature births Participate in statewide hospital breastfeeding initiatives to increase the proportion of babies who are breastfed Increase the number of lactation professionals available to help breastfeeding mothers Increase access to long acting reversible contraceptives (LARCs)
Programs	Promote healthy eating and increase access to fresh, local produce: <ul style="list-style-type: none"> UPMC Chautauqua Employee Worksite Wellness (e.g., on-site exercise rooms) Promote walking routes, paths, and seasonal activities Mothers and infants: <ul style="list-style-type: none"> Baby & Me Tobacco Free Program Great Beginnings NY Childbirth classes Prenatal Clinic Maternal and Infant Health Coalition Women’s and Maternity Care Center

PREVENTION AND COMMUNITY-WIDE HEALTHY LIVING

Target Population	General community, mothers and infants
Anticipated Impact Three-Year Goal	Improve general health and wellbeing for residents in the community
Planned Collaborations	Chautauqua County Health Department, TLC Health Network, Westfield Memorial Hospital, Cornell Cooperative Extension, Conduit Ministries, Jamestown Renaissance Corporation, local farmers market participants

Community Health Improvement Progress and Plans

*2016 – 2019 Progress Reports and
2019 – 2022 Implementation Plans*



UPMC | HAMOT

Caring for the Community

UPMC Hamot is a nonprofit, acute-care teaching hospital, regional referral center, and tertiary hub located in Erie, Pennsylvania. Founded in 1881, the state-of-the-art facility delivers a full range of quality medical services, including highly specialized medical and surgical treatment, a Level III neonatal intensive care unit, and the region’s only Level II Trauma Center. Specialized services also include renal transplant, digital mammography, minimally invasive surgery, and a women’s hospital.

Since affiliating with UPMC in 2011, UPMC Hamot has benefited from more than \$300 million in investments, which include improvements to inpatient and outpatient clinical care, equipment, and information technology. UPMC Hamot also is a Magnet® designated hospital — the highest international recognition for nursing excellence and leadership.

	VITAL STATISTICS Fiscal Year 2018		JOBS AND STRENGTHENING THE LOCAL ECONOMY	
	Licensed Beds	423	Employees	3,524
	Hospital Patients	28,077	Community Benefits Contributions	\$26 million
	Emergency Dept. Visits	77,632	Free and Reduced Cost Care	\$11 million
	Total Surgeries	13,364	Total Economic Impact of Hospital Operations	\$680 million

Addressing the Community’s Significant Health Needs

When the Fiscal Year 2016 CHNA was conducted, UPMC Hamot affirmed the following significant health needs:

- Preventive Screenings
- Maternal and Infant Health
- End-of-Life Care
- Behavioral Health



GOALS

Increase awareness about screenings for chronic disease

STRATEGY

The hospital is leading efforts to raise awareness about preventive screenings

ACTIONS:

- ✓ Continue to educate patients about importance of preventive screenings.
- ✓ Continue to collaborate with UPMC Hamot Outpatient Coordination Center in contacting patients.
- ✓ Continue to provide health education and screenings at community events.



PROGRAMS:

Screening Awareness

Community Education and Events

- Mammo Marathon
- Erie County Medical Society
- Erie Zoo Senior Day
- Eastside YMCA Health Fair

- Women's Health Fair by UPMC Health Plan
- Success by 6
- State Rep. Parke Wentling Senior Fair
- WearRed
- Gannon University Health Fair
- PA Rep. Ryan Bizzarro Senior Health Fair
- For Women Only Expo

- YMCA Healthy Kids Day
- Veterans Resource Expo - Sen. Dan Laughlin

Screening Assessment

Improve Screening Rates

- Colon Cancer
- Mammography
- Diabetes

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (EST. ANNUAL TOTALS)



17
Total Events



12,308
Event Attendees



743
Attendees Screened

PROGRAM HIGHLIGHTS:*Promoting Healthy Behaviors and Preventive Screenings at Community Events*

UPMC Hamot regularly promotes health education and screening events throughout the community. To help increase access to preventive screenings for women and seniors, the hospital participates in a range of events, including: Mammo Marathon, For Women Only Expo, Erie Zoo Senior Day, and YMCA Healthy Kids Day.

- **YMCA Healthy Kids Day:** UPMC Hamot continues to sponsor Healthy Kids Day, a free, annual event to inspire kids to keep their minds and bodies active. This event is part of a national YMCA initiative to improve health and wellbeing for kids and families and encourage participation in summer activities, such as sports and camping. In 2018, the hospital also hosted an activity for participants to learn about safety and assemble mini first aid kits. Attendance at the 2018 Healthy Kids Day was the highest ever at the Glenwood YMCA, with more than 1,000 participants — more than double the attendance of 2017's event.

Encouraging Preventive Screenings

Hospital programs are connecting patients with primary care physicians and encouraging preventive screenings.

- **UPMC Hamot Primary Care Network:** With more than 122,000 patients enrolled in UPMC primary care practices in Erie County, including family medicine, internal medicine, and pediatrics, primary care providers view screenings as an important part of preventive care. They are ordering screenings suggested by evidence-based guidelines and following up with patients to improve screening rates.
- **UPMC Hamot Outpatient Coordination Center:** Using electronic medical records, the hospital is tracking screening rates, reminding patients about the importance of screenings, and reaching out to those who have not been in for a primary care visit in 18 months.
- **Improving Screening Rates for Targeted Populations:** The hospital is focused on measuring and improving screening rates for mammography, diabetes, and colon cancer. In Calendar Year 2017, the hospital achieved improved screening rates:
 - » Mammography: 62.04 percent
 - » Diabetes: 71.05 percent
 - » Colon Cancer: 61.68 percent

As part of UPMC Hamot's participation in the American Cancer Society and National Colorectal Cancer Roundtable 80% by 2018 pledge, the hospital offered free colon cancer screening kits to Erie residents over the age of 50 who had not yet had a colonoscopy. By distributing 75 kits in 2018, the hospital helped to raise awareness and allowed people to screen for colon cancer in the comfort of their own homes.

COMMUNITY PARTNERS:

UPMC Hamot Primary Care Network, Gannon University, Voices for Independence, YMCA, Erie365, African American Concerned Clergy, Word of Faith Development Corp., Multicultural Health Evaluation Delivery System

GOALS

Encourage healthy behaviors through community education and support programs focused on prenatal care

STRATEGY

The hospital is improving access to prenatal care through education and support

ACTIONS:

- ✓ Hold quarterly prenatal classes at community locations.
- ✓ Increase enrollment in navigation services.
- ✓ Translate educational materials into 5 languages.
- ✓ Collaboration with New Directions and Esper Treatment Center to develop care plan for patients prior to delivery.
- ✓ Continue to provide education about safe sleep.



PROGRAMS:

Refugee Populations

- Prenatal Care Access and Coordination of Care
- Prenatal classes
- One-on-One Navigation Services
- Educational classes
- Translated materials

Parenting Education

- Safe Sleep Initiative
- Gold Safe Sleep Champion Certification
- Prenatal and Grandparent classes
- Healthy Pregnancy and Parenting Courses

Pregnant Women with Substance Addiction

- Educational clinics
- Staff Training
- Women's Recovery Center

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2016-2018)



3 Language Options for Prenatal Materials



Launched Women's Recovery Center



Gold Safe Sleep Champion

PROGRAM HIGHLIGHTS:*Increasing Access to Education and Prenatal Care*

The hospital offers a range of classes, such as childbirth education, breastfeeding, and infant care, and provides outreach at community events and health fairs. Hospital efforts over the past three years have resulted in:

- Educating more than 3,500 individuals about healthy pregnancies and prenatal care from 2016 to 2018
- A decrease of 3.8 percent in deliveries prior to 39 weeks gestation

Targeting At-Risk Populations

UPMC Hamot is targeting women of childbearing age and pregnant women who are minorities, low-income individuals, and immigrants. A significant number of refugees have settled in Erie County, and the hospital is improving outreach to this population through a childbirth education program for non-native English speakers. Achievements over the last three years include:

- Received a Women's Health Outreach Grant from the World Health Organization to improve the health of immigrant and refugee populations in Erie County through prenatal education, in collaboration with the Multicultural Resource Center.
- Translated and purchased prenatal education materials in Spanish, Somali, and Swahili.
- Collaborated with the Multicultural Community Resource Center, International Institute, and Catholic Charities to reach 30 refugee women. 2017 efforts resulted in 11 prenatal classes offered in both Spanish and Swahili, facility tours, and 1:1 Health Navigation Services, which utilized interpreter services provided by the Multicultural Community Resource Center.
- In 2016, UPMC Hamot nurses led a coalition to develop relationships with community leaders to assess refugee needs and advance the cultural competency of caregivers and improve health care outcomes at the hospital.
 - » Birth Stories Around the World was held at Magee-Womens, UPMC Hamot. Seven refugee women agreed to be interviewed and professionally videotaped telling their childbirth stories from a variety of countries. This video is used for staff education, and community resettlement classes at the International Institute of Erie.

Encouraging Families to Practice Safe Sleep

UPMC Hamot teaches parents to create a safe sleeping environment for their babies at home. UPMC Hamot has been officially recognized as a Cribs for Kids National Gold Certified Safe Sleep Hospital. The award was made possible with help from the UPMC Hamot Aid Society and its SleepSack® campaign. The sleep sacks help ensure parents have the help they need to sustain the safe sleep practices they learn in the hospital once they go home.

Supporting Pregnant Women in Recovery

The hospital is improving care coordination for pregnant women who have a history of substance use disorder. Over the past three years, the hospital has developed programs to help support women in treatment and care for babies born with Neonatal Abstinence Syndrome (NAS), including:

- **Women's Recovery Center at Magee-Womens, UPMC Hamot:** The hospital opened an outpatient program that offers substance use disorder treatment for women with families and expectant mothers who also need prenatal care. Treatment combines opioid withdrawal medications, behavioral counseling, peer support, and routine prenatal check-ups.
- **Collaborating with Local Clinics:** Through Safe Harbor Behavioral Health of UPMC Hamot and the Women's Recovery Center, the hospital has developed partnerships with New Directions and Esper Treatment Center to help create care plans for patients before and after delivery. The hospital is also hosting educational sessions on a range of topics, including: Coping with Changes During Pregnancy and Beyond, The Facts about Substance Abuse During Pregnancy, and Drinking During Pregnancy.

COMMUNITY PARTNERS:

Catholic Charities, Multicultural Community Resource Center, Multicultural Health Evaluation Delivery System, Maternal and Child Health Task Force, New Directions Methadone Clinic, Esper Treatment Center, Cribs for Kids

GOALS

Enhance end-of-life programs

STRATEGY

The hospital is improving community and provider education to aid end-of-life decisions

ACTIONS:

- ✓ Continue to participate in programs educating the community about end-of-life care and concerns. Explore approaches to educate special needs population and their caregivers.
- ✓ Continue to support palliative care program, including engaging patients in Goals of Care conversation and palliative care consults.



PROGRAMS:

Community Awareness

- Advance Directives
- Living Wills
- Hospice
- Palliative Care

Improve Utilization of End-of-Life Care

- Goals of Care Conversations
- Palliative Care Consults
- Hospice Admissions

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (EST. ANNUAL TOTALS)



21 Educational Programs and Trainings



380 Attendees of Educational Programs and Trainings



2,960 Palliative Care Consults

PROGRAM HIGHLIGHTS:*Educating Providers and Community Members about End-of-Life Care*

The hospital worked with Erie Homes for Children and Adults, including in residential homes, at the main campus facility, and at the Ambulatory Training Facility.

- Presented end-of-life education to an estimated 350 staff members at Erie Homes for Children and Adults, resulting in:
 - » Education of all executives, leaders, nurses, and direct care providers
 - » Preparation of educational materials
 - » Improved knowledge of end-of-life care
- Partnered with local assisted-living facilities to host “Being Mortal” educational programming and engaged people in discussions about terminal illness and difficult treatment decisions.
- Hosted educational film screening of *Defining Hope*, a documentary that tells the stories of people confronting life-threatening illnesses and decisions about care. This event provided an opportunity for attendees to meet with local professionals to discuss advance directives and end-of-life care.

Improving Quality of Life for Seriously Ill Patients

As part of the UPMC Palliative and Supportive Institute, the hospital is improving communication around end-of-life decisions. The hospital is working to ensure that patients and their families are equipped with information and support.

- In 2017, 100 percent of palliative care patients were engaged in a “Goals of Care” conversation and more than 50 percent of those individuals reported a decrease in pain.

COMMUNITY PARTNERS:

Erie Home for Children and Adults, Barber National Institute, Erie County Care Management, Great Lakes Home Health and Hospice, UPMC Palliative and Supportive Institute

GOALS

Increase access to behavioral health services

STRATEGY

The hospital is integrating behavioral health services, especially for substance use disorder support

ACTIONS:

- ✓ Expand efforts to provide services, such as drug and alcohol treatment, including exploration of efforts to become a Center of Excellence.
- ✓ Explore approaches to establish crisis residential services for adolescents.
- ✓ Explore approaches to enhance access to behavioral health care services in other settings, such as emergency department, post-partum, bariatric services, and primary care offices.



PROGRAMS:

Community Awareness

- Access to Drug and Alcohol Services
- Application for drug and alcohol treatment license
- Evaluate need for crisis residential unit for adolescents
- Women’s Recovery Center

Integration of Behavioral Health Services

- UPMC Hamot Emergency Department
- Magee-Womens, UPMC Hamot
- Primary Care Practices
- UPMC Hamot Bariatric Surgery and Weight Management Center
- United Way Community Schools

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (EST. ANNUAL TOTALS)



Obtained Drug and Alcohol Treatment License



11 Classes Offered



6 Physician Practices with Behavioral Health Provider

PROGRAM HIGHLIGHTS:*Expanding Substance Use Disorder Support Services*

Safe Harbor Behavioral Health at UPMC Hamot is expanding its array of services to better meet the growing needs in the community.

Safe Harbor obtained three new licenses, which allow it to integrate behavioral health services into other health care entities across the care spectrum.

- Safe Harbor established an early onset clinic for severe mental illness.
- Safe Harbor is the lead partner for the United Way Community Schools initiative at East Middle School and employs the Community Schools Director and program coordinator.
- In 2018, the hospital established the Women's Recovery Center, an outpatient program that supports and cares for women with substance use disorder.



Behavioral health is now available through Magee-Womens, UPMC Hamot; Pine Crest Family Medicine; Vineyard Primary Care; Bay Harbor, Primary Care Partners; and UPMC Bariatric Surgery and Weight Management Center.

COMMUNITY PARTNERS:

Erie County Dept. of Human Services, PA Department of Health, Office of Mental Health and Substance Abuse, school districts, Regional Health Services, Safe Harbor Behavioral Health at UPMC Hamot

UPMC HAMOT IS ADDRESSING HIGH PRIORITY HEALTH ISSUES:

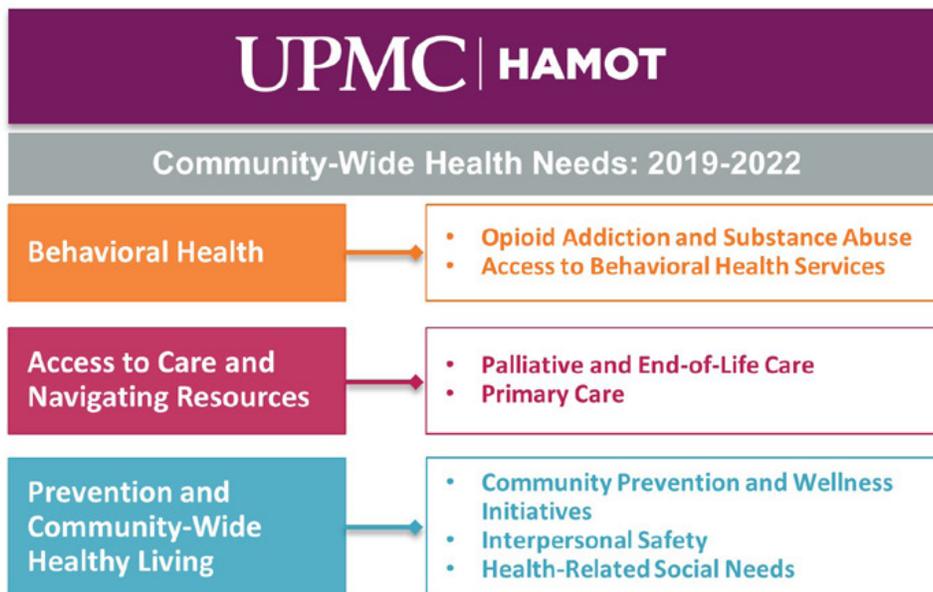
Adoption of the Implementation Plan

On January 31, 2019, the UPMC Hamot Board of Directors adopted an implementation plan to address the significant health needs identified:

- Behavioral Health
- Access to Care and Navigating Resources
- Prevention and Community-Wide Healthy Living

UPMC Hamot Is Leveraging UPMC and Community Resources

By providing a comprehensive suite of programs, UPMC Hamot plays an important role in addressing the community health needs that were identified in the recent Community Health Needs Assessment. The hospital will support the priority areas with internal resources, through grants, and by strengthening collaborations with numerous community partners.



Addressing Behavioral Health

UPMC Hamot will maintain and expand its ongoing efforts to support the community’s needs relating to behavioral health and substance abuse through multiple channels. Efforts include expanding outreach initiatives, investing in programs to support people with substance use disorders, and partnering with community-based behavioral health service organizations and other UPMC entities, such as the Women’s Recovery Center at UPMC Magee-Womens Hospital and UPMC Health Plan.

BEHAVIORAL HEALTH

	Opioid Addiction and Substance Use Disorder	Access to Behavioral Health Services
Intended Actions	<p>Create integrative and responsive programming to address the substance use disorder needs of the community</p> <ul style="list-style-type: none"> • Create programming and services to stem addiction and substance use • Provide educational support services to schools to help serve students who may be at risk for substance use 	<p>Take a comprehensive approach to addressing behavioral health</p> <ul style="list-style-type: none"> • Increase awareness, training, and support services for behavioral health concerns • Expand access to behavioral health services (e.g., telehealth, school partnerships) • Better integrate medical and behavioral health care
Programs	<ul style="list-style-type: none"> • Safe Harbor Behavioral Health of UPMC Hamot’s Addiction Medicine Services (e.g., outpatient services, warm hand off, and certified recovery specialist) • Women’s Recovery Center • Participation in Medication-Assisted Treatment Prescription Drug and Opioid Addiction (MAT-PDOA) grant • Integrated Opioid Management Committee initiatives (e.g., clinical pathways, service development) • Co-location initiative to embed specialists in primary care practices • Community support opportunities (e.g., substance use disorder loss support group, Vigil of Hope) 	<p>Provider and Community Training and Support</p> <ul style="list-style-type: none"> • Educational Clinics to support staff knowledge of behavioral health services, referral pathways, and effective engagement strategies • Community awareness and training events, (e.g., suicide prevention conference; training in school districts, Trail of Treats, HER Expo, Veteran’s Expo, and the Out of the Darkness Walk) • Community support services (e.g., Survivors of Suicide loss support group) <p>Access to behavioral health services</p> <ul style="list-style-type: none"> • Expand telemedicine offerings for behavioral health • School partnerships (e.g., participation in Community Schools initiative) <p>Better integrate medical and behavioral health care</p> <ul style="list-style-type: none"> • Embed counselors in primary and specialty care offices
Target Population	Mothers and infants, general community, medically underserved, low-income populations	Mothers and infants, general community, medically underserved, low-income populations
Anticipated Impact Three-Year Goal	Improve awareness of and access to services to support people with substance use disorders	Increase awareness of and access to behavioral health resources
Planned Collaborations	UPMC Magee-Womens Hospital, UPMC Health Plan, Safe Harbor Behavioral Health of UPMC Hamot, Hamot Health Foundation, Magee-Womens OB/GYN Specialty Group and key funders, United Way of Erie County, KeyBank, Erie Women’s Fund at the Erie Community Foundation, the Beckwith Institute, Community Care Behavioral Health, Center for High Value Healthcare, Erie County Department of Drug and Alcohol Abuse, Great Lakes Home Health, Department of Health Pay for Performance initiative, Erie County Department of Human Services, Regional Health Services, Erie School District, East Middle School, Family Services	

Addressing Access to Care and Navigating Resources

UPMC Hamot will continue to address access and navigating resources in the community through a variety of channels, from supporting patients with palliative and end-of-life care, to providing access to primary care, with a focus on raising awareness of care options through grassroots community outreach initiatives.

ACCESS TO CARE AND NAVIGATING RESOURCES		
	Palliative and End-of-Life Care	Primary Care
Intended Actions	Take a comprehensive approach to offer palliative and end-of-life services to the community <ul style="list-style-type: none"> Continue to participate in programs that educate the community about end-of-life care and concerns Explore approaches to educate special needs populations and their caregivers Continue to support palliative care program, including engaging patients in Goals of Care conversations and palliative care consults 	Improve and promote access to primary care services <ul style="list-style-type: none"> Continue to recruit physicians Promote primary care access through grassroots efforts
Programs	<ul style="list-style-type: none"> Improve awareness and use of advance directives and living wills in the community Improve utilization of end-of-life care services, including goals of care conversations, palliative care consults and services, and hospice admissions 	<ul style="list-style-type: none"> Continue to focus on physician recruitment Continue to build relationship with Primary Health Network (e.g., Wayne Primary Care) Assess ways to implement grassroots community outreach initiatives (e.g., navigators) Explore launch of call-in line for cardiac care
Target Population	General community	General community, medically underserved, low-income populations
Anticipated Impact Three-Year Goal	Increase utilization of palliative and end-of-life care services	Increase patient engagement with primary care
Planned Collaborations	Erie Home for Children and Adults, Barber National Institute, Erie County Care Management, Great Lakes Home Health and Hospice, UPMC Palliative and Supportive Institute, Primary Health Network (PHN)	

Addressing Prevention and Community-Wide Healthy Living

UPMC Hamot will address preventive health and wellness through an extensive suite of programs, including community education, screenings, and customized programming for maternal and infant health. Additionally, UPMC Hamot is dedicating considerable resources and efforts to address health-related social needs, such as combating unemployment, exploring avenues for community revitalization, and creating targeted programs to support interpersonal safety initiatives.

PREVENTION AND COMMUNITY-WIDE HEALTHY LIVING			
	Community Prevention and Wellness Initiatives	Interpersonal Safety	Health-Related Social Needs
Intended Actions	<p>The hospital is taking a comprehensive, community- oriented approach to improve the health and wellness of residents in the community. Efforts include targeted initiatives to support general community outreach and maternal and infant health.</p> <ul style="list-style-type: none"> • Continue to educate residents about the importance of preventive screenings • Continue to collaborate with UPMC Hamot Outpatient Coordination Center in contacting and scheduling follow-up appointments for patients after discharge from hospital • Continue to provide health education and screenings at community events • Provide services to improve maternal and infant health • Create dedicated programming and materials for at-risk populations • Increase prevention and wellness initiatives offered through the UPMC Hillman Cancer Center (e.g., education, screenings, pain management) 	<p>Support and expand programs to prevent accidental injuries</p>	<p>Explore and conceptualize innovative programs to address non-medical health needs</p> <ul style="list-style-type: none"> • Continue to offer programs to assist in community employment • Support community groups to improve neighborhoods

PREVENTION AND COMMUNITY-WIDE HEALTHY LIVING			
Programs	<p>Community Education and Events:</p> <ul style="list-style-type: none"> Participate in various community health fairs (e.g., PA Rep. Ryan Bizzarro Senior Health Fair, State Rep. Parke Wentling Senior Fair, Gannon University Health Fair, Women’s Health Fair by UPMC Health Plan, Veterans Resource and Job Expo- Sen. Dan Laughlin, HER Expo, WearRed, Erie Zoo Senior Day, Eastside YMCA Health Fair) Participate in various community wellness programs (e.g., Blue Zones Project, YMCA Healthy Kids Day) Participate in various community educational programs (e.g., Erie County Medical Society, Hamot Transplant Town Hall, Donate Life Flag Raising Ceremony, Erie Zoo Senior Day, Obesity education and prevention, educating refugee populations on maternal and infant health) Participate in various community screening programs (e.g., Mammo Marathon) <p>Screening Assessments:</p> <ul style="list-style-type: none"> Colon Cancer, Mammography, Diabetes Maternal and Infant Health NICU Follow-Up Clinic Prenatal and Postpartum support programs (e.g., lactation services, Baby and Me Smoke Free) Refugee and Immigrant Outreach (e.g, translated materials) Parenting and caregiver efforts (e.g., Parenting Education, Prenatal and grandparent classes, Healthy Pregnancy and Parenting courses) Safe sleep education efforts (e.g., Safe Sleep Initiative, Gold Safe Sleep Champion Certification) 	The Flipside Program	<ul style="list-style-type: none"> Project SEARCH Eagle’s Nest Affordable housing investments Our West Bayfront BEST Success by 6 Unwanted Med Collection Event
Target Population	General community, mothers and infants, medically underserved, low-income, and minority populations	Medically underserved, low-income, and minority populations	Medically underserved, low-income, and minority populations
Anticipated Impact Three-Year Goal	Increase awareness of disease prevention and management and promote healthy behaviors	Increase awareness of and utilization of injury prevention programming	Enhance community health by addressing health-related social needs, such as creating employment opportunities and contributing to community investment
Planned Collaborations	UPMC Hamot Primary Care Network, Gannon University, Voices for Independence, YMCA, Erie365, African American Concerned Clergy, Word of Faith Development Corp., Catholic Charities, Multicultural Community Resource Center, Multicultural Health Evaluation Delivery System, Maternal and Child Health Task Force, New Directions Methadone Clinic, Esper Treatment Center, Cribs for Kids, BEST, Our West Bayfront, Erie Insurance		

Community Health Improvement Progress and Plans

*2016 – 2019 Progress Reports and
2019 – 2022 Implementation Plans*



UPMC | KANE

Caring for the Community

UPMC Kane is a nonprofit, acute-care hospital located in McKean County, Pennsylvania. As one of two hospitals in McKean County, UPMC Kane provides quality medical services to area residents, who may otherwise have to travel long distances for care. UPMC Kane provides access to medical, surgical, rehabilitation, and transitional care, as well as specialized services, which include virtual care, diagnostic imaging, gastroenterology, cardiopulmonary services, cardiac rehabilitation, and cancer care.

UPMC Kane is supported by an active medical staff representing many disciplines. The hospital is part of UPMC, one of the country's leading Integrated Delivery and Financing Systems (IDFS), which positions the hospital to draw on the expertise of the larger organization when patients require access to more complex or highly specialized care. The medical staff is augmented by specialists who travel to McKean County from UPMC Hamot in Erie to hold regular office hours and provide inpatient consultations.

	VITAL STATISTICS Fiscal Year 2018		JOBS AND STRENGTHENING THE LOCAL ECONOMY	
	Licensed Beds	31	Employees	161
Hospital Patients	802	Community Benefits Contributions	\$2 million	
Emergency Dept. Visits	6,508	Free and Reduced Cost Care	\$2 million	
Total Surgeries	1,228	Total Economic Impact of Hospital Operations	\$38 million	

Addressing the Community's Significant Health Needs

When the Fiscal Year 2016 CHNA was conducted, UPMC Kane affirmed the following significant health needs:

- Cancer
- Heart Disease
- Access to Providers: Primary Care and Specialists



GOALS

Increase awareness of prevention, detection, and management of chronic disease

STRATEGY

The hospital is leading efforts to address chronic disease in the community

ACTIONS:

- ✓ Promote breast cancer education and awareness, and provide mammogram screenings.
- ✓ Provide quality breast cancer care through the Breast Center of Excellence.
- ✓ Implement the Silver and Fit Program.
- ✓ Expand Ladies Night Out event to include information about heart disease prevention.
- ✓ Promote screenings, including lung and cardiac disease screening.
- ✓ Continue to provide smoking cessation program.
- ✓ Work with schools to provide nutrition information.



PROGRAMS:

Cancer

Education and Resources Focused on Breast Cancer

- Breast Center of Excellence
- Ladies Night Out
- Mammogram and ultrasound testing
- Monthly mammogram reminders

Heart Disease

Screenings, Education, and Support

- Silver and Fit
- Wellness screenings
- Smoking cessation
- Nutrition counseling

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (EST. ANNUAL TOTALS)



2,191
Wellness Screenings



1,086
Mammogram Screenings

PROGRAM HIGHLIGHTS:*Promoting Cancer Prevention, Detection, and Education*

- **Promoted breast cancer education and mammogram awareness:** UPMC Kane hosts an annual Ladies Night Out event for community members. In September 2017, approximately 140 women attended the event. Ladies Night Out aims to educate attendees about women's health issues, such as osteoporosis, hormone replacement therapy, and signs and symptoms of cervical and uterine cancer. The event also offers women an opportunity to sign up for mammograms and participate in health screenings. In 2017, the hospital expanded the event to include heart disease information, blood pressure checks, and varicose vein screenings.
- **Provided mammogram testing and ultrasounds at reduced cost:** The hospital partners with Family Health Council of Central Pennsylvania to help provide health care for underserved populations.
- **Reminded patients about the importance of early cancer detection:** From July 2017 to June 2018, UPMC Kane sent out 1,051 reminders to patients about screening for breast cancer. The hospital maintains a stable return rate within three months of patients receiving a reminder — 61 percent.
- **Expanded detection capabilities:** UPMC Kane added a new low-dose CT scanner, which has allowed the hospital to perform 391 CT chest scans in 2017-2018. This not only helps patients detect cancer earlier, but also helps them access tests locally.
- **Maintained Breast Center of Excellence Certification** from the American College of Radiology.

*Raising Awareness and Improving Cardiac Health*

- **Promoted healthy eating:** 139 seniors learned about healthy eating for cardiac wellness through dietician-led programs at senior centers, and 70 school-aged children received nutrition counseling in 2017.
- **Increased participation in fitness activities:** UPMC Kane launched the Silver and Fit Program, an exercise program tailored to seniors to help improve cardiac wellness. In just three years, the program has grown significantly — participation has increased by 229 percent.
- **Encouraged preventive care:** In 2017, UPMC Kane provided 2,191 wellness screenings, including cholesterol checks — results shared with Primary Care Physicians (PCPs) because routine screenings are key to preventing and detecting disease early.
- **Provided support to help quit smoking:** UPMC Kane provided smoking cessation programs, with 108 inpatients participating in Fiscal Year 2018, and explored approaches to expand to outpatient and community settings.

COMMUNITY PARTNERS:

Local hospital-based primary care practices, Family Health Council of Central Pennsylvania, Johnsonburg and Kane School Districts, and other community organizations

GOALS

Increase community access to primary and specialty care

STRATEGY

The hospital is leveraging UPMC's extensive provider network

ACTIONS:

- ✓ Opening of Express Care.
- ✓ Continue to offer specialty services, including GI Clinic, Cardiac Clinic, telemedicine for cardiac visits, pain management, eye surgery, surgery, urology, and oncology.



PROGRAMS:

Primary Care

- Express Care

Specialty Care

- GI Clinic
- Cardiac Clinic
- Pain Management
- Eye Surgery
- Surgery
- Urology
- Oncology

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (EST. ANNUAL TOTALS)



1,678
Patients Seen at
New Express Care



7
Specialty Services



9,876
Specialty Visits

PROGRAM HIGHLIGHTS:

Offering New Express Care Facility

In 2016, UPMC Kane opened a new Express Care facility to meet the need for greater access to care. Key accomplishments over the last three years include:

- **Patient visits nearly doubled:** With 924 patient visits in 2016 and 1,678 patient visits in 2017, Express Care has experienced an increase of 46 percent in patient visits in a single year, demonstrating a high demand for this service.
- **Expanded services:** The facility extended hours and developed a walk-in visit program so that patients can see a practitioner without making an appointment.

Making Access to Specialty Appointments Easier

- **Helped patients coordinate care:** 100 percent of appointments are scheduled within 30 days for 4 specialties, including GI Clinic, Cardiac Clinic, Eye Surgery, and Urology Services.

COMMUNITY PARTNERS:

UPMC System, UPMC Hamot Physicians, UPMC Northwest

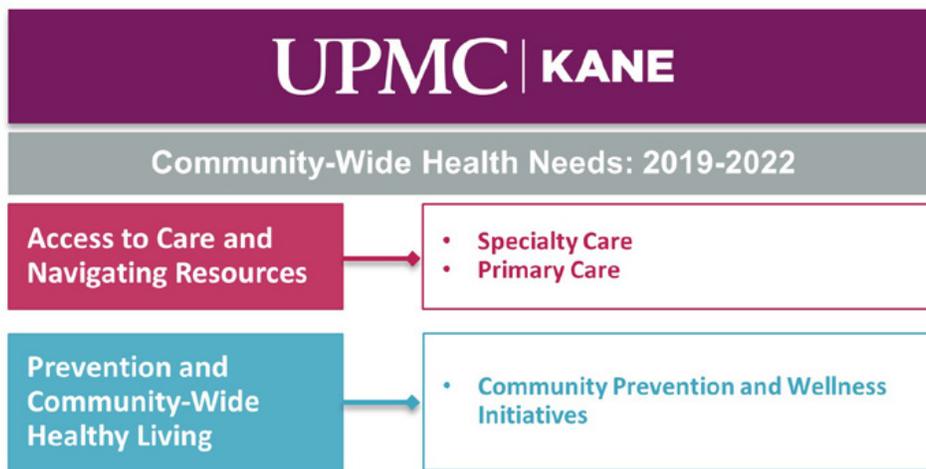
UPMC KANE IS ADDRESSING HIGH PRIORITY HEALTH ISSUES:*Adoption of the Implementation Plan*

On January 29, 2019, the UPMC Kane Board of Directors adopted an implementation plan to address the significant health needs identified:

- **Access to Care and Navigating Resources**
- **Prevention and Community-Wide Healthy Living**

UPMC Kane Is Leveraging UPMC and Community Resources

By providing a comprehensive suite of programs, UPMC Kane plays an important role in addressing the community health needs that were identified in the recent Community Health Needs Assessment. The hospital will support the priority areas with internal resources, through grants, and by strengthening collaborations with numerous community partners.



Addressing Access to Care and Navigating Resources

UPMC Kane will continue to address access to care and navigating resources in the community by providing access to UPMC's world-renowned specialty care in the local community, as well as supporting new channels for residents to receive primary care services.

ACCESS TO CARE AND NAVIGATING RESOURCES

	Specialty Care	Primary Care
Intended Actions	Improve access to specialists in local communities <ul style="list-style-type: none"> Expand specialty services in the community 	Improve access to primary care in local communities <ul style="list-style-type: none"> Express Care Initiative
Programs	Continue to offer specialty services, including GI Clinic, pain management, cardiac clinic, telemedicine for cardiac visits, eye surgery, surgery, urology, gynecology	Express Care facility
Target Population	General community	General community
Anticipated Impact Three-Year Goal	Expand access to primary care and specialty services	
Planned Collaborations	UPMC System, UPMC Hamot Physicians, UPMC Northwest	

Addressing Prevention and Community-Wide Healthy Living

UPMC Kane is addressing prevention and community-wide healthy living through a spectrum of initiatives, with a dedicated focus on supporting seniors and helping residents dealing with cancer and heart disease. Efforts include: community education, preventive screenings, and other community outreach initiatives.

PREVENTION AND COMMUNITY-WIDE HEALTHY LIVING**Community Prevention and Wellness Initiatives**

Intended Actions	<p>Enhance and expand multi-pronged effort to improve the health and wellness of the community</p> <ul style="list-style-type: none"> ▪ Promote and provide community education, screenings, and community outreach events to increase awareness, prevention, and management of cancer and heart disease ▪ Work with schools to provide nutrition information ▪ Explore and conceptualize new rural health transformation model
Programs	<p>Cancer Education, Prevention, and Management:</p> <ul style="list-style-type: none"> ▪ Breast Center of Excellence ▪ Ladies Night Out ▪ Mammogram and ultrasound testing ▪ Monthly mammogram reminders ▪ Smoking cessation program <p>Heart Disease Education, Prevention, and Management:</p> <ul style="list-style-type: none"> ▪ Silver and Fit ▪ Wellness screenings ▪ Nutrition counseling <p>Rural Health Transformation Model:</p> <ul style="list-style-type: none"> ▪ Develop and assess feasibility to implement rural health transformation model
Target Population	General population, seniors
Anticipated Impact Three-Year Goal	Increase awareness of disease prevention and management and encourage healthy behaviors in the community
Planned Collaborations	Local hospital-based primary care practices, Family Health Council of Central Pennsylvania, Johnsonburg and Kane School Districts

Community Health Improvement Progress and Plans

*2016 – 2019 Progress Reports and
2019 – 2022 Implementation Plans*



UPMC | NORTHWEST

Caring for the Community

UPMC Northwest is a nonprofit, acute-care hospital located in Venango County, Pennsylvania. Operating from a campus in Seneca, Pennsylvania, this state-of-the-art facility is the only hospital in Venango County. The hospital offers a full range of quality medical services, providing area residents with access to medical, surgical, behavioral health, rehabilitation, and transitional care, as well as cutting-edge medical services not typically found at a local community hospital. Specialized services include telemedicine, behavioral health, CT imaging, MRI, stroke and diabetes care, and a UPMC Hillman Cancer Center.

UPMC Northwest is supported by an active medical staff representing many disciplines. The medical staff is augmented by specialists who travel to Venango County to hold regular office hours and provide inpatient consultations.

	VITAL STATISTICS Fiscal Year 2018		JOBS AND STRENGTHENING THE LOCAL ECONOMY	
	Licensed Beds	174	Employees	659
	Hospital Patients	7,962	Community Benefits Contributions	\$10 million
	Emergency Dept. Visits	29,828	Free and Reduced Cost Care	\$6 million
	Total Surgeries	4,499	Total Economic Impact of Hospital Operations	\$175 million

Addressing the Community's Significant Health Needs

When the Fiscal Year 2016 CHNA was conducted, UPMC Northwest affirmed the following significant health needs:

- Maternal and Infant Health
- Diabetes
- Respiratory Diseases

MATERNAL AND FETAL HEALTH

DIABETES

RESPIRATORY DISEASES

GOALS

Encourage healthy behaviors through community education and support programs focused on prenatal and postpartum care

STRATEGY

The hospital is enhancing efforts to educate and support pregnant women and new mothers

ACTIONS:

- ✓ Provide prenatal education classes.
- ✓ Work together with community organizations to help address drug dependency.
- ✓ Promote breastfeeding through educational programs and with continued efforts from certified breastfeeding counselors on staff.



PROGRAMS:

- Prenatal Health Initiatives
- Efforts related to Neonatal Abstinence Syndrome
- Neonatal Abstinence Syndrome (NAS) Education
- Safe Sleep Education
- Breastfeeding Initiative/Keystone 10

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (EST. ANNUAL TOTALS)



4
Partnerships
with Local
Schools



420
People Educated
about Neonatal
Abstinence
Syndrome (NAS)



63 Babies
Observed for
Signs of NAS

PROGRAM HIGHLIGHTS:

Helping Pregnant Women and New Mothers Get Care and Support

- **Prenatal Education Classes:** The hospital offers a variety of classes to educate pregnant women about healthy behaviors during and after pregnancy.
- **Keystone 10 Initiative:** The hospital supports exclusive breastfeeding, and has added a Breastfeeding Support class. Hospital protocols also encourage uninterrupted skin-to-skin contact immediately after birth, with 80 percent of new mothers engaging in skin-to-skin contact after the birth of a baby.



Treating Infants for Withdrawal Symptoms

Since 2008, the number of babies born in the UPMC Northwest service area with Neonatal Abstinence Syndrome (NAS) has continued to grow. To address this problem, the hospital is:

- Educating community members, including foster parents and high school students, about NAS and the implications of drug use during pregnancy.
- Observing babies for signs of NAS and treating those identified with NAS for withdrawal. In 2017, 625 babies were delivered at UPMC Northwest — 63 were observed for NAS and 16 were treated for withdrawal.

Recognized as a National Certified Silver Safe Sleep Leader

The UPMC Northwest Family Birthing Center is helping every baby sleep more safely. The hospital is continuing to promote safe sleep education at community events — teaching parents about safe sleep practices, such as replacing receiving blankets with wearable blankets to eliminate loose bedding in cribs.

COMMUNITY PARTNERS:

Venango County Overdose Task Force, Venango County Human Services, Venango County Children and Youth Services, local schools, Hospital Association of Pennsylvania

GOALS

Increase community members' participation in prevention, detection, and management of diabetes

STRATEGY

The hospital is leveraging the power of telemedicine and UPMC's extensive provider network

ACTIONS:

- ✓ Offer diabetes prevention and management education programs.
- ✓ Provide endocrinology consults through UPMC Northwest's Teleconsult Center.
- ✓ Present information about diabetes risk factors and prevention at health fairs and education through community events.



PROGRAMS:

- Diabetes Prevention Program
- The Diabetes Center at UPMC Northwest
- Diabetes Self-Management Education
- Endocrinology Telemedicine Program
- Community outreach

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (EST. ANNUAL TOTALS)

 **26**
Diabetes
Education Events

 **744**
Participants

 **49**
Endocrinology
Telemedicine
Appointments

PROGRAM HIGHLIGHTS:*Helping Patients with Diabetes
Adopt Healthier Habits*

- The hospital improved the availability of one-on-one consultations with a diabetes educator by adding appointments at UPMC Venango Internal Medicine Associates in Oil City.
- In 2017, the hospital connected 102 patients with a diabetes educator for one-on-one consultations to help manage their condition and set goals.
- In 2017, the hospital offered three group classes, which helped 12 patients with diabetes to learn about their disease and how best to manage their condition, while in a safe and supportive group setting.

*Using Telemedicine to Support Diabetes Care*

In Venango County, subspecialty care is limited. To address this problem, UPMC Northwest is using state-of-the-art technology to connect patients with diabetes with UPMC endocrinologists outside the area.

- In 2017, diabetes patients consulted with endocrinologists through 49 telemedicine appointments, which helps keep care local and saves patients travel time.

COMMUNITY PARTNERS:

Telemedicine specialists, home health agencies, and primary care offices

GOALS

Increase awareness of respiratory disease prevention, screening, and management

STRATEGY

The hospital is leveraging available resources to address respiratory diseases in Venango County

ACTIONS:

- ✓ Provide education about lung screenings throughout the community through participation at health fairs, community events, community organizations' meetings, and at UPMC Northwest.
- ✓ Provide smoking cessation education.



PROGRAMS:

- Lung Screening Program
- Community education

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (EST. ANNUAL TOTALS)



16 Respiratory Disease Education events



370 Lung Cancer Screenings

PROGRAM HIGHLIGHTS:*Encouraging Early Detection of Lung Cancer*

- Using mailings to reach patients directly to remind them about lung screenings.
- Lung navigators from UPMC Northwest worked with lung navigators from across UPMC's system to help design and launch a lung cancer screening tool. The hospital uses this tool to track patient screenings and to access a snapshot of patients' exams and results, as well as additional notes pertinent to their cases.

Screening More Patients with Expanded Services

- Increased the number of certified radiology technicians for CT scans who are available to assist with lung cancer screenings
- Expanded scanning capabilities with the addition of a second CT scanner and a new MRI/CT suite.
- Added local appointment availability for a UPMC Hamot cardiothoracic surgeon once a month, which resulted in 45 patient screenings in 2017.

Supporting Patient Efforts to Quit Smoking

In 2017, the hospital supported 24 community members in their efforts to quit smoking through smoking cessation classes.

**COMMUNITY PARTNERS:**

UPMC Hamot, Lung Cancer Alliance, UPMC Health Plan, American College of Radiology, Venango-Forest Cancer Coalition

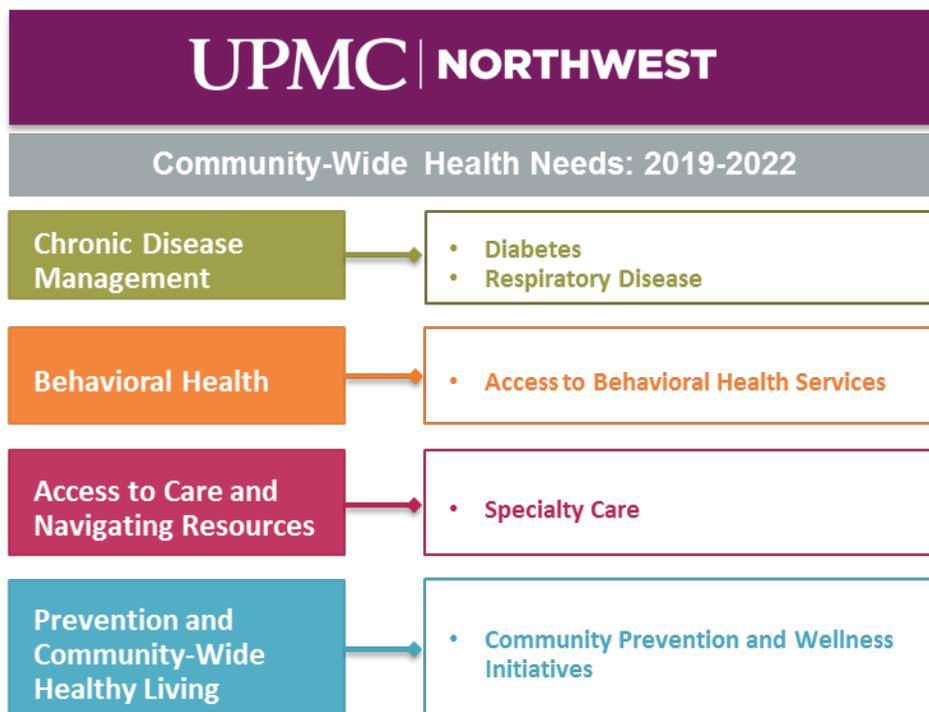
UPMC NORTHWEST IS ADDRESSING HIGH PRIORITY HEALTH ISSUES:*Adoption of the Implementation Plan*

On January 29, 2019, the UPMC Northwest Board of Directors adopted an implementation plan to address the significant health needs identified:

- **Chronic Disease Management**
- **Behavioral Health**
- **Access to Care and Navigating Resources**
- **Prevention and Community-Wide Healthy Living**

UPMC Northwest Is Leveraging UPMC and Community Resources

By providing a comprehensive suite of programs, UPMC Northwest plays an important role in addressing the community health needs that were identified in the recent Community Health Needs Assessment. The hospital will support the priority areas with internal resources, through grants, and by strengthening collaborations with numerous community partners.



Addressing Chronic Disease Management

UPMC Northwest serves as an important resource to the community in promoting diabetes and respiratory disease prevention and management. UPMC Northwest will continue to address these chronic conditions through a wide variety of initiatives, including community education, screenings, and customized programming.

CHRONIC DISEASE MANAGEMENT

	Diabetes	Respiratory Disease
Intended Actions	Improve diabetes awareness, prevention, and management <ul style="list-style-type: none"> • Offer diabetes prevention and management education programs • Provide endocrinology consults through UPMC Northwest Teleconsult Center • Provide education about diabetes risk factors and prevention at health fairs and community events 	Increase respiratory disease awareness, prevention, and management <ul style="list-style-type: none"> • Offer community education, screenings, and programming to help prevent and manage respiratory disease
Programs	<ul style="list-style-type: none"> • Diabetes Prevention Program • The Diabetes Center at UPMC Northwest • Diabetes Self-Management Education • Endocrinology Telemedicine Program • Community outreach 	<ul style="list-style-type: none"> • Lung Screening Program • Smoking Cessation Program • Community education (e.g., school presentations, workplace health fairs) • Expansion of Better Breathing Clinic
Target Population	General community	
Anticipated Impact Three-Year Goal	Improve disease prevention awareness and management	
Planned Collaborations	Telemedicine specialists, home health agencies, primary care offices, UPMC Hamot, Lung Cancer Alliance, UPMC Health Plan, American College of Radiology, Venango-Forest Cancer Coalition	

Addressing Behavioral Health

UPMC Northwest will continue to address the growing need for behavioral health services by leveraging existing offerings (e.g., inpatient units) and working collaboratively with UPMC Western Psychiatric Hospital to explore efforts to expand outpatient behavioral health services.

BEHAVIORAL HEALTH

	Access to Behavioral Health Services
Intended Actions	Take a comprehensive approach to addressing behavioral health <ul style="list-style-type: none"> • Continue to maintain and build behavioral health offerings in the community • Continue to screen for Neonatal Abstinence Syndrome
Programs	<ul style="list-style-type: none"> • Neonatal Abstinence Syndrome (NAS) prevention efforts • Inpatient behavioral health unit • Work to recruit behavioral health specialists
Target Population	Mothers and infants, general community
Anticipated Impact Three-Year Goal	Increase awareness of and access to behavioral health resources
Planned Collaborations	Venango County Overdose Task Force, local schools, Titusville Women's Services, local women's shelters

Addressing Access to Care and Navigating Resources

UPMC Northwest will continue to address access to care and navigating resources in the community by providing access to UPMC's world-renowned specialists through extensive telehealth offerings for residents to receive the best quality care in their locality.

ACCESS TO CARE AND NAVIGATING RESOURCES

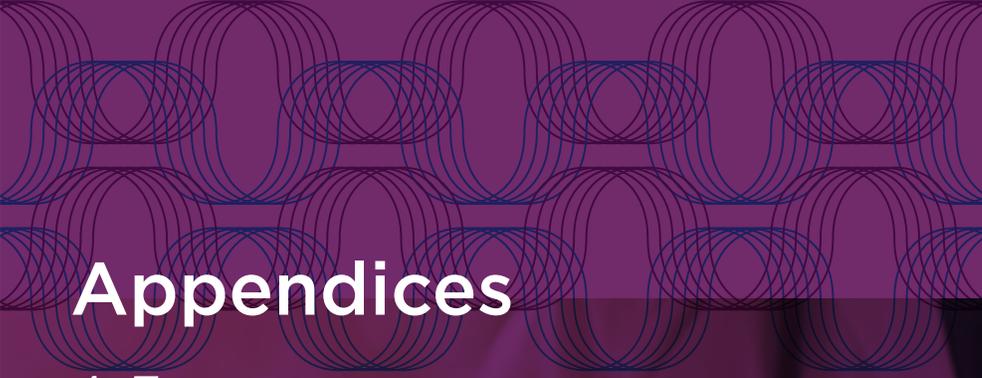
	Specialty Care
Intended Actions	Improve access to specialists in local communities <ul style="list-style-type: none"> ▪ Continue to offer access to specialists through the UPMC Northwest Teleconsult Center ▪ Increase the number of services provided through telehealth
Programs	UPMC Northwest Teleconsult Center
Target Population	General community
Anticipated Impact Three-Year Goal	Increase access to specialty services for residents
Planned Collaborations	Telemedicine specialists, UPMC Enterprises, Curavi Medical and Psychiatric Telemedicine Services

Addressing Prevention and Community-Wide Healthy Living

UPMC Northwest is helping to promote prevention and healthy living by targeting mothers and infants through its Family Birthing Center and Obstetrics and Gynecology services, as well as through support classes that help educate families about breastfeeding, siblings, and infant care practices, such as safe sleep.

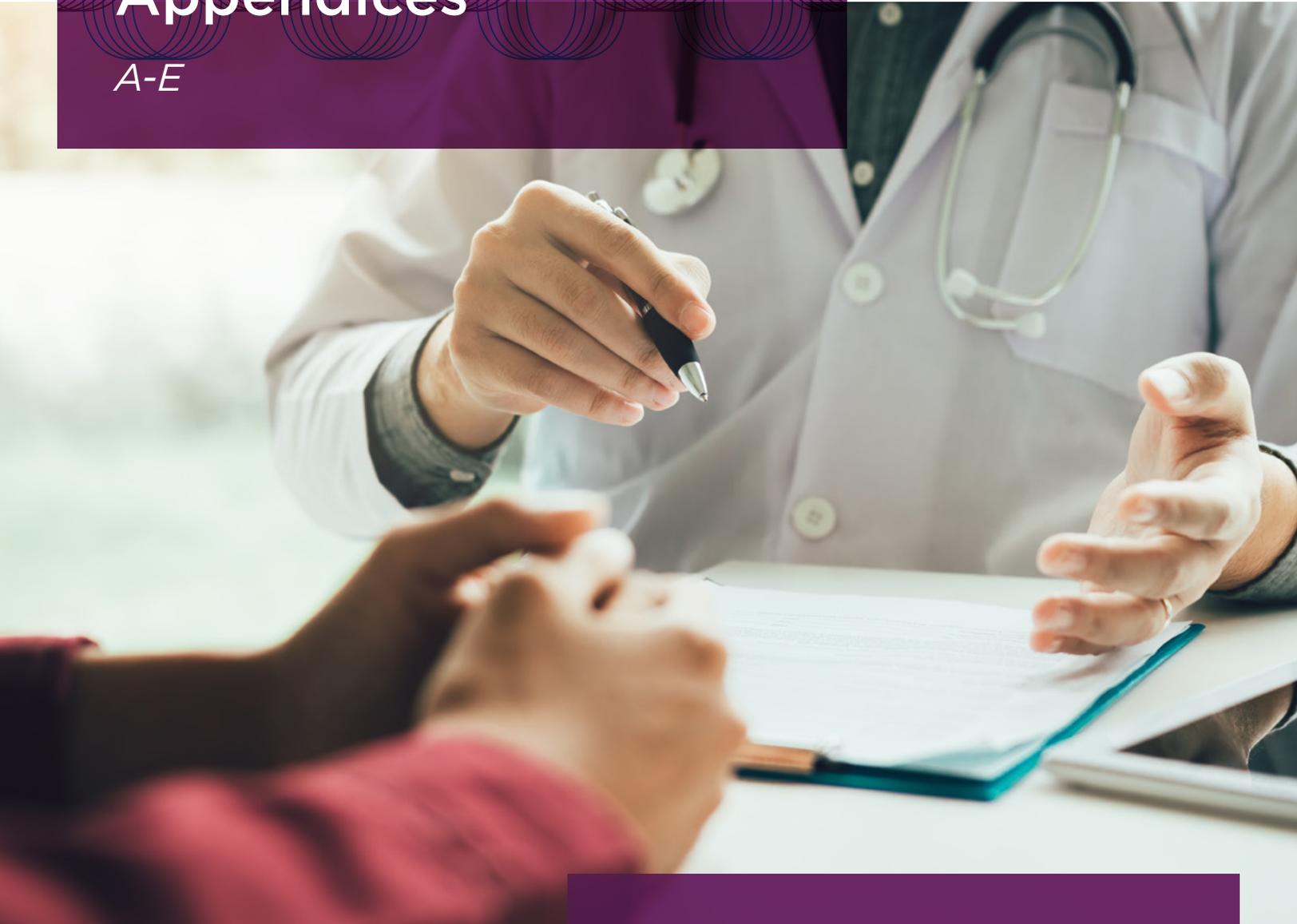
PREVENTION AND COMMUNITY-WIDE HEALTHY LIVING

	Community Prevention and Wellness Initiatives
Intended Actions	The hospital is taking a comprehensive, community-oriented approach to improve the health and wellness of residents in the community. Efforts include targeted initiatives to support maternal and infant health: <ul style="list-style-type: none"> ▪ Provide prenatal education classes ▪ Promote breastfeeding through educational programs and with continued efforts from certified breastfeeding counselors on staff ▪ Promote safe sleep practices
Programs	<ul style="list-style-type: none"> ▪ Prenatal Health Initiatives ▪ Breastfeeding Initiative/Keystone 10 ▪ Safe Sleep Education
Target Population	Mothers and infants
Anticipated Impact Three-Year Goal	Improve general health and wellbeing for mothers and infants in the community
Planned Collaborations	Venango County Human Services, Venango County Children and Youth Services, local schools, Hospital Association of Pennsylvania, Community Services of Venango County



Appendices

A-E



APPENDIX A: Secondary Data Sources and Analysis

Overview:

To identify the health needs of a community, UPMC conducted an analysis of publicly available data. Secondary data — including population demographics, mortality, morbidity, health behavior, and clinical care data — were used to identify and prioritize significant community health needs. Data which informed this CHNA were compiled from a variety of state and national data sources and are reflected in the table below.

Population characteristics, socioeconomic, and health status data were also examined. Community-level data (county-level) were compared to the state, nation, and *Healthy People 2020* benchmarks to help identify key health issues. When available, data specific to low-income individuals, underserved minorities, and uninsured populations were examined. In addition, analysis considered federal designations of Health Professional Shortage Areas (HPSAs) — defined as “designated as having a shortage of primary medical care providers” and Medically Underserved Areas (MUAs) — which may consist of a whole county or a group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts.

Publicly Available Data and Sources Used for Community Health Needs Assessment

Data Category	Data Items	Description	Source
Demographic Data	Population Change	Comparison of total population and age-specific populations in 2000 and 2010 by county, state, and nation.	U.S. Census
	Age and Gender	Median age, gender, and the percent of Elderly Living Alone by county, state, and nation in 2010.	
	Population Density	2010 total population divided by area in square miles by county, state, and nation.	
	Median Income/Home Values	By county, state, and nation in 2010.	
	Race/Ethnicity	Percent for each item by county, state, and nation in 2010.	
	Insurance: Uninsured, Medicare, Medicaid		
	Female Headed Households		
	Individuals with a Disability		
	Poverty		
	Unemployed		
No High School Diploma			

Data Category	Data Items	Description	Source
Morbidity Data	Adult Diabetes	2013-2017 data collected and compared by county, state, and nation.	Erie County Health Survey, 2016-2017.
	Mental Health		
	Birth Outcomes		
Health Behaviors Data	Obesity (Childhood and Adult)		PA Department of Health Behavioral Risk Factors Surveillance System; Birth, Death, and Other Vital Statistics.
	Alcohol Use		
	Tobacco Use		NY State Department of Health Behavioral Risk Factors Surveillance System; Other Vital Statistics.
	Sexually Transmitted Disease		
Clinical Care Data	Immunization	2013-2018 data collected and compared by county, state, and nation.	Erie County Health Survey, 2016-2017.
	Cancer Screening (Breast/Colorectal)		
	Primary Care Physician Data		
Clinical Care Data			PA Department of Health Behavioral Risk Factors Surveillance System.
			NY State Department of Health Behavioral Risk Factors Surveillance System.
			U.S. Centers for Disease Control and Prevention Behavioral Risk Factors Surveillance System.
Clinical Care Data			Robert Wood Johnson County Health Rankings & Roadmaps.
Benchmark Data	Mortality Rates, Morbidity Rates, Health Behaviors, and Clinical Care Data	National benchmark goal measures on various topics for the purpose of comparison with current measures for county, state, and nation.	Healthy People 2020.

In addition, local and state public health department input and data were obtained and utilized in this community health needs assessment. UPMC relied on publicly available Pennsylvania Department of Health reports, New York State Department of Health reports, and additional local health department information accessed both online and via email communication.

Information Gaps Impacting Ability to Assess Needs Described:

The best available data were used to obtain the most meaningful comparison and analysis possible. Public data sources, however, are limited by some information gaps, and small sample sizes can represent statistically unreliable estimates.

The community definition hinged at the county level, in part, because the quality and availability of data at this level was generally most comprehensive and allowed for meaningful comparisons with state and national data. Whenever possible, population health data were examined for sub-populations, including low-income, minority, and uninsured populations.

APPENDIX B: Detailed Community Health Needs Profile

Population Demographics:

Characteristics	Chautauqua County	Erie County	McKean County	Venango County	New York	Pennsylvania	United States
Area (square miles)	1,060.2	799.2	979.2	674.3	47,126.4	44,742.7	3,531,905.4
Density (persons per square mile)	127.2	351.1	44.4	81.5	411.2	283.9	87.4
Total Population, 2010	134,905	280,566	43,450	54,984	19,378,102	12,702,379	308,745,538
Total Population, 2000	139,698	280,843	45,936	57,565	18,977,026	12,281,054	281,424,600
Population Change ('00-'10)	-4,793	-277	-2,486	-2,581	401,076	421,325	27,320,938
Population % Change ('00-'10)	-3.4	-0.1	-5.4	-4.5	2.1	3.4	9.7
Age							
Median Age	40.9	38.6	41.5	44.3	38.0	40.1	37.2
% <18	21.8	22.7	21.1	21.5	22.3	22.0	24.0
% 18-44	33.3	35.5	33.7	29.3	37.5	34.3	36.5
% 45-64	28.3	27.4	28.2	31.2	26.7	28.1	26.4
% >65+	16.6	14.6	17.0	18.0	13.5	15.4	13.0
% >85+	2.6	2.4	2.6	2.3	2.0	2.4	1.8
Gender							
% Male	49.3	49.2	51.0	48.9	48.4	48.7	49.2
% Female	50.7	50.8	49.0	51.1	51.6	51.3	50.8
Race/Ethnicity							
% White*	92.6	88.2	95.9	97.1	65.7	81.9	72.4
% African-American*	2.4	7.2	2.4	1.0	15.9	10.8	12.6
% American Indian and Alaska Native*	0.5	0.2	0.2	0.2	0.6	0.2	0.9
% Asian*	0.5	1.1	0.4	0.4	7.3	2.7	4.8
% Native Hawaiian/Other Pacific Islander*	0.0	0.0	0.0	0.0	0.0	0.0	0.2
% Hispanic or Latino**	6.1	3.4	1.7	0.9	17.6	5.7	16.3
% Disability	14.0	15.6	17.5	17.3	10.6	13.1	11.9

*Reported as single race; **Reported as any race
Source: U.S. Census, 2010

Social and Economic Factors:

Characteristics	Chautauqua County	Erie County	McKean County	Venango County	New York	Pennsylvania	United States
Income, Median Household	\$40,443	\$42,519	\$39,717	\$40,734	\$54,148	\$49,288	\$50,046
Home Value, Median	\$84,300	\$117,500	\$72,100	\$79,000	\$296,500	\$165,500	\$179,900
% No High School Diploma*	12.5	9.8	10.6	12.3	15.1	11.6	14.4
% Unemployed**	10.4	9.4	10.6	8.5	9.9	9.6	10.8
% of People in Poverty	17.1	17.4	15.0	15.8	14.9	13.4	15.3
% Elderly Living Alone	12.6	11.3	12.9	12.0	10.5	11.4	9.4
% Female-headed households with own children <18	7.2	7.9	6.5	6.1	7.5	6.5	7.2
Health Insurance							
% Uninsured	9.8	9.6	10.0	9.0	11.9	10.2	15.5
% Medicaid	17.5	16.9	15.8	17.8	18.2	13.1	14.4
% Medicare	11.4	10.5	10.3	12.2	9.4	11.2	9.3

*Based on those ≥25 years of age; **Based on those ≥16 years and in the labor force
Source: U.S. Census, 2010

Leading Causes of Mortality for the United States Compared to New York, Pennsylvania, and the Following Counties: Chautauqua, Erie, McKean, and Venango:

Causes of Death	Chautauqua County	Erie County	McKean County	Venango County	New York	Pennsylvania	United States
	Percent of Total Deaths						
All Causes	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Diseases of Heart	27.5	21.3	26.7	27.2	28.6	24.0	23.1
Malignant Neoplasms (Cancer)	21.9	21.2	20.6	22.7	22.9	21.4	21.8
Accidents (Unintentional Injuries)	5.0	5.3	4.2	4.7	4.8	6.3	5.9
Chronic Lower Respiratory Diseases	5.9	6.2	7.9	7.1	4.4	4.9	5.6
Cerebrovascular Diseases	4.9	4.9	3.6	3.9	4.1	5.0	5.2
Alzheimer's Disease	2.0	3.0	1.4	2.6	2.2	3.1	4.2
Diabetes Mellitus	1.8	2.7	3.0	3.4	2.6	2.7	2.9
Influenza and Pneumonia	1.4	1.9	2.6	1.0	2.9	1.9	1.9
Nephritis, Nephrotic Syndrome and Nephrosis	1.7	3.0	2.4	1.9	1.5	2.1	1.8
Intentional Self-Harm (Suicide)	1.2	1.6	1.8	1.3	1.1	1.5	1.6

Sources: Pennsylvania Department of Health, 2016; National Center for Health Statistics, 2016

Comparison of Additional Health Indicators for Chautauqua, Erie, McKean, and Venango Counties to New York, Pennsylvania, United States, and Healthy People 2020:

Characteristics	Chautauqua County	Erie County	McKean County	Venango County	New York	Pennsylvania	United States	Healthy People 2020
Morbidity								
Diabetes (%)	7.6	12.4	12.0	12.0	10.5	11.0	10.5	NA
Mental Health (Mental health not good ≥1day in past month) (%)	14.1	42.3	40.0	36.0	11.3	39.0	NA	NA
Low Birthweight (% of live births)	5.2	8.5	6.5	7.6	7.8	8.2	8.2	7.8
Health Behaviors								
Obesity (Adult) (%)	28.3	34.8	35.0	34.0	25.5	30.0	29.9	30.5
Childhood Obesity (Grades K-6) (%)	17.9	17.3	20.2	22.4	16.3	16.7	17.4	15.7
Childhood Obesity (Grades 7-12) (%)	20.7	19.1	24.7	26.0	18.5	19.1	20.6	16.1
Excessive Alcohol Use (%)	11.5	20.7	21.0	18.0	17.5	19.0	16.9	24.2
Current Tobacco Use (%)	24.7	17.9	23.0	22.0	14.2	18.0	17.1	12.0
STDs (Gonorrhea per 100,000)*	103.2	129.5	35.2	120.5	129.5	111.2	297.1	251.9
Clinical Care (%)								
Immunization: Ever had a Pneumonia Vaccination (65+) (%)	75.3	78.1	71.0	71.0	69.3	75.0	73.4	90.0
Cancer Screening								
Mammography (%)	79.3	62.5	NA	NA	73.9	70.5	72.5	81.1
Colorectal Screening (%)	69.8	71.7	NA	NA	68.5	65.3	63.5	70.5
Primary Care Physician: Population (PCP Physicians/100K Population)	57.3	79.5	47.2	60.2	83.2	81.2	75.8	NA
Receive Prenatal Care in First Trimester (%)	69.3	82.5	79.9	69.5	75.4	73.8	77.1	77.9

Sources:

Chautauqua County Data: New York State Department of Health, 2013-2016; Data from Behavioral Risk Factor Surveillance System, 2013-2014; Robert Wood Johnson County Health Rankings & Roadmaps, 2018

Erie County Data: Erie County Health Survey, 2016-2017; Pennsylvania Department of Health 2016; Robert Wood Johnson County Health Rankings & Roadmaps, 2018

McKean and Venango County Data: Pennsylvania Department of Health, 2014-2016; Data from Behavioral Risk Factor Surveillance System, 2014-2016; Robert Wood Johnson County Health Rankings & Roadmaps, 2018

New York Data: New York State Department of Health, 2013-2016; U.S. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2016; Robert Wood Johnson County Health Rankings & Roadmaps, 2018

Pennsylvania Data: Pennsylvania Department of Health, 2016; U.S. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2016; Robert Wood Johnson County Health Rankings & Roadmaps, 2018

U.S. Data: U.S. Centers for Disease Control and Prevention, 2016; Robert Wood Johnson County Health Rankings & Roadmaps, 2018; Healthy People, 2020

**Gonorrhea data: Chautauqua County and New York rates are for men and women of all ages; Erie County and Pennsylvania rates are per 15-35+ year old women; McKean County rate includes women 15-24 and women 35+ (data for women 25-34 years of age was unavailable due to small sample size); Venango County rate is per 15-24 year old women (data for women 25-35+ years of age was unavailable due to small sample size); National and Healthy People 2020 rates are per 15-44 year old women*

APPENDIX C: Input from Persons Representing the Broad Interests of the Community

Community Representation and Rationale for Approach:

UPMC hospitals solicited and took into account input received from individuals representing the broad interests of the community to identify and prioritize significant health needs. Each hospital's community advisory panel consisted of hospital board members, physicians, hospital leadership, and community members. Community members were leaders of organizations that represented different patient constituencies and medically underserved, low-income, and minority populations, and were invited to participate to ensure that a wide range of community interests were engaged in identifying community health needs. Organizations serving the medically underserved were well represented on the panels. In addition to hospital panels, the CHNA also included a system-wide panel consisting of health departments, mental health service providers, philanthropies, and other agencies providing health services not linked to particular hospitals.

Community survey responses were analyzed at the local hospital level, the regional level, and at the system-wide level in collaboration with the University of Pittsburgh's Graduate School of Public Health. Further analyses disaggregated ratings to confirm that they were stable across different stakeholders.

The panels ensured that a wide variety of constituencies had an opportunity to weigh in on hospital community health priorities. Use of advisory panels and a survey explicitly assessing the continuing relevance of prior health priorities offers a number of advantages:

- It explicitly assesses stability/change of community health needs, while allowing participants an opportunity to consider new health priorities
- It uses the same measures to assess importance, impact, and hospital ability to address health priorities, which will allow tracking over time
- It elicits perceptions of a broad and inclusive list of hospital and community leaders, who in turn represent a broad group of constituents
- It allows assessment of consensus across different kinds of stakeholders

UPMC hospitals in the four-county region invited representatives from the following organizations to participate in the community health needs survey conducted in May-June 2018:

UPMC Chautauqua

- ALSTAR EMS, WCA Services Corporation, Jamestown, NY
- Chautauqua County Department of Health and Human Services, Mayville, NY
- Chautauqua County Health Network Inc., Jamestown, NY
- Chautauqua County Mental Hygiene Department, Mayville, NY
- Chautauqua Opportunities, Inc., Dunkirk, New York
- Chautauqua Region Community Foundation, Jamestown, NY
- Cornell Cooperative Extension, Jamestown, NY
- Cummins Engine, Jamestown, NY
- Health Care Action Team, Jamestown, NY
- Heritage Ministries, Gerry, New York
- J. Edwards Insurance Agency, Inc., Panama, NY
- Jamestown Primary Care, Jamestown, NY
- Lutheran Jamestown, Jamestown, NY
- Office of U.S. Congressman Tom Reed, New York's 23rd Congressional District, Jamestown, NY

- The office of Mary Hajdu, Attorney at Law, Lakewood, NY
- The Resource Center, Jamestown, NY
- United Way of Southern Chautauqua County, Jamestown, NY
- Workforce Investment Board, Jamestown, NY

UPMC Hamot

- Adagio Health, Erie, PA
- Bayfront East Side Taskforce, Erie, PA
- Benedictine Sisters of Erie, Erie, PA
- BKD, LLP, Erie, PA
- Center for Hearing and Deaf Services, Inc., Pittsburgh, PA
- CMIT Solutions of Erie, Erie, PA
- Community Health Net, Erie, PA
- EmergyCare, Erie, PA
- Erie Bank, Erie, PA
- Erie County Department of Health, Erie, PA
- Erie Homes for Children and Adults, Inc., Erie, PA
- Erie Insurance, Erie, PA

- Erie School District, Erie, PA
- Fralo Industries, Erie, PA
- Gannon University, Erie, PA
- Greater Erie Community Action Committee, Erie, PA
- Hamot Health Foundation, Erie, PA
- Inter-Church Ministries of Erie County, Erie, PA
- John F. Kennedy Center, Inc., Erie, PA
- Knox McLaughlin Gornall & Sennett, P.C., Erie, PA
- Mayor's Office, City of Erie, Erie, PA
- McCarthy McDonald Schulberg & Joy, Pittsburgh, PA
- Mercyhurst University, Erie, PA
- MLK Center, Erie, PA
- Multicultural Community Resource Center, Erie, PA
- Our West Bayfront, Erie, PA
- Penn State Erie, The Behrend College, Erie, PA
- Persad Center, Erie, PA
- Primary Health Network, Sharon, PA
- Russian Orthodox Church, Erie, PA
- Safe Harbor Behavioral Health, Erie, PA
- Sisters of St. Joseph Neighborhood Network, Erie, PA
- The Erie Community Foundation, Erie, PA
- The Erie Voice, Erie, PA
- The Office of the Erie County Executive, Erie, PA
- U.S. Committee for Refugees and Immigrants, Erie Office, Erie, PA
- United Way of Erie County, Erie, PA
- Urban Erie Community Development Corporation, Erie, PA
- Voices for Independence, Erie, PA
- Welders Supply Company, Jamestown, NY
- Word of Faith Development Corporation, Erie, PA
- Youth Leadership Institute of Erie (YLI), Erie, PA

UPMC Kane

- Borough Manager, Borough of Kane, Kane, PA
- Collins Hardwood - Kane, Kane, PA
- Cummings Funeral Home, Inc., Kane, PA
- Edward S. Kocjancic, Inc., Kane, PA

- Flickerwood Wine, Kane, PA
- Geci and Associates, PC, Kane, PA
- Halcolm Bard, CPA and Consultants, Kane, PA
- Kane Chamber of Commerce, Kane, PA
- Kane Community Hospital Foundation, Kane, PA
- Mayor's Office, Borough of Kane, Kane, PA
- Myers Trucking, Inc., Mt. Jewett, PA
- Northwest Bank, Kane, PA
- St. Callistus Roman Catholic Church, Kane, PA
- State Farm Insurance, Kane, PA
- The Kane Republican, Kane, PA
- The Office of State Representative Martin Causer, Legislative District 67, Kane, PA
- The Sweet Shoppe Creamery, Kane, PA
- University of Pittsburgh at Bradford, Bradford, PA
- W.E. Swanson Agency, Inc., Kane, PA
- Woods Baker & Ross, Kane, PA
- Zook Motors, Kane, PA

UPMC Northwest

- Adagio Health, Seneca, PA
- Barr's Insurance, Franklin, PA
- Clarion University of Pennsylvania, Clarion, PA
- Community Ambulance Service, Inc., Franklin, PA
- Community Services of Venango County, Oil City, PA
- Dale Woodard Gent McFate Law Firm, Franklin, PA
- Daugherty Brothers Real Estate, Oil City, PA
- Family Service and Children's Aid Society of Venango County, Oil City, PA
- Northwest Bank, Cranberry, PA
- Primary Health Network, Sharon, PA
- Riverview Intermediate Unit 6, Clarion, PA
- Sugar Valley Lodge, Franklin, PA
- The County of Venango, County Commissioners' Office, Franklin, PA
- United Way of Venango County, Reno, PA
- Venango County Human Services, Franklin, PA
- Visiting Nurses Association of Venango County, Franklin, PA

Additionally, a UPMC system-wide group comprised of individuals and organizations representing the broad interests of the region's communities — including representatives from medically underserved, low-income, and minority populations — was invited to participate in the survey. Invitees included representatives from the following organizations:

- 100 Black Men of Western Pennsylvania Inc., Pittsburgh, PA
- Acculturation for Justice, Access, and Peace Outreach [AJAPO], Pittsburgh, PA
- ACH Clear Pathways, Pittsburgh, PA
- ACHIEVA, Pittsburgh, PA
- ACTION-Housing, Inc., Pittsburgh, PA
- Advance African Development, Inc., Pittsburgh, PA
- AHEDD, Pittsburgh, PA
- Alderdice Girls' Basketball Team, Pittsburgh, PA
- Allegheny County Department of Human Services, Pittsburgh, PA
- Allegheny County EARN Program, Pittsburgh, PA
- Allegheny County Health Department, Pittsburgh, PA
- Allegheny County/City of Pittsburgh Transition Coordinating Council, Pittsburgh, PA
- Allegheny Intermediate Unit, Homestead, PA
- Allen Place Community Services, Inc., Pittsburgh, PA
- American Association of People with Disabilities (AAPD), Washington, DC
- Anchorpoint Counseling Ministry, Pittsburgh, PA
- Auberle, McKeesport, PA
- Bethlehem Haven, Pittsburgh, PA
- Bidwell Training Center, Inc., Pittsburgh, PA
- Big Brothers Big Sisters of Greater Pittsburgh, Pittsburgh, PA
- Boy Scouts of America - Laurel Highlands Council, Pittsburgh, PA
- Brightwood Career Institute in Pittsburgh, PA, Pittsburgh, PA
- Butler Community College, Butler, PA
- Career Training Academy, Pittsburgh, PA
- Carlow University, Pittsburgh, PA
- Carnegie Library of Pittsburgh, Pittsburgh, PA
- Carnegie Library of Pittsburgh - Homewood, Pittsburgh, PA
- Carnegie Library of Pittsburgh - McKeesport, McKeesport, PA
- Carnegie Library of Pittsburgh - Oakland, Pittsburgh, PA
- Carnegie Mellon University, Pittsburgh, PA
- Casa San José, Pittsburgh, PA
- Catholic Charities Free Health Care Center, Pittsburgh, PA
- Catholic Diocese of Pittsburgh, Pittsburgh, PA
- Center for Organ Recovery & Education (CORE), Pittsburgh, PA
- Change Agency, All for All, Pittsburgh, PA
- Church in the Round (CIR), Aliquippa, PA
- Cincinnati Children's Hospital Medical Center-Project Search, Cincinnati, OH
- City of Pittsburgh, Department of Personnel, Pittsburgh, PA
- Community Care Behavioral Health Organization, Pittsburgh, PA
- Community College of Allegheny County, Pittsburgh, PA
- Community Empowerment Association, Pittsburgh, PA
- Consortium for Public Education, McKeesport, PA
- Consumer Health Coalition, Pittsburgh, PA
- CORO Pittsburgh, Pittsburgh, PA
- DeLoJe, LLC, Pittsburgh, PA
- Delta Foundation of Pittsburgh, Pittsburgh, PA
- Disability Options Network, New Castle, PA
- DLJ & Associates, Canonsburg, PA
- Dreams of Hope, Pittsburgh, PA
- Dress for Success Pittsburgh, Pittsburgh, PA
- East Liberty Development, Inc., Pittsburgh, PA
- Ebenezer Missionary Baptist Church, Pittsburgh, PA
- EDSI Solutions, Pittsburgh, PA
- Educating Teens about HIV/Aids Inc., Pittsburgh, PA
- Emmaus Community of Pittsburgh, Pittsburgh, PA
- Epilepsy Foundation Western/Central Pennsylvania, Pittsburgh, PA
- Expanding Minds, LLC, Pittsburgh, PA
- Family & Friends Initiative of Pittsburgh, Pittsburgh, PA
- Family Guidance, Pittsburgh, PA
- Family Services of Western Pennsylvania, Pittsburgh, PA
- Familylinks, Pittsburgh, PA
- FOCUS Pittsburgh, Pittsburgh, PA
- Gateway Rehabilitation Center, Pittsburgh, PA
- GIFT - Giving It Forward, Together, Pittsburgh, PA
- Global Pittsburgh, Pittsburgh, PA
- Goodwill of Southwestern Pennsylvania, Pittsburgh, PA

- Greater Erie Community Action Committee, Erie, PA
- Greater Pittsburgh Community Food Bank, Duquesne, PA
- Greater Pittsburgh Literacy Council, Pittsburgh, PA
- Habitat for Humanity of Greater Pittsburgh, Pittsburgh, PA
- Healthy Lungs Pennsylvania, Cranberry Township, PA
- Higher Achievement, Pittsburgh, PA
- Hill District Consensus Group, Pittsburgh, PA
- Hill District Education Council, Pittsburgh, PA
- Hosanna House, Wilksburg, PA
- Housing and Education Resource Program Inc., Pittsburgh, PA
- Imani Christian Academy, Pittsburgh, PA
- Institute of Medical and Business Careers, Career Services Department, Pittsburgh, PA
- InVision Human Services, Wexford, PA
- Islamic Association of Erie, Erie, PA
- Islamic Center of Pittsburgh, Pittsburgh, PA
- Ivy Charitable Endowment of Pittsburgh, Inc., The foundation of Alpha Kappa Alpha Sorority, Incorporated, Alpha Alpha Omega Chapter, Pittsburgh, PA
- JADA House International Inc., Pittsburgh, PA
- Jewish Family and Community Services, Pittsburgh, PA
- Josh Gibson Foundation, Pittsburgh, PA
- Junior Achievement of Western Pennsylvania, Pittsburgh, PA
- Kappa Chapter, Inc. of Chi Eta Phi Sorority Incorporated, Pittsburgh, PA
- Kappa Scholarship Endowment Fund of Western PA, Pittsburgh, PA
- Latino Community Center, Pittsburgh, PA
- Latino Family Center, Pittsburgh, PA
- LEAD Pittsburgh, Pittsburgh, PA
- Light of Life Rescue Mission, Pittsburgh, PA
- Macedonia Church of Pittsburgh, Pittsburgh, PA
- Macedonia Family and Community Enrichment Center, Inc., Pittsburgh, PA
- Mainstay Life Services, Pittsburgh, PA
- Manchester Bidwell Corporation, Pittsburgh, PA
- Manchester Youth Development Center (MYDC), Pittsburgh, PA
- Mel Blount Youth Leadership Initiative, Claysville, PA
- Merck, Pittsburgh, PA
- Michael Making Lives Better, Erie, PA
- Mon Valley Circles, McKeesport, PA
- Mon Valley Initiative, Homestead, PA
- Mon Valley Youth Community Services,
- Mt. Ararat Community Activity Center, Pittsburgh, PA
- Nabhi Christian Ministries, Pittsburgh, PA
- NAMI Keystone PA, Pittsburgh, PA
- National Association for the Advancement of Colored People (NAACP), Blair County Branch, Altoona, PA
- National Association for the Advancement of Colored People (NAACP), Mon Valley, Monessen, PA
- National Association for the Advancement of Colored People (NAACP), Pittsburgh Unit, Pittsburgh, PA
- National Black MBA Association, Pittsburgh Chapter, Pittsburgh, PA
- NEED, Pittsburgh, PA
- Neighborhood Learning Alliance, Pittsburgh, PA
- New Pittsburgh Courier, Pittsburgh, PA
- Northern Area Multi Service Center - Community Assistance and Refugee Resettlement, Pittsburgh, PA
- Northern Area Multi-Service Center, Pittsburgh, PA
- OMA Center for Mind Body Spirit, Pittsburgh, PA
- Operation Troop Appreciation, Pittsburgh, PA
- PA CareerLink, Allegheny East, Pittsburgh, PA
- PA CareerLink, Alle-Kiski, New Kensington, PA
- PA CareerLink, Downtown Pittsburgh, Pittsburgh, PA
- Partner4Work, Pittsburgh, PA
- Pennsylvania College Access Program (PA-CAP), Pittsburgh, PA
- Pennsylvania Department of Labor and Industry, Pittsburgh, PA
- Pennsylvania Health Access Network (PHAN) - Pittsburgh, Office, Pittsburgh, PA
- Pennsylvania Women Work, Pittsburgh, PA
- Pennsylvania Office of Vocational Rehabilitation - Pittsburgh, Pittsburgh, PA
- Peoples Oakland, Pittsburgh, PA
- PERSAD Center, Pittsburgh, PA
- PFLAG Pittsburgh, Pittsburgh, PA
- Pittsburgh Action Against Rape (PAAR), Pittsburgh, PA
- Pittsburgh Black Pride, Pittsburgh, PA
- Pittsburgh Board of Education, Pittsburgh, PA
- Pittsburgh Career Institute, Pittsburgh, PA
- Pittsburgh Community Services, Inc., Pittsburgh, PA
- Pittsburgh Institute of Mortuary Science (PIMS), Pittsburgh, PA

- Pittsburgh Job Corps Center, Pittsburgh, PA
- Pittsburgh Labor Council for Latin American Advancement (LCLAA), Pittsburgh, PA
- Pittsburgh Lesbian & Gay Film Society, Pittsburgh, PA
- Pittsburgh Parks Conservancy, Pittsburgh, PA
- Pittsburgh Partnership, Pittsburgh, PA
- Pittsburgh Technical College, Oakdale, PA
- Pittsburgh Urban Media, Pittsburgh, PA
- Primary Care Health Services, Inc., Pittsburgh, PA
- Professional Women’s Network (PWN), Pittsburgh, PA
- Program to Aid Citizen Enterprise (PACE), Pittsburgh, PA
- PublicSource, Pittsburgh, PA
- Ralph A. Falbo, Inc., Pittsburgh, PA
- Randall Industries, LLC, Pittsburgh, PA
- Rodman Street Missionary Baptist Church, Pittsburgh, PA
- Silk Screen, Asian American Arts & Culture Organization, Pittsburgh, PA
- Small Seeds Development Inc., Pittsburgh, PA
- Smart Futures, Pittsburgh, PA
- Squirrel Hill Health Center, Pittsburgh, PA
- St. Paul Baptist Church, Pittsburgh, PA
- Student National Medical Association, University of Pittsburgh School of Medicine Chapter, Pittsburgh, PA
- Talk Minority Action Group, Pittsburgh, PA
- Temple Emmanuel of South Hills, Pittsburgh, PA
- The Black Political Empowerment Project (B-PEP), Pittsburgh, PA
- The Door Campaign, Pittsburgh, PA
- The Kingsley Association, Pittsburgh, PA
- The Mentoring Partnership of Southwestern PA, Pittsburgh, PA
- The Midwife Center for Birth and Women’s Health, Pittsburgh, PA
- The Pennsylvania Health Law Project, Pittsburgh, PA
- The Pittsburgh Black Nurses in Action, Pittsburgh, PA
- The Pittsburgh Promise, Pittsburgh, PA
- The Reemployment Transition Center, Pittsburgh, PA
- The Springboard Foundation, Florida
- The University of Pittsburgh Coalition of Pre-Health Students, Pittsburgh, PA
- The Waters Foundation, Pittsburgh, PA
- The Western Pennsylvanian Conservancy, Pittsburgh, PA
- The Wynning Experience, Pittsburgh, PA
- Trade Institute of Pittsburgh, Pittsburgh, PA
- Union of African Communities in SWPA, Pittsburgh, PA
- United Way of Allegheny County, Pittsburgh, PA
- University of Pittsburgh, Cancer Institute, Pittsburgh, PA
- University of Pittsburgh, Center for Health Equity, Pittsburgh, PA
- University of Pittsburgh, Clinical & Translational Science Institute, Pittsburgh, PA
- University of Pittsburgh, Health Career Scholars Academy, Pittsburgh, PA
- University of Pittsburgh, Office of Health Sciences Diversity, Pittsburgh, PA
- Urban Impact, Pittsburgh, PA
- Urban Impact Foundation, Pittsburgh, PA
- Urban League of Greater Pittsburgh, Pittsburgh, PA
- Ursuline Support Services, Pittsburgh, PA
- Veterans Leadership Program of Western Pennsylvania, Inc., Pittsburgh, PA
- Veterans Place of Washington Boulevard, Pittsburgh, PA
- Vibrant Pittsburgh, Pittsburgh, PA
- Vision Towards Peace, LLC, Wilkinsburg, PA
- Voice of America - Pennsylvania, Pittsburgh Satellite Office, Pittsburgh, PA
- Warren United Methodist Church, Pittsburgh, PA
- Wesley Center AME Zion Church, Pittsburgh, PA
- Westminster Presbyterian Church, Pittsburgh, PA
- Westmoreland Agricultural Fair, Greensburg, PA
- Women for a Healthy Environment, Pittsburgh, PA
- Women’s Center & Shelter of Greater Pittsburgh, Pittsburgh, PA
- Workforce Investment Board, Westmoreland and Fayette Counties, Youngwood, PA
- Wounded Warrior Project, Pittsburgh, PA
- YMCA of Greater Pittsburgh, Pittsburgh, PA
- YMCA of Greater Pittsburgh- Homewood-Brushton Branch, Pittsburgh, PA
- YouthPlaces, Pittsburgh, PA
- YWCA of Greater Pittsburgh, Pittsburgh, PA

APPENDIX D: Concept Mapping Methodology

Overview:

In 2013, UPMC hospitals, with consultation and support from Pitt Public Health, utilized a research method known as concept mapping to develop a better understanding of perceived health problems for their communities. Concept mapping is well suited for a Community Health Needs Assessment because the research method involves stakeholders in the process and allows for prioritization of health problems based on community input.

Concept mapping is a participatory research method that yields a conceptual framework for how a group of stakeholders views a particular topic or issue. The method explores the relationships of ideas and concepts and allows for the development of group consensus. It allows for the collection of a wide range of stakeholder-generated ideas and applies quantitative analytical tools (i.e., multidimensional scaling and hierarchical cluster analysis). Concept mapping output includes a concept map which is a diagram that illustrates the relationships between ideas. The research method is used to facilitate the creation of a shared vision and understanding within a group. The research method synthesizes individual data and includes a rating process that is used to prioritize key issues.

In 2013, each UPMC hospital completed concept mapping, and through the process, identified hospital-specific community health priorities based on stakeholder input. In the concept mapping effort, community advisory panels at each UPMC hospital participated in focus groups to brainstorm and then sort a set of 50 community health problems. Concept mapping software used this sorting data to create a display that illustrated the relationships between health topics and allowed for aggregation of topics into thematic areas. The 50 topics were grouped into three main thematic areas: prevention and healthy living, chronic disease, and navigating the health care system. UPMC's 2019 CHNA builds on the assessment process originally applied in 2013.

Application of Concept Mapping - Two-Stage Process:

UPMC hospitals established community advisory councils. Participants contributed through face-to-face meetings and online input.

The concept mapping research method consisted of two stages:

- **Brainstorming — gathering stakeholder input**
- **Sorting and Rating — organizing and prioritizing the stakeholder input**

Brainstorming - Identifying Health Needs:

In the brainstorming meeting, each hospital's Community Advisory Council met in person to solicit members' input on the focal question, "What are our community's biggest health problems?"

Council members first brainstormed independently, and then shared their lists with the Pitt Public Health research team. Their responses were then compiled to generate a full list of community health problems for the hospital. The Pitt Public Health research team shared the full list with the group and facilitated a group discussion of the responses to ensure the list was comprehensive and reflected the scope of health problems faced in the community.

All of the hospital-specific brainstorming lists were integrated together to develop a final master list of community health problems to be used in the subsequent concept mapping sorting and rating. A consolidated final master list of the 50 community health problems was distilled from the robust community input. The following table presents each of the 50 community health problems and provides a numerical value in parentheses so that the item can be linked with the concept map in the following figure.

Final Master List of 50 Community Health Problems				
Nutrition and healthy eating (1)	Diabetes (11)	Medication management and compliance (21)	High blood pressure/Hypertension (31)	Smoking and tobacco use (41)
Immunizations/Vaccinations (2)	Health literacy – ability to understand health information and make decisions (12)	Exercise (22)	Breast cancer (32)	Adolescent health and social needs (42)
Lung cancer (3)	Urgent care for non-emergencies (13)	Navigating existing healthcare and community resources (23)	Pediatrics and child health (33)	Depression (43)
Maternal and infant health (4)	End of life care (14)	Preventive Screenings (cancer, diabetes, etc) (24)	Sexual health including pregnancy and STD prevention (34)	Support for families/caregivers (44)
Alcohol abuse (5)	Asthma (15)	Heart Disease (25)	Dementia and Alzheimer’s (35)	Health insurance: understanding benefits and coverage options (45)
Adult obesity (6)	Prenatal care (16)	Primary Care (26)	Chronic Obstructive Pulmonary Disease (COPD) (36)	Preventive health/wellness (46)
Drug abuse (7)	Dental care (17)	Childhood obesity (27)	Stroke (37)	Injuries including crashes and sports related, etc (47)
Access to specialist physicians (8)	Financial access: understanding options (18)	Intentional injuries including violence and abuse (28)	Post-discharge coordination and follow-up (38)	Childhood developmental delays including Autism (48)
Behavioral health/Mental Health (9)	High cholesterol (19)	Cancer (29)	Arthritis (39)	Eye and vision care (49)
Geographic access to care (10)	Care coordination and continuity (20)	Social support for aging and elderly (30)	Senior health and caring for aging population (40)	Environmental health (50)

Sorting and Rating - Prioritizing Health Needs:

All of the hospitals' Community Advisory Councils completed the sorting and rating activities via the Internet. Each participant was asked to sort the master list of 50 community health problems into thematic areas, and to then rate the problems using a 1 to 5 Likert scale, according to the following criteria:

Importance:

How important is the problem to our community?

(1 = not important; 5 = most important)

Measurable Impact:

What is the likelihood of being able to make a measurable impact on the problem?

(1 = not likely to make an impact; 5 = highly likely to make an impact)

Hospital Ability to Address:

Does the hospital have the ability to address this problem?

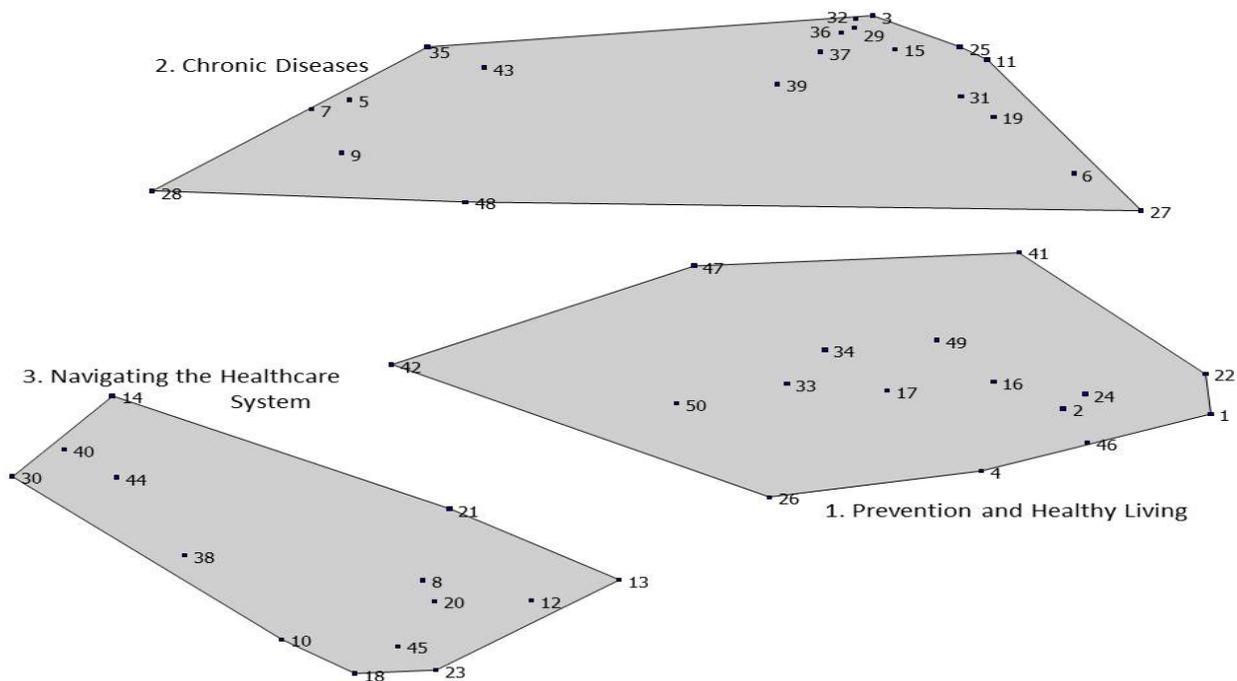
(1 = no ability; 5 = great ability)

Multi-dimensional scaling was applied to the sorting data to examine similarities between the 50 community health problems. Hierarchical clustering was used to group the sorting data into common thematic areas and to establish a final cluster map which provided a visual representation of the data. The final cluster map of the 50 community health problems reflects three thematic areas (See Figure below):

- **Prevention and Healthy Living (16 items)**
- **Chronic Diseases (20 items)**
- **Navigating the Healthcare System (14 items)**

Each of the 50 community health problems are represented in the figure below as a point. The numbers next to each point correspond to the item number. For example, item #31 is High Blood Pressure/Hypertension. The proximity of the points to each other illustrates the group thoughts about the degree of similarity between the items. For example, item #31 (High Blood Pressure/Hypertension) and item #19 (High Cholesterol) were felt to be very similar. Those two community health problems appear on the right side of the Chronic Diseases cluster.

Final Cluster Map:



For each of the rating criteria, the rating levels were broken into three equal distributions (tertiles) representing high, moderate, and low priority. The cut points for each rating criteria are as follows:

Importance:

Low (1-3.67); Moderate (3.68-4.06); High (4.07-5.0)

Measurable Impact:

Low (1-3.33); Moderate (3.34-3.83); High (3.84-5.0)

Hospital Ability to Address:

Low (1-3.20); Moderate (3.21-3.85); High (3.86-5.0)

Within each cluster, the rating data for each individual community health problem was examined across all three rating criteria. For example, in the Prevention and Healthy Living cluster, the 16 individual community health problems were identified as being low, moderate, or high for the importance, measurable impact, and hospital ability to address rating criteria.

The rating categories results were then combined with results from secondary data analyses and used to identify high priority community health problems for each UPMC hospital. UPMC hospital leadership next consulted with experts from Pitt Public Health and members of the community advisory council to review the list of high priority community health problems and identify the set of needs that are critical, addressable, and have high levels of urgency in the community. The resulting list constituted the top tier of health problems for the community.

APPENDIX E: Chautauqua County 2016-2018 CHNA

As part of the New York State Department of Health's (NYSDOH) Prevention Agenda, UPMC Chautauqua collaborated with the Chautauqua County Department of Health and Human Services (CCDHHS), Brooks Memorial Hospital, TLC Health Network, and Westfield Memorial Hospital to update the Chautauqua County 2016-2018 Community Health Assessment and Improvement Plan and Community Service Plan, which includes collaborative health improvement efforts spanning 2016-2018.

Chautauqua County 2016-2018 Community Health Assessment and Improvement Plan and Community Service Plan



Service Area: Chautauqua County, New York

Local Health Department:

Chautauqua County Department of Health and Human Services, Division of Public Health (CCDHHS)

Address: 7 North Erie Street Mayville, NY 14757

Contact: Breeanne Agett, MPH, Junior Planner, 716-753-4771, AgettB@co.chautauqua.ny.us

Hospitals:

Brooks Memorial Hospital (BMH)

Address: 529 Central Ave Dunkirk, NY 14048

Contact: Sheila Walier, Director of Marketing and Community Relations, 716-363-3313,
swalier@brookshospital.org

TLC Health Network (TLC)

Address: 845 Rts 5 & 20 Irving, NY 14081

Contact: Tracy A. Stevens, MS, RN, CDE, Clinics Manager, 716-532-8100, tstevens@tlchealth.org

WCA Hospital (WCA)

Address: 207 Foote Avenue, PO Box 840, Jamestown, NY 14702-0840

Contact: Toni DeAngelo, RN, Community Health and Wellness Director, 716-664-8677,
toni.deangelo@wcahospital.org

Westfield Memorial Hospital (WMH)

Address: 189 E. Main Street Westfield, NY 14787

Contact: Peter M. Pascale, MS, FASHP, Administrator, 716-793-2200, ppascale@svhs.org

Executive Summary

Selection of Prevention Agenda Priority Areas

Consideration of public input and secondary health data from the NYSDOH led the Chautauqua County Community Health Planning Team (CCCHPT) to select the following priorities, focus areas, and disparities:

1) Prevent Chronic Diseases

Focus Areas: 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 Areas: Reproductive, Preconception, and Inter-Conception 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: Prevent Substance Abuse and Other Mental Emotional and Behavioral Disorders

Changes from Plan Developed in 2013

Several strategies and activities have changed since the last assessment, but overall goals and health outcomes that we intend to monitor over the next several years are essentially unchanged. We selected a new focus area for the Promote Mental Health and Prevent Substance Abuse priority area that captures more of the strategies and activities that we will carry out over the next two years.

Data Reviewed

The CCCHPT reviewed many data sources to confirm existing priorities, including: NYS Prevention Agenda Tracking Indicator Dashboard; Sub-County Health Data Reports for County Health Rankings-Related Measures; Community Health Indicator Reports; County Health Indicators by Race/Ethnicity; County/ZIP Code Perinatal Data Profile; Vital Statistics; NYS Cancer Registry; Expanded (County-Level)

Behavioral Risk Factor Surveillance System; Keys to Health (P2 of WNY's data clearinghouse) Chautauqua County PRIDE Survey Data (youth substance abuse and risk factor surveys); and, New York State County Opioid Quarterly Report for Counties Outside NYC (Published 10/2016).

Partner Roles

Please see Table 1 for a list of partners and their roles in the planning and implementation process.

Community Engagement

To involve the community in our health assessment and improvement planning efforts, the CCCHPT solicited survey responses from 1,353 County residents and held four community conversations that engaged ~200 individuals. A stakeholder meeting, which was attended by 19 organizations, was held to share our plan with community partners, and ask for feedback. Once finalized, the plan will be posted on hospital and health department websites. A press release will be submitted to media contacts and shared via social media outlets and email lists.

Evidence-based Interventions and Process Measures

The following evidence-based interventions and strategies and their corresponding process measures (PM) were selected due to identified need and availability of resources.

Chronic Disease Prevention

- Work with institutions to improve nutrition standards for healthy food and beverage procurement. (PM: # of hospitals promoting Chautauqua Grown, # of institutions adopting or maintaining healthy beverage or vending policies, # institutions signed CHQ250 pledges)
- Increase the number of municipalities that have and implement Complete Streets policies. (PM: # of municipalities with policies, # of people impacted by improvements and policies)
- Increase the number of schools with comprehensive and strong local wellness policies. (PM: # of schools completing school health index and ASCD assessments, # policies changed)

- Promote the use of evidence-based interventions to prevent or manage chronic diseases. (PM: # of people who have completed Living Healthy or NDPP programs, # trainings and # people trained in hands-only CPR, # practices working to meet Million Hearts benchmarks)

Promote Healthy Women, Infants, and Children

- Provide evidence-based home visiting and community health worker program models to mothers during and after pregnancy. (PM: # of moms/babies in programs, # moms in smoking cessation programs)
- Work with hospital, medical, and community partners to improve policies and breastfeeding (BF) support for BF moms. (PM: # hospitals with BF policies and working w/NYS program, # moms visited in hospital, # designated BF-friendly practices, # BF support groups)
- Encourage employers to implement breastfeeding-friendly policies and practices. (PM: # employers trained, # employers that made improvements for BF moms)
- Work with community partners to increase access to sexual health education and birth control methods. (PM: # hospitals providing methods post-delivery, # community partners referring clients to or providing birth control methods to high-risk women)

Promote Mental Health and Prevent Substance Abuse

- Work with CASAC and CASAC's HOPE Chautauqua coalition to address prevention, prescriber education, and adopt environmental strategies to prevent drug use. (PM: # providers educated, # schools using prevention programs, # environmental strategies)
- Offer Mental Health First Aid gate keeper training in community. (PM: # MHFA trainings held, # participants trained)
- Implement SBIRT process in medical facilities. (PM: # medical providers using SBIRT)

Table 1. Chautauqua County Community Health Improvement Plan and Community Service Plan Partners and their Roles

Organization	Role in Assessment and Implementation									
	Meeting facilitation	Data review and planning process	Survey design	Data Compilation	Report Writing	Solicited Survey Responses	Assisted with Community Conversations	Identification of key stakeholders	Review and critique of plan	Proposed implementation partner
Blackwell Chapel Baby Café									X	X
Brooks Memorial Hospital		X	X		X	X	X	X	X	X
Catholic Charities- WIC				X					X	X
CC Dept. of Mental Hygiene		X	X		X	X		X	X	X
CC DHHS	X	X	X	X	X	X	X	X	X	X
CC Health Network	X	X	X		X	X	X	X	X	X
CC Mental Health Association						X			X	X
CC Office for the Aging									X	X
CCE- Eat Smart NY									X	X
Chautauqua Alcohol and Substance Abuse Council				X		X			X	X
Chautauqua Opportunities, Inc.										X
Chautauqua Striders									X	X
Community Partners of WNY								X	X	X
Cornell Cooperative Extension of CC										X
E-2CC BOCES									X	X
Evergreen Health Services								X	X	X
P2 of WNY	X	X	X	X	X	X			X	X
Teenage Education and Motherhood (TEAM) Program										X
The Chautauqua Center		X	X			X		X	X	X
The Resource Center									X	X
TLC Health Network		X	X		X	X	X	X	X	X
United Way of Southern CC								X	X	X
WCA Hospital		X	X		X	X	X	X	X	X
Westfield Memorial Hospital		X	X		X	X	X	X	X	X
YWCA of Jamestown									X	X

CC=Chautauqua County

Report

At the request of the New York State Commissioner of Health, the Chautauqua County 2016-2018 Community Health Assessment and Health Improvement Plan and Community Service Plan was developed collaboratively by Brooks Memorial Hospital, Chautauqua County Department of Health and Human Services (Division of Public Health), TLC Health Network, WCA Hospital, and Westfield Memorial Hospital. This unified plan outlines much of the work conducted in 2016 and will serve as a blueprint for action through 2018.

Description of the Community

The geographic area captured by the Chautauqua County Community Health Improvement Plan is the entirety of Chautauqua County, NY. Each of our four hospitals has been actively engaged in the planning process, and their respective community service plans are included in this county-wide plan.

Chautauqua County is the westernmost county in New York State, located along the shore of Lake Erie between Erie, PA and Buffalo, NY. Chautauqua County is made up of two cities, Dunkirk and Jamestown, twenty-seven towns, and fifteen villages that cover 1,060 square miles with an estimated population of 130,779 in 2015 (US Census American Community Survey). In Chautauqua County, 18.5% of residents are aged 65 years and older (2015, ACS), which is slightly higher than New York State's rate of 15.0%.

Of Chautauqua County residents, 88.6% are white, non-Hispanic, 6.6% are Hispanic or Latino (of any race), 2.3% are black or African-American and non-Hispanic, 1.3% are multi-racial, 0.6% are Asian, and 0.5% are American Indian or Alaska Native (2014, ACS).

The median household income in 2014 was \$42,720 (2010-2014). In 2014, 19.4% of all residents and 29.9% of residents less than 18 years old were living in poverty. During the same

Chautauqua County

time period, New York State's median household income was \$58,687, and 15.6% of state residents, including 22.1% of residents less than 18 years old, were living below the federal poverty level (ACS, 2014). As of September 2016, 5.5% of adults in the Chautauqua County labor force were unemployed-6th highest of all counties in NYS (NYS Department of Labor, September, 2016).

Chautauqua County residents (ages 25 and up) are more likely (88.0%) to have graduated from high school than New York State as a whole (85.4%), and less likely to hold a bachelor's degree or higher (21.1% compared to NYS 33.7%) (ACS, 2010-2014).

Supporting Data

The CCCHPT reviewed data from the following sources to confirm existing priorities:

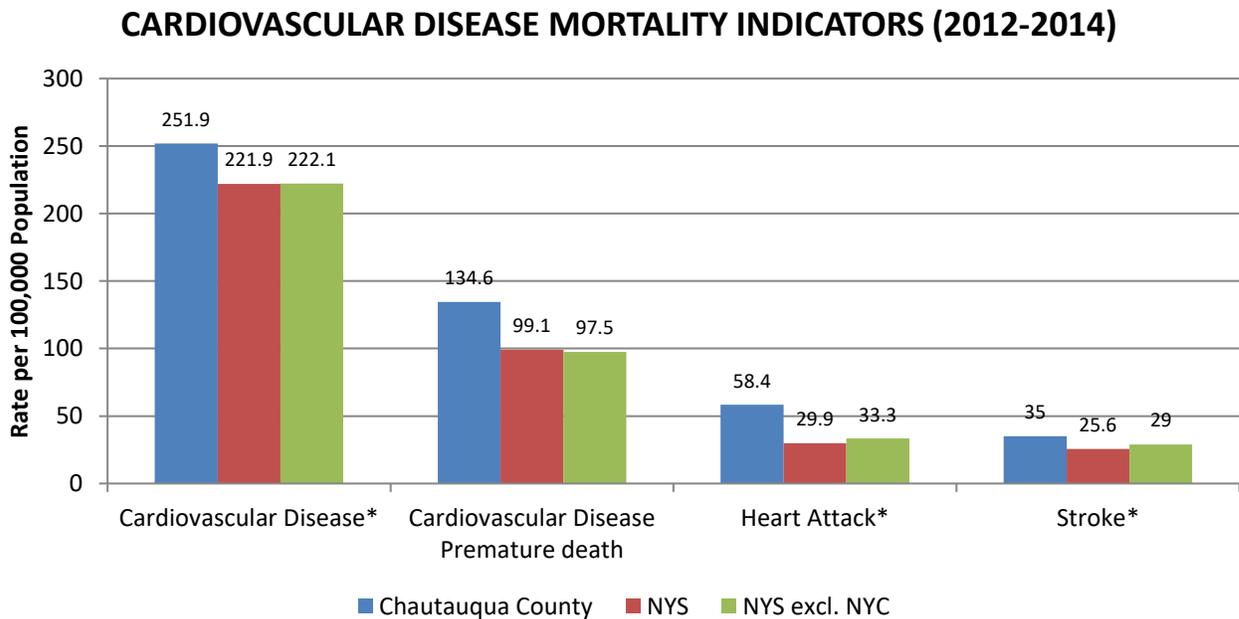
- New York State Prevention Agenda Tracking Indicator Dashboard
- Sub-County Health Data Reports for County Health Rankings-Related Measures
- Community Health Indicator Reports
- County Health Indicators by Race/Ethnicity
- County/ZIP Code Perinatal Data Profile
- Vital Statistics
- NYS Cancer Registry
- Expanded (County-Level) Behavioral Risk Factor Surveillance System
- Keys to Health (P2 of WNY's data clearinghouse)
- Chautauqua County PRIDE Survey Data (youth substance abuse and risk factor surveys)
- New York State County Opioid Quarterly Report for Counties Outside NYC (Published 10/2016)

Prevent Chronic Diseases

The leading causes of death in Chautauqua County in 2014 were heart disease, cancer, chronic lower respiratory disease, stroke, and unintentional injury, respectively (NYS Leading Causes of Death by County, 2014).

Review of NYSDOH’s Community Health Indicator Reports showed that Chautauqua County experiences significantly higher rates of mortality for cardiovascular disease, including significant rates of premature death (ages 35-64) and pretransport mortality. Death rates for heart attack, stroke, and stroke premature death were all significantly higher in Chautauqua County than New York State as well. See Chart 1 below for more details. Corresponding hospitalization rates appear to be lower than the state averages, likely due to travel outside of Chautauqua County (and New York State) for health care relating to these conditions.

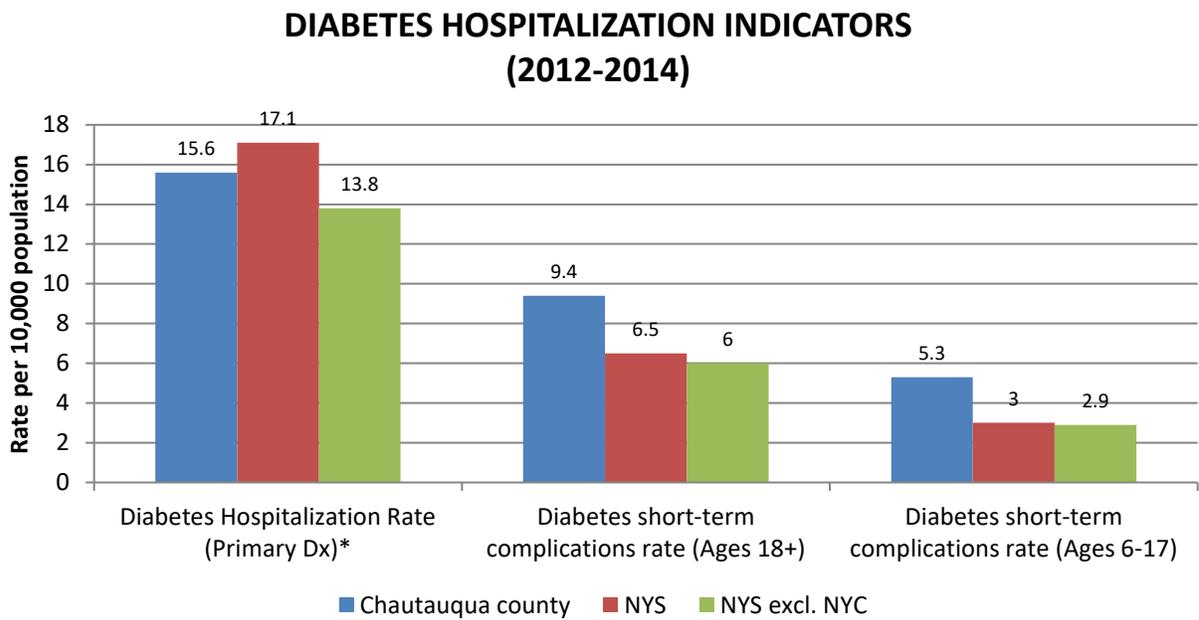
Chart 1. Cardiovascular Disease Mortality Indicators



*=Age-adjusted, Premature death= death to individuals aged 35-64 years
Data obtained from NYSDOH, Community Health Indicator Reports
Sources: Vital Statistics, 2012-2014

Diabetes and Cirrhosis-related Community Health Indicator Reports were reviewed. Diabetes mortality rates, while higher than the state average, have dropped over the past eight years, and are no longer as concerning as they once were. Short-term complications for both the 6-17 year old and 18 and older age groups seem to have risen over the past several years.

Chart 2. Diabetes Hospitalization Indicators



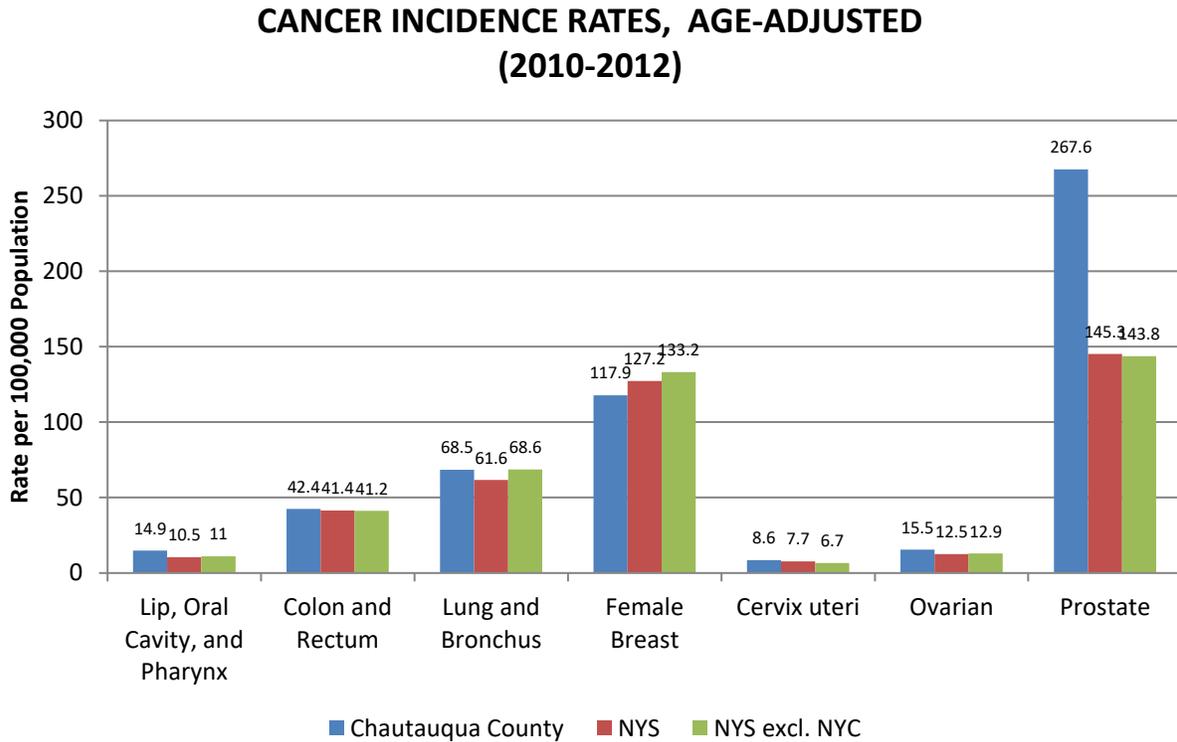
*=Age-adjusted

Data obtained from NYSDOH, Community Health Indicator Reports, 2012-2014

Sources: SPARCS Data

The age-adjusted incidence rate for all cancers was significantly higher in Chautauqua County than New York State for all cancers (559.4 per 100,000, compared to 489.2, respectively). Cancer sites that were significantly elevated over the state rates included lip, oral cavity, and pharynx cancer and prostate cancer. It is important to note that local screening efforts for prostate cancer likely skew the reported number of prostate cancer cases, which make it difficult to compare to state figures. Corresponding treatment is reflected in the resulting lower prostate cancer mortality rates.

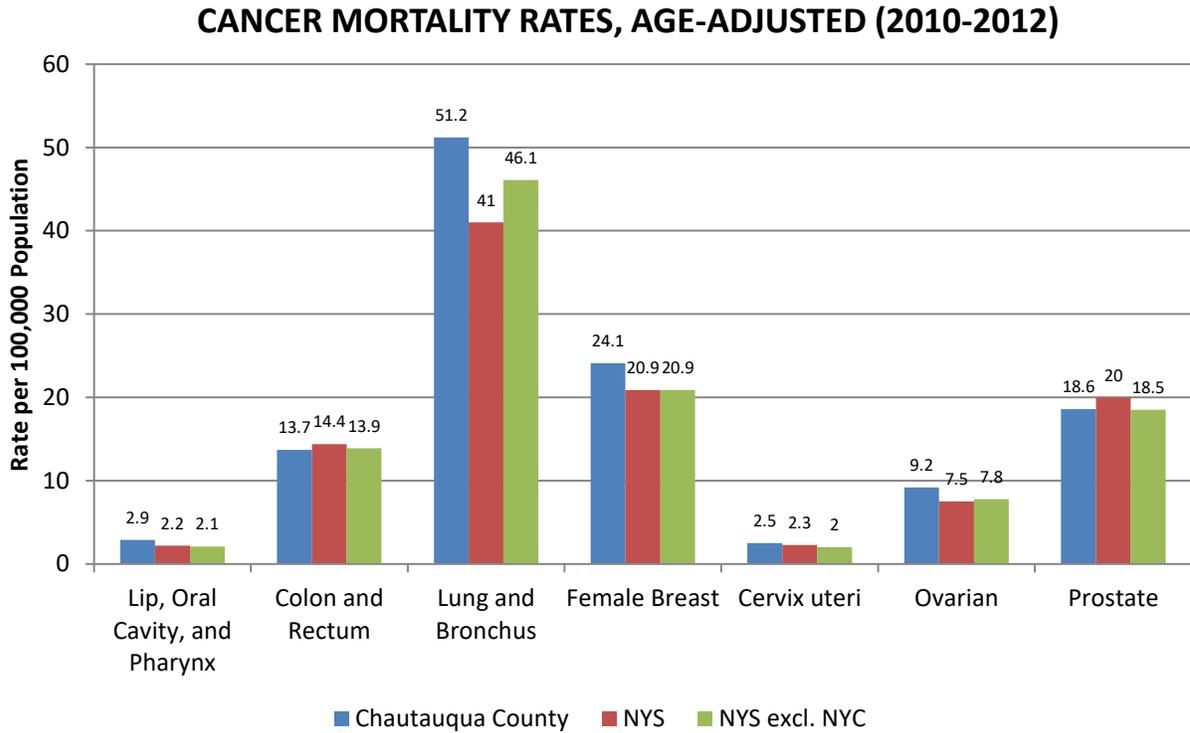
Chart 3. Cancer Incidence Rates, Age-Adjusted



Data obtained from NYSDOH, Community Health Indicator Reports, 2012-2014
Sources: SPARCS Data

The age-adjusted cancer mortality rate for Chautauqua County (176.6 per 100,000) is significantly higher than that of New York State (158.6 per 100,000), but non-significantly higher than that of New York State excluding New York City (165.6 per 100,000). The highest age-adjusted mortality rates were observed for lung and bronchus cancer (51.2 per 100,000), and female breast cancer (24.1 per 100,000).

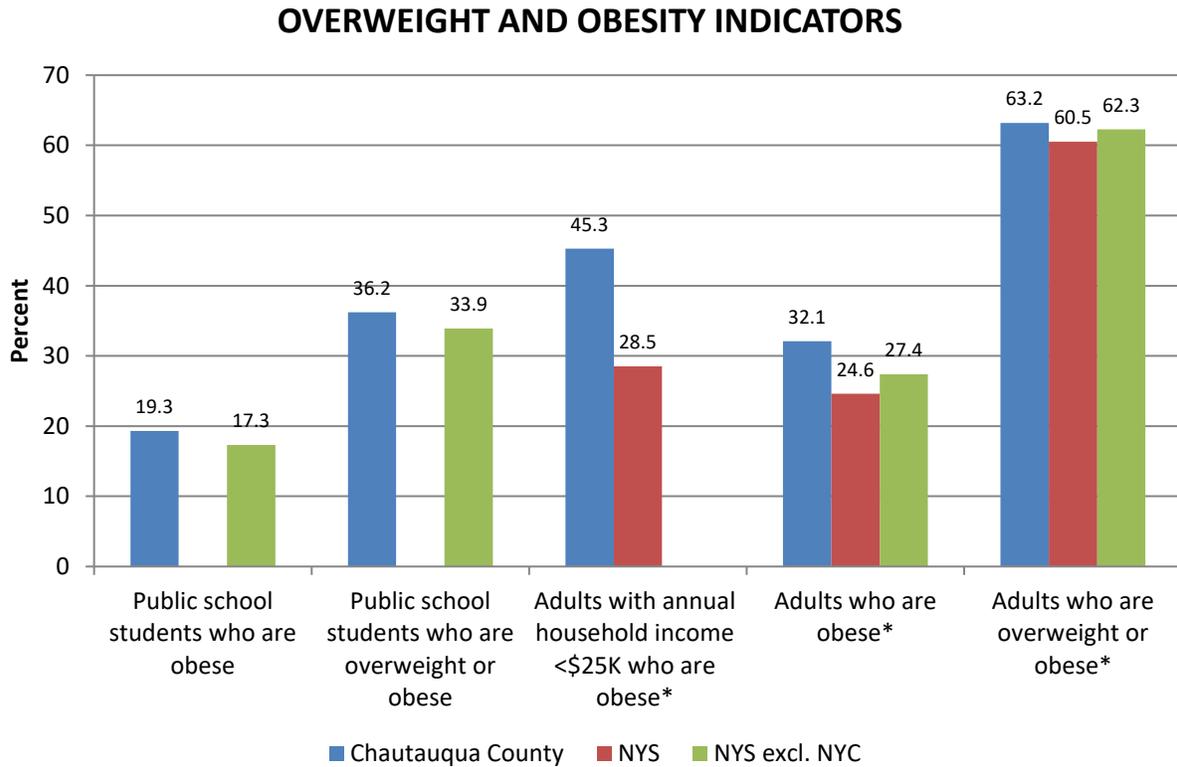
Chart 4. Cancer Mortality Rates, Age-Adjusted



Data obtained from NYSDOH, Community Health Indicator Reports, 2012-2014
 Sources: Vital Statistics

Overweight and obesity indicators for Chautauqua County are not overwhelmingly different from state-level averages, but are still very concerning because these conditions affect the majority of our adult residents, as well as a growing number of our youth residents. In Chautauqua County, an estimated 32.1 of adults are obese and an additional 31.1% of adults are overweight (NYS eBRFSS 2013-2014). Of public school students, 36.2% were overweight or obese (SWSCRS 2012-2014).

Chart 5. Overweight and Obesity Indicators



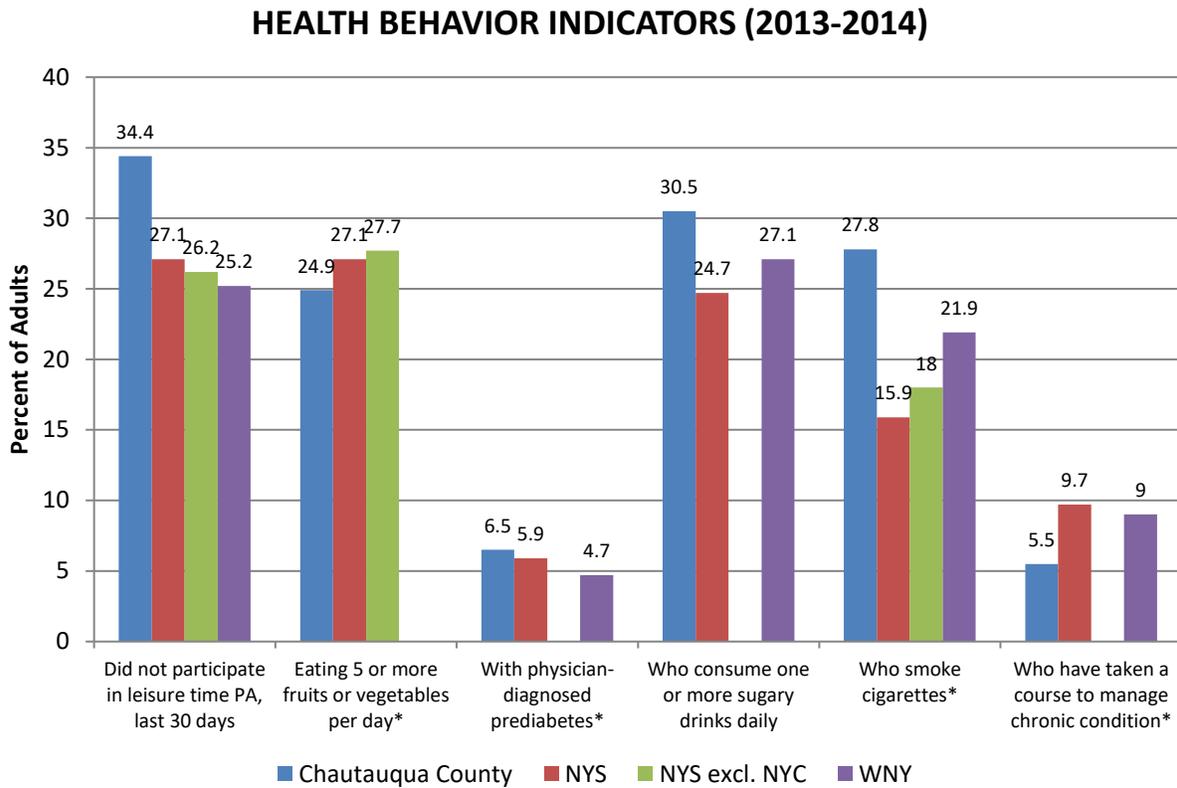
*=Age-adjusted

Data obtained from NYSDOH, Community Health Indicator Reports

Sources: Student Weight Status Category Reporting System 2012-2014, Expanded BRFSS 2013-2014

Additional measures from the expanded BRFSS show that Chautauqua County adult residents are less likely to participate in leisure-time physical activity, consume at least 5 fruits or vegetables per day, or to have taken a class to help manage a chronic condition. Chautauqua County residents are more likely to have physician-diagnosed prediabetes, consume one or more sugary drinks per day, and smoke cigarettes than New York State adults (NYS eBRFSS 2013-2014).

Chart 6. Health Behavior Indicators



*=Age-adjusted

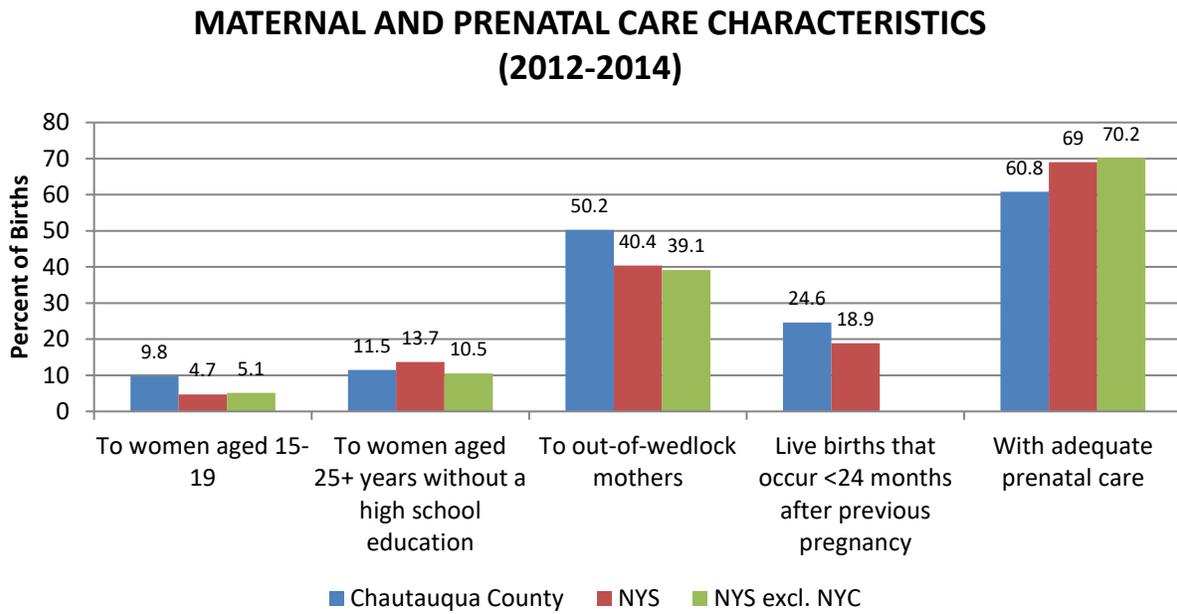
Data obtained from NYSDOH, Community Health Indicator Reports

Sources: Expanded BRFSS 2013-2014

Healthy Women, Infants, and Children

Chautauqua County sees proportionately more births to women aged 15-19, and to out-of-wedlock mothers than New York State as a whole. Fewer births are to babies who have received adequate prenatal care (NYSDOH CHIRS, Vital Statistics). Chautauqua County also experiences a higher percentage of babies born within 24 months of a previous pregnancy. Among live births, 36.7% are a result of unintended pregnancy in Chautauqua County, compared to 24.5% in New York State.

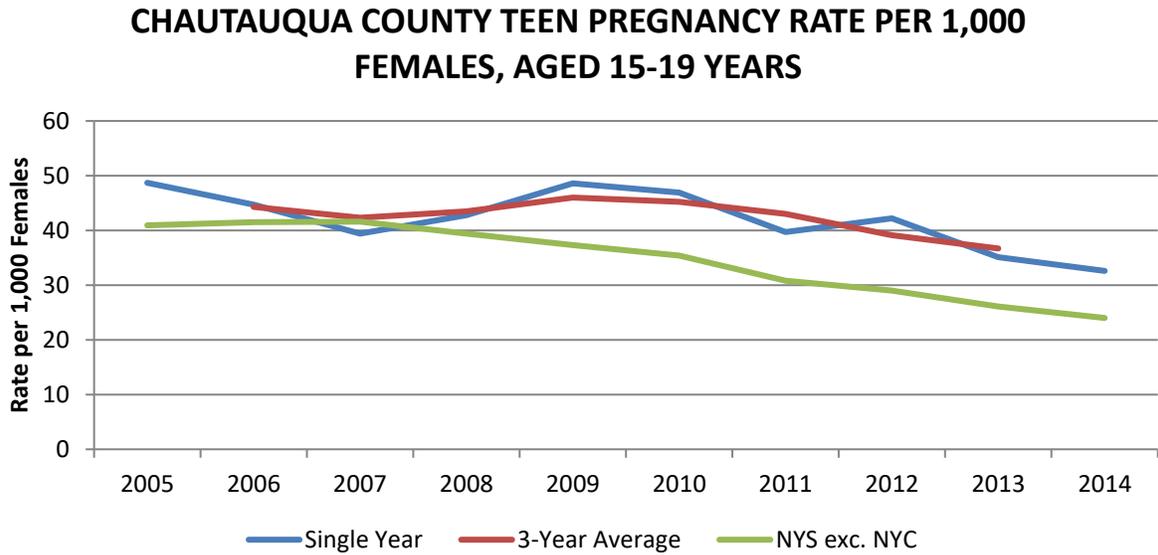
Chart 7. Maternal and Prenatal Care Characteristics



Data obtained from NYSDOH, Community Health Indicator Reports
Sources: Vital Statistics

Teen pregnancy rates among 15-19 year olds have been on the decline in Chautauqua County from 2005 to 2014. A breakdown of pregnancies by race and ethnicity shows that teen pregnancy rates are twice as high among Hispanic girls than white and black or African-American subgroups (CHIRS, 2012-2014).

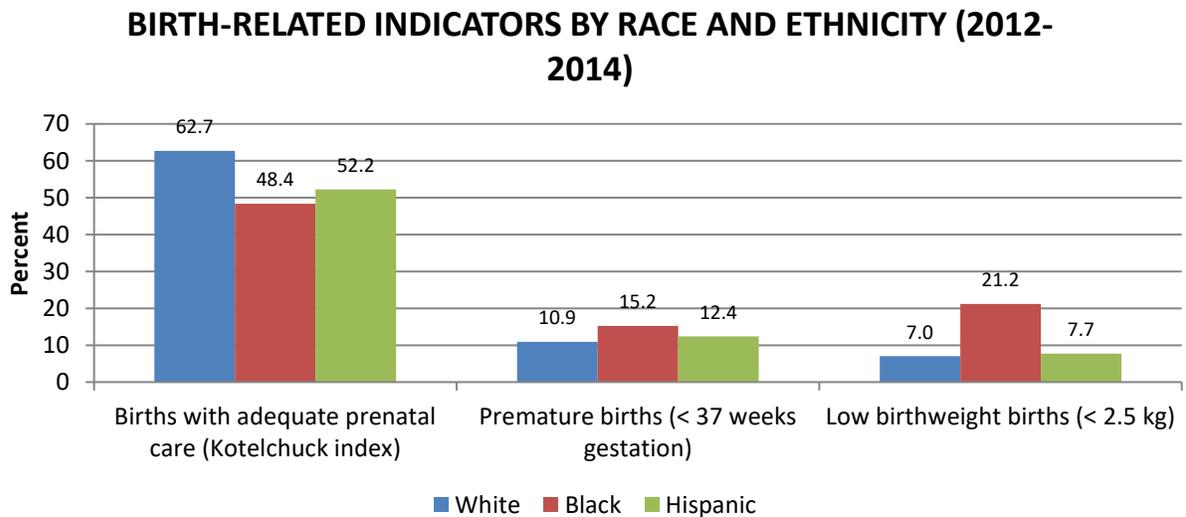
Chart 8. Teen Pregnancy Rates



Data obtained from NYSDOH, Community Health Indicator Reports
Sources: Vital Statistics

Chautauqua County moms who are white are more likely to receive adequate prenatal care than their African-American or Hispanic counterparts. African-American babies are more likely to be born premature and at a low birth weight.

Chart 9. Birth-Related Indicators by Race and Ethnicity

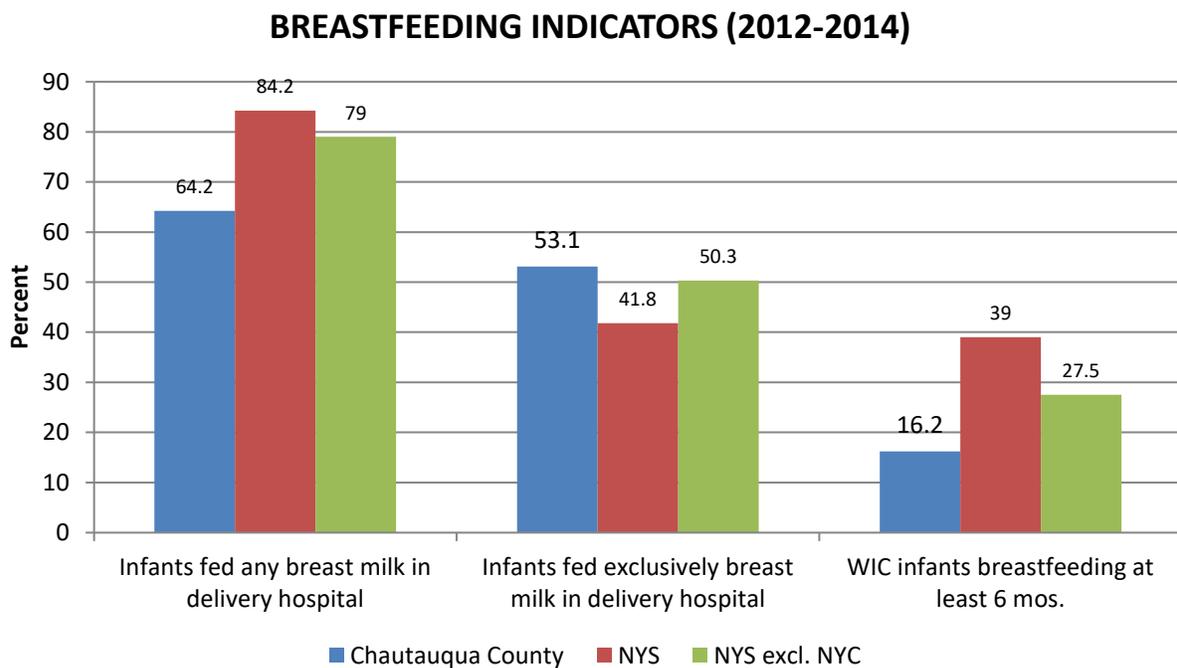


Data obtained from NYSDOH, Community Health Indicator Reports
Sources: Vital Statistics

Chautauqua County

During 2012-2014, babies in Chautauqua County were less likely to be fed any breast milk in the delivery hospital (64.2%, compared to 84.2% in New York State), but were more likely to be fed exclusively breast milk (53.1%, compared to 41.8% in New York State). WIC infants in Chautauqua County (16.2%) were less likely to be breastfeeding at 6 months compared to New York State (39.0%) and New York State excluding New York City (27.5%).

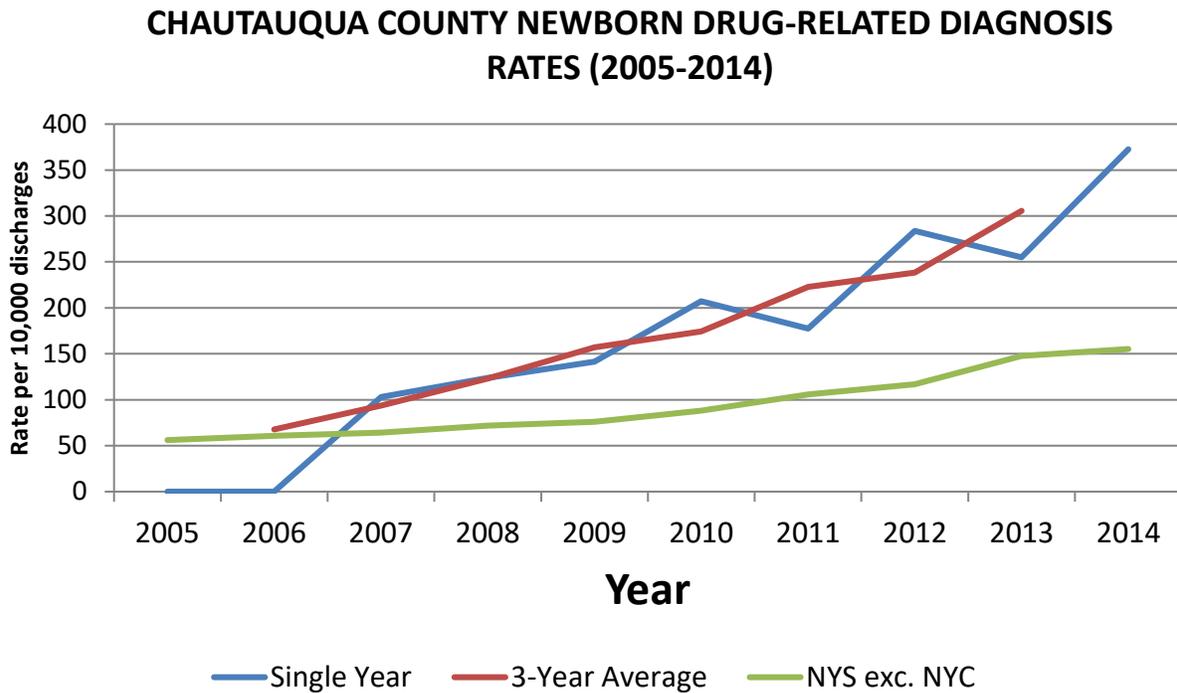
Chart 10. Breastfeeding Indicators



Data obtained from NYSDOH, Community Health Indicator Reports
Sources: NYS Pregnancy Nutrition Surveillance System, Vital Statistics

From 2005 to 2014, newborn drug-related diagnosis rates have drastically increased in Chautauqua County. From 2012 to 2014, 118 babies born tested positive for drugs in the delivery hospital, resulting in a rate of 305.6 per 10,000 newborn discharges, nearly three times greater than the New York State rate of 103.5 per 10,000.

Chart 11. Chautauqua County Newborn Drug-Related Diagnosis Rates



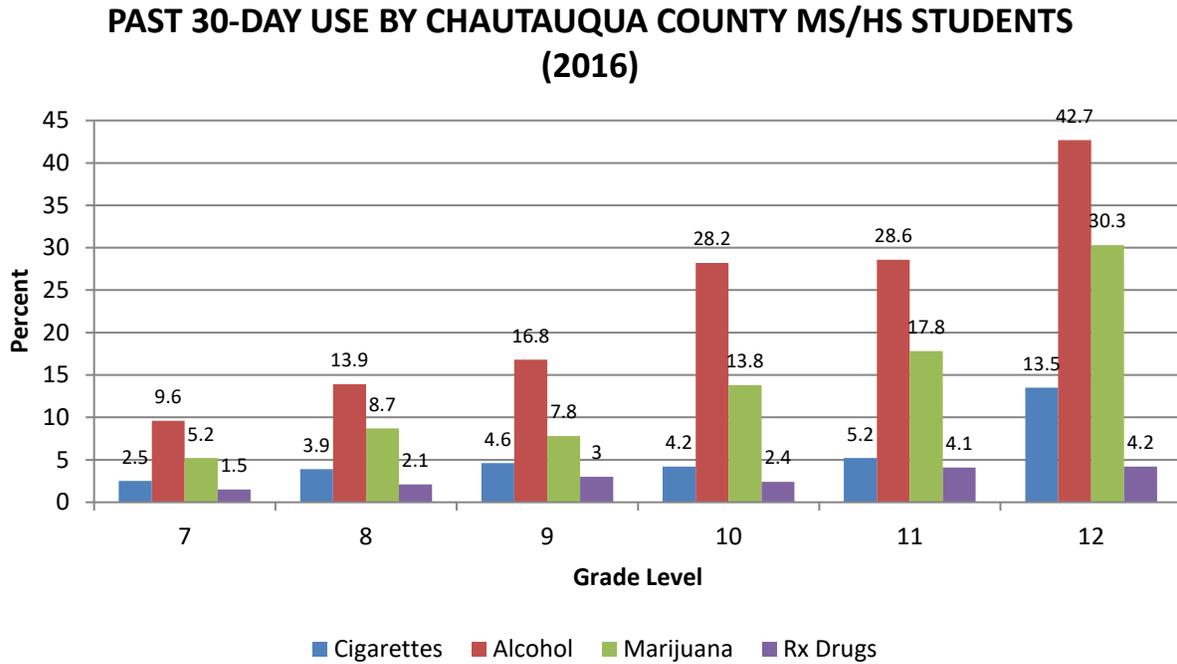
Data obtained from NYSDOH, Community Health Indicator Reports
Sources: SPARCS data

Promote Mental Health and Prevent Substance Abuse

Poor Mental Health and Substance Abuse are growing concerns in Chautauqua County. During the 2013-2014 eBRFSS survey period, 16.3% of Chautauqua County adults indicated that they had poor mental health during 14 or more days within the past month, compared to 11.1% of NYS adults. From 2012 to 2014, the age-adjusted suicide mortality rate in Chautauqua County was 12.6 per 100,000, compared to 7.9 per 100,000 in New York State (NYS Vital Statistics).

The 2016 PRIDE survey, conducted by the Chautauqua Alcohol and Substance Abuse Council, surveyed middle and high school students in 9 public school districts. The study found that alcohol and marijuana were the most-frequently used substances, and that cigarette and prescription drug use are also concerns. Use of substances typically increased with grade level.

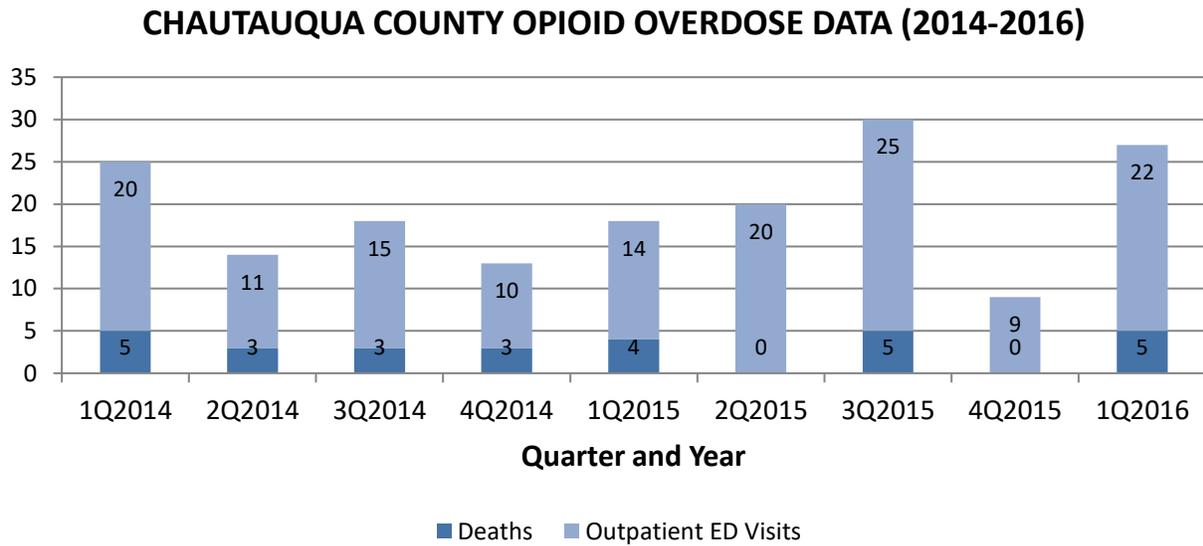
Chart 12. Past 30-Day Use of Substances by Chautauqua County Middle and High School Students



Data obtained from Chautauqua Alcohol and Substance Abuse Council
Sources: PRIDE Survey 2016, Data from 9 CC school districts

Opioid overdose data provided by the New York State Department of Health provides a picture of overdose deaths, emergency room visits, and hospitalizations by quarter that both provides a snapshot of this issue and serves as a baseline to monitor this issue over time. Overdose deaths declined from 2014 to 2015 (14 down to 9), while emergency room visits increased (56 up to 68).

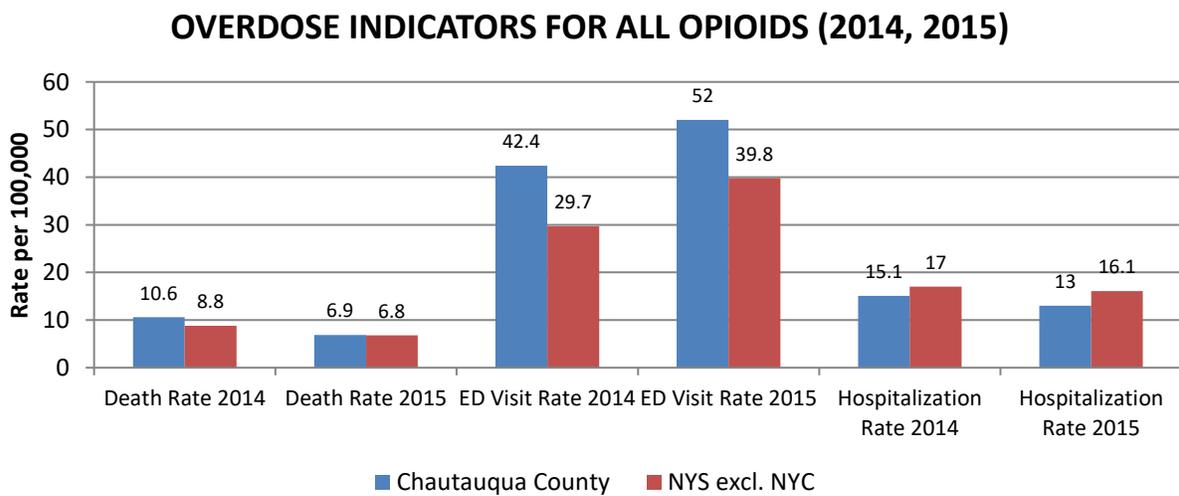
Chart 13. Chautauqua County Opioid Overdose Data



Data obtained from NYSDOH, New York State- County Opioid Quarterly Report for Counties outside NYC Published October 2016
Sources: Vital Statistics, SPARCS data

Chautauqua County experienced higher death rates and emergency room visit rates for opioid overdoses in 2014 and 2015, compared to New York State. Hospitalization rates in Chautauqua County were slightly lower than New York State rates during the same time period.

Chart 14. Overdose Indicators for All Opioids



Data obtained from NYSDOH, New York State- County Opioid Quarterly Report for Counties outside NYC Published October 2016
Sources: Vital Statistics, SPARCS data

Selected Priorities and Health Disparity

The CCCHPT adopted a three-pronged approach to determine Chautauqua County's health priority areas. We took into consideration input from community members, secondary health data from NYSDOH and other available sources, and input from local content-area experts. Community input was gathered through a survey (offered electronically and paper formats) and through a series of four community conversations

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

4) 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

5) Promote Healthy Women, Infants, and Children

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

6) Promote Mental Health and Prevent Substance Abuse

Focus Area(s): Prevent Substance Abuse and Other Mental Emotional and Behavioral Disorders

Changes from Plan Developed in 2013

Several strategies and activities have changed since the last assessment, but overall goals and health outcomes that we intend to monitor over the next several years are essentially unchanged. We selected a new focus area for the Promote Mental Health and Prevent Substance Abuse priority area that captures more of the strategies and activities that we will carry out over the next two years.

Goals, Objectives, and Plans for Action

Priority Area: Prevent Chronic Diseases

Focus Area: Reduce Obesity in Children and Adults

Disparity: Low-income residents

Goal: Create community environments that promote and support healthy food and beverage choices and physical activity.

Objective	Interventions/ Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?
By December 31, 2018, at least 15 organizations will implement a policy or practice change that impacts healthy food and beverage procurement (Baseline 11/2016= 10). At least 8 of these will be institutions that primarily serve low-income clients (Baseline 11/2016= 5).	Work with institutions (hospitals, municipal employers, private employers, non-profits, schools, etc.) to improve nutrition standards (policy or practice change) for healthy food and beverage procurement.	# institutions adopting/maintaining healthy meeting, beverage and/or vending policies	BMH, CCDHHS, TCC, TLC, WCA, WMH will ensure that healthy vending policies are being implemented.	Staff time	1/17, 1/18	Yes
		# institutions serving primarily low-income clients or employees adopting/ maintaining healthy beverage, meeting and/or vending policies	CCDHHS, CCHN, and CHAT will recruit and assist organizations in developing policy and practice changes.	Staff time, printed materials, sample policies, travel time and costs as needed	12/18	Yes
By December 31, 2018, at least 6 hospitals and/or community agencies will establish a mechanism to promote access to local foods, including promotion of the Chautauqua Grown website and initiative.	Promote Chautauqua Grown (online local foods directory) to clients, patients, and general public.	# hospitals and partners promoting Chautauqua Grown	CCE to upkeep website, work to identify local food access points, provide promotional materials.	Staff time, printed materials, funds for promotional materials.	Ongoing through 12/18	No
			BMH, TLC, WCA, WMH will convene marketing staff to develop plan for how to promote to patient and employee populations	Staff time, marketing tools and funds as plan is identified, meeting space.	3/18	No
			CCDHHS, CCHN, CCE, CHAT to promote Chautauqua	Staff time, social media outlets	Ongoing through	No

			Grown to general public through social and traditional media outlets.		12/18	
Growing Food Connections will identify local policy-level changes that should be made to improve the sustainability of the local food system.	TBD		Growing Food Connections Steering Committee to identify local opportunities for action to increase sustainability of the local foods system.	Staff time, travel time and costs,	12/17	No
Increase access to fresh, local produce.	# new outlets serving fresh, local produce		WCA and BMH to continue to offer farmer's markets on site during the growing season.	Staff time, promotional materials, space.	Ongoing through 12/18	No
			WMH to explore possibility of acting as an OFA farmer's market coupon distribution site.	Staff time, promotional materials, space.	3/18	Yes
			CCHN continue to work with Noe Place and others on healthy corner store initiative.	Staff time, grant funds	Ongoing through 12/18	Yes
WCA will offer lower saturated fat and increase healthier options for entrees in the WCA Cafeteria and promote healthy eating among employees.	# sales for Grab N Go entrée choices in cafeteria for 2017. # employee recipe submissions for Grab N Go less than 500 calories campaign.		WCA will educate employees about benefits of choosing low fat/cholesterol items; promote healthy snacks during meetings and in departments; remove fryer from cafeteria and replace with Grab N Go <500 calorie meals; engage employees in <500 calorie entrée recipe contest; hold	Staff time, funds for promotional materials, posters, etc.	Ongoing through 12/2018	No

			monthly drawings to make submissions as healthy options to be sold in cafeteria.			
By December 31, 2018, at least 50 organizations will submit a CHQ250 pledge to do at least one thing to create a healthier environment for users (Baseline 11/2016= 4).	Obtain CHQ250 pledges from community organizations to commit to making change to promote healthy places	# organizations that signed CHQ250 pledges	CHAT partners recruit organizations, groups, etc. to submit pledges.	Staff time, printed materials.	Ongoing through 12/18	No
			CCDHHS purchase window clings and blood pressure cuffs to promote CHQ250.	Staff time, funds for window clings and BP cuffs.	12/16	No
By December 31, 2018, at least 9 Chautauqua County municipalities will have Complete Streets policies in place (Baseline: 11/2016= 7).	Offer Complete Streets trainings and technical assistance to interested municipalities.	# policies in place	CCDHHS, CCHN (CHSC grant) to reach out to communities to gauge interest, hold trainings. (Falconer, Westfield Fall 2016)	Staff time	Ongoing through 12/18	Yes
Disparity objective: By December 31, 2018, 2 new municipalities with census tracts designated as low income, low access (USDA ERS map) will pass Complete Streets policies.	Offer guidance to participating municipalities to encourage compliance with existing policies	# CS improvements implemented	CCHN will hire groups and individuals in CHSC districts to conduct walkability assessments, identify opportunities for improvement.	CHSC grant funds, staff time	Summer 2016- Summer 2017	Yes
			CCDHHS, CCHN to offer technical assistance, presentations, materials, etc.	Staff time, materials	Ongoing through 12/18	Yes
			Municipalities reach out to CCHN, CCDHHS as needs arise. CCHN, CCDHHS inform municipalities of grant opportunities.	Staff time	Ongoing through 12/18	Yes

<p>By December 31, 2018, at least 8 school districts in Chautauqua County will adopt and implement wellness policies that support healthier foods and increased opportunities for physical activity.</p> <p>Disparity Objective: At least 5 low-income school districts will adopt and implement wellness policies.</p>	Educate school districts about the Whole School, Whole Community, Whole Child model.	# schools participating in ICE-8 initiative, CHSC grant	BOCES, CCDMH, CCDHHS, CCHN encourage schools to participate in ICE-8.	Staff time	8/2016	Yes
	Provide Michigan Model curriculum to school districts.	# schools trained and implementing Michigan Model	CCDHHS, CCDMH provide funds to purchase Michigan Model for all school districts.	Staff time, local funds	1/2016	Yes
			BOCES offer Michigan Model trainings and technical assistance.	Staff time, training space	6/2016	Yes
			Schools incorporate Michigan Model curriculum into classrooms	Staff time	9/2016	Yes
	Provide technical assistance for assessment and development of plans, as well as linkages to community services.	# schools with completed School Health Index and Healthier School Report Card # schools with improved wellness plans	Schools sign on to ICE-8 co-ser or agree to participate in CHSC grant. Provide space for community conversations.	Staff time, meeting space	12/2017	Yes
			CCHN CHSC staff work with schools to complete assessments, hold community conversations.	Staff time, grant funds	6/2017	Yes
			BOCES hires School Health Specialist to work with school districts.	Staff time, personnel funds	1/2017	Yes
			School Health Specialist meets with schools, provides technical assistance to complete assessments, hold	Staff time, funds	12/2017	Yes

	community conversations, and develop plans.					
	Schools work with students to become youth advocates for the community, with assistance of BOCES.	Staff time, BOCES training funds	12/2017	Yes		
	CCDHHS regularly convenes community partners to develop community side of ICE-8.	Staff time, meeting space	Ongoing through 12/2018	Yes		
	WMH to offer health screening and healthy lifestyle education opportunities at schools in service area.	Staff time, educational materials	Ongoing through 12/2018	No		

Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

Disparity: Low-income residents

Goal: Promote evidence-based care to manage chronic diseases.

Objective	Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?
By December 31, 2018, increase by 30% the number of Chautauqua County Adults that have completed chronic disease self-management programs, including Living Healthy and National Diabetes Prevention Program Classes. (Baseline: 332 (140 NDPP completers, 192 LH completers), 2013-November 2016)	Coordinate trainings, provide outreach to physician offices, and enroll referred patients into appropriate classes.	# of patients enrolled in programs, # of patients who complete programs	CCHN will coordinate trainings, provide outreach to physician offices, and enroll referred patients into appropriate classes.	Staff time, outreach materials	Ongoing through 12/18	No
	Hospitals will convene marketing staff to promote evidence-	Plan developed (yes/no)	BMH, TLC, WCA, WMH marketing personnel meet to	Staff time, meeting space, marketing funds as identified.	03/2017	No

Objective	Interventions/ Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?
	based programs to patients and residents.		develop marketing strategy.			
	Train new NDPP and Living Healthy leaders from hospital, government, non-profit and community settings.	# of new leaders trained	CCHN will identify training opportunities. BMH, TLC, WCA, WMH will identify and send staff to trainings.	Training funds, staff time, meeting space	06/2017	No
	Hospitals will host at least 1 LH and 1 NDPP class per year.	# classes held by hospital/year	BMH, TLC, WCA, WMH host at least 1 training per year.	Staff time, Meeting space.	12/2017, 12/2018	No
			WCA will continue to provide referrals to community-facilitated NDPP support group for those who have completed the program.	Staff time	Staff time	No
By December 31, 2018, at least 10 primary care practices in the Chautauqua Integrated Delivery Network will be aligned with Million Hearts initiative benchmarks for success.	CCHN will train practices to use best practices for monitoring blood pressure in patients, and train them to educate patients about the ABCS (aspirin when appropriate, blood pressure control, cholesterol control, and smoking cessation).	# practices (and # practices that serve low-income populations) using evidence-based practices to measure blood pressure	CCHN will train practices and track participation in program.	Staff time	Ongoing through 12/2018	Yes
Disparity objective: At least 5 PCPs who serve low-income populations will align with Million Hearts initiative benchmarks.		# practices educating patients about	CHAT coalition will continue to work on promoting community messages that mirror Million Hearts ABCS goals.	Staff time, meeting space, media outlets, funds to pay for promotional and educational materials and tools.	Ongoing through 12/2018	Yes

Objective	Interventions/ Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?
		ABCS	BMH, WCA, WMH, and TLC will provide smoking cessation services.	Staff time, meeting space, cessation tools	Ongoing through 12/2018	Yes
			WCA to explore feasibility of offering carotid artery scans; educate community about designated Stroke Center status.	Staff time, funds to purchase scanner	12/2017	No
			WMH will offer monthly blood pressure screenings at community locations.	Staff time, travel, medical equipment	Ongoing through 12/2018	No
			BMH will offer annual blood screening program that includes a colorectal screening kit.	Staff time, educational materials, kits	12/2017, 12/2018	No
	CCHN will monitor MH benchmarks to track success of practices.	Observed improvements in patient blood pressure and cholesterol numbers, # of patients who have quit smoking.	CCHN will track improvements in patient records.	Staff time, technology tools.	Ongoing through 12/2018	Yes

Objective	Interventions/ Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?
By December 21, 2018, at least 15 hands-only CPR trainings (reaching at least 250 community members) will be held throughout Chautauqua County.	Educate community members about heart attack and stroke symptoms, and educate them on how to do hands-only CPR. .	# trainings held, # participants trained	CCDHHS and CHAT will provide trainers.	CCDHHS and CHAT member staff time, CC Emergency Services manikins, CCDHHS technology (computers, speakers, etc.),	12/2017, 12/2018	No
			BMH, TLC, WCA, WMH will host at least 1 hands-only CPR training in their services areas per year.	Training spaces as identified by hospitals, hospital staff time, marketing tools/funds as needed.	12/2017, 12/2018	No

**Priority Area: Promote Healthy Women, Infants, and Children
(Not including TLC Health Network or Westfield Memorial Hospital)**

Focus Area: Maternal and Infant Health

Goal: Reduce premature births; Increase the proportion of babies who are breastfed

Objective	Interventions/ Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?
By December 31, 2018, increase by 30% the number of income-eligible pregnant and parenting moms who participate in maternal home visiting programs. (Baseline= 672 mothers (as of 11/16))	Offer evidence-based home visiting programs including CCDHHS MICHC Community Health Worker Program, CCDHHS Nurse Family Partnership, and TCC Community Health Worker Program. Combine efforts and offer central intake to connect patients with	# moms and babies enrolled in programs	CCDHHS, TCC continue to offer home visiting programs.	Staff time, grant funds, travel costs, promotional and educational materials	Ongoing through 12/2018	No
			MCC provides funding for TCC CHW Program.	Grant funds	Ongoing through 12/2018	No
			CHP provides funding to run CCDHHS NFP.	Grant funds	Ongoing through 12/2018	No

Objective	Interventions/ Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?
	appropriate programs and educate providers and community partners about services.		CCDHHS and TCC convene to plan for central intake and collaboration; carry out plans.	CCDHHS, TCC Staff time, meeting space	11/2016	No
			WCA's prenatal clinic (Chautauqua OB/GYN) refers patients to home visiting programs.	Staff time	Ongoing through 12/2018	No
	Provide maternal smoking cessation services.	# moms who have made quit attempts and successfully quit smoking	CCDHHS and TCC offer maternal smoking cessation programs through home visiting programs.	Staff time, grant funds, cessation tools and equipment	Ongoing through 12/2018	No
			WCA and BMH offer Baby & Me Tobacco Free Program.	Staff time, cessation tools and equipment, Baby & Me resources	Ongoing through 12/2018	No
	Hold Chautauqua County Maternal and Infant Health Coalition meetings to engage community partners in collaborative efforts and cross-promote programs.	# partners engaged	CCDHHS to host MIH Coalition meetings. Gateway Center to offer meeting space.	Staff time, meeting space	Quarterly through 12/2018	No
	Educate mothers about child birth and breastfeeding.	# moms participating in education sessions	WCA and BMH offer child birth and breastfeeding educational classes	Staff time, education spaces, promotional materials, educational materials	Ongoing through 12/2018	No

Objective	Interventions/ Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?
			to expectant parents.			
	Conduct visits at hospital maternity wards to connect any eligible new moms with home visiting programs.	# moms visited at WCA and BMH	CCDHHS, TCC to conduct ward rounds; BMH and WCA to provide access to patients.	Staff time, promotional materials	Weekly through 12/2018	No
By December 31, 2018, increase the number of lactation professionals (goal=25) and community support groups (goal=2) available to help breastfeeding mothers. (Baseline: 17 CLCs, 2 IBCLCs, 1 Baby Café (as of 12/16).	Provide resources and access to educational opportunities to increase the number of individuals trained to offer breastfeeding support to mothers.	# practicing CLCs and IBCLCs in Chautauqua County	CCDHHS provides grant funds and/or CLC training opportunities to WCA, BMH, practices, partners, and Baby Café.	CCDHHS grant funds, partner staff time to participate in CLC trainings and provide lactation support to patients/clients.	12/2016	No
			CCDHHS hosts CLC training in Jamestown.	CCDHHS staff time, JCC training space	05/2017	No
	Collaborate with community groups and breastfeeding advocates to establish and sustain community-led support systems (support groups or Baby Cafes).	# community-led breastfeeding support systems, # moms who participate in programs	CCDHHS, BMH, WCA engage with community advocates, participates in community meetings, and promotes programs.	CCDHHS, BMH, WCA staff time, grant funds, promotional materials (Breastfeeding Resource Guides)	Ongoing through 12/2018	No
	Provide assistance through Chautauqua County Breastfeeding Helpline.	# calls to helpline, # follow-up home visits	CCDHHS staffs BF helpline. WCA, BMH refer patients to line.	CCDHHS staff time, grant funds; BMH, WCA staff time	Ongoing through 12/2018	No
	Maintain "Chautauqua	# people in	CCDHHS maintains	CCDHHS staff time	Ongoing	

Objective	Interventions/ Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?
	County Breastfeeding Moms (and moms to be!)” closed Facebook group.	closed Facebook group	page, refers patients to group during ward rounds.		through 12/2018	No
By December 31, 2018, 2 hospitals will participate in NYSDOH Hospital Breastfeeding initiatives.	WCA and BMH will participate in either Great Beginnings NY or Breastfeeding Quality Improvement in Hospitals Initiatives.	# hospitals that participated in GBNY or BQIH programs	WCA, BMH to enroll in and fulfill requirements of NYSDOH programs.	WCA, BMH staff time	Ongoing through 12/2018	No
	WCA and BMH will adopt policies and practices that support breastfeeding moms and remove formula handouts.	# BF policies established	WCA, BMH OB and Maternity Units will partner with hospital administration to establish and carry out breastfeeding-friendly policies.	WCA, BMH staff time	12/2016	No
By December 31, 2018, at least 8 employers will make policy, promotional, or physical changes to support breastfeeding mothers in the workplace.	Provide outreach and trainings, policy and environmental examples, Making it Work Toolkit to employers.	# employers trained # employers reached out to # policy or environmental changes made	CCDHHS conducts outreach to employers to encourage policy and environmental changes to support BF moms. WIC provides training support.	CCDHHS staff time, grant funds, WIC staff time, training space (JCC)	Ongoing through 12/2018	No
			BMH and CCDHHS establish on-site lactation rooms.	BMH, CCDHHS physical space, grant funds, renovation costs	12/2017	No
By December 31, 2018, at least 3 OB/GYN, Family, or Pediatric Providers will be designated as NYSDOH Breastfeeding	CCDHHS provides support to interested practices.	# designated practices	CCDHHS identifies interested practices, provides technical assistance to help	Staff time, grant funds	Ongoing through 12/2018	No

Objective	Interventions/ Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?
Friendly Practices.			obtain designation.			

Focus Area: Reproductive, Preconception and Inter-Conception Health

Goal: Reduce rates of teen and unplanned pregnancy.

Disparity: Reduce unplanned pregnancies among patients in care for mental health or substance abuse disorders.

Objective	Interventions/ Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?
By December 31, 2018, both BMH and WCA will increase access to long acting reversible contraceptives (LARCs) by providing post-delivery or through prenatal clinics.	BMH and WCA will convene meetings with perinatal experts to obtain expert opinions on post-delivery LARC insertion. CCDHHS will partner as needed.	# hospitals implementing post-delivery LARC methods	BMH, WCA meet w/experts, carry out plans.	Staff time, access to perinatal specialists, meeting space	12/2017	No
			Chautauqua OB/GYN offers LARCs and other birth control methods to patients post-delivery.	Staff time	12/2017	Yes
			CCDHHS offers access to LARC training opportunities as needed.	Staff time, access to trainers.	06/2018	No
By December 31, 2018, CCDHHS will improve reproductive health referral processes by partnering with at least 7 community organizations. Disparity objective: By December 31, 2018, CCDHHS will partner with at least 5 Mental Health and Substance	CCDHHS will conduct assessment of reproductive health services in Chautauqua County to determine needs and opportunities for improvement.	Assessment completed	CCDHHS conducts assessment, health care providers complete surveys and interviews.	Staff time, grant funds, interviewee time	12/2016	No
	Connect interested	# providers	CCDHHS connects	Staff time, access to	12/2017	No

Objective	Interventions/ Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?
Abuse agencies to improve access to birth control methods for patients at risk for substance use.	practices with Family Planning Benefit Program and LARC insertion trainings.	trained in FPBP or LARC insertion	interested parties with appropriate trainings.	training resources		
	Conduct outreach to agencies and institutions with access to women with high-risk for unplanned pregnancy (schools, mental health and substance abuse organizations, poverty action groups, etc.) to develop referral system (or possibly offer on-site clinics) to reproductive health services and especially LARCs.	# referral systems established	CCDHHS meets with identified agencies to identify needs and establish referral systems.	Staff time, meeting space, partner time and resources, promotional materials	12/2017	Yes

Priority Area: Promote Mental Health and Prevent Substance Abuse

Focus Area: Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders

Goal: Prevent underage drinking, non-medical use of prescription pain relievers by youth, and excessive alcohol consumption by adults.

Objective	Interventions/ Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?
By December 21, 2017, CCCHPT will develop a plan to engage local medical providers in patient education around safe medication disposal, monitoring of patient pain	CCCHPT will convene a workgroup to identify issues leading to miscommunications between physicians and emergency rooms	Convening of work group Development of plan	BMH, CCDMH, CCDHHS, TLC, TCC, WCA, WMH, CASAC to identify work group members, convene group, and	Staff time, meeting spaces, accessing training opportunities	12/2017	No

Objective	Interventions/ Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?		
contracts, and other access issues that lead to prescription drug misuse.	and develop a plan to educate local physicians about how to inform patients about safe disposal of medications and reduce access to opiates. CCCHPT will partner with the Western New York Chemical Dependency Consortium.	Completion of plan	work to identify needs and opportunities for action.	CASAC to facilitate connection to WNY Chemical Dependency Consortium to access regional activities that mirror our local objective.	Staff time, connections to partners	6/2017	No	
			Work group to develop plan for action.			Staff time	12/2017	No
			Work group to carry out plan.			Staff time, training funds and materials as identified	12/2018	No
By December 31, 2018, collaborate with CASAC and Chautauqua HOPE Coalition to carry out environmental strategies to reduce prescription drug use by youth and adults.	Collaborate with community partners (CASAC and HOPE Chautauqua) to identify appropriate environmental and policy-level strategies to reduce access and increase awareness of prescription drug abuse in Chautauqua County.	# environmental and policy-level strategies carried out, # people impacted by strategies	CASAC and HOPE Chautauqua Coalition identify environmental and policy-level strategies.	Staff time, grant funds, meeting space	6/2017	No		
			CCDHHS, CCDMH, BMH, TLC, WCA, and WMH assist in carrying out environmental strategies as appropriate.				Staff time, marketing tools as identified, resources as available to assist	Ongoing through 12/2018

Objective	Interventions/ Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?
By December 31, 2018, identify at least 2 medical providers to implement SBIRT process.	Reach out to at least 10 local medical providers to gauge interest in implementing SBIRT (Screening, Brief Intervention, and Referral to Treatment) in medical settings. Monitor funding opportunities to identify sources that would fund an individual to provide technical assistance to practices.	# providers reached out to, # providers implementing SBIRT process	CCHN, CCDMH, CCDHHS to identify funding sources and conduct outreach to medical providers to gauge interest in SBIRT.	Staff time	12/2017	No
			BMH, TLC, WCA, WMH to identify opportunities to incorporate SBIRT within emergency room settings.	Staff time	12/2017	No
			CCHN, CCDMH, CCDHHS to provide technical assistance as appropriate.	Staff time	12/2018	No

Focus Area: Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders

Goal: Prevent suicides among youth and adults.

Objective	Interventions/ Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?
By December 31, 2018, hold at least 8 Mental Health First Aid trainings (2 in each hospital service area) open to employees, patients and community members.	Host community-level Mental Health First Aid trainings to identify and assist individuals experiencing one or more mental health crises or are in the	# trainings hosted by each hospital # individuals trained	BMH, TLC, WCA, WMH to identify appropriate training venues and times (at least 1 training per year in 2017 and 2018).	Staff time, marketing, meeting space.	12/2017, 12/2018	No

Objective	Interventions/ Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity?
	early stages of one or more chronic mental health problems.		CCDMH, CHP to offer MHFA training resources (trainers, materials).	Staff time, grant/DSRIP funds	12/2017, 12/2018	No
			CCCHPT (all partners) collaborates with Community Alliance for Suicide Prevention to assist with community-level suicide prevention efforts.	Staff time, media connections	Ongoing through 12/2018	No

Maintaining Engagement

By committing to collaborate on the initiatives described above, the Chautauqua County Community Health Planning Team (CCCHPT) will maintain close contact during the project period. CCCHPT and partners county-wide understand that to make real, long-term change, we must work together. In addition to intense topic-specific collaboration involved as described above, CCCHPT partners will meet quarterly to review the CHIP, assess progress, and make appropriate amendments to these plans. Each partner will report out on respective tracking indicators at quarterly meetings.

The Chautauqua County Department of Health and Human Services will coordinate periodic meetings. The tentative meeting schedule for the CCCHPT for 2017-2018 is as follows:

- January, April, July, October 2017
- January, April, July, October 2018

Plans for Dissemination

The CCCHPT will make the 2016-2018 Community Health Assessment and Community Health Improvement Plan available to the community through a number of means.

These include:

- Posting the Executive Summary and Report on the following websites:
 - Brooks Memorial Hospital: <http://www.brookshospital.org/>
 - Chautauqua County DHHS: <http://www.co.chautauqua.ny.us/219/Health-Human-Services>
 - TLC Health Network: <http://tlchealth.org/>
 - WCA Hospital: <https://www.wcahospital.org/>

- Westfield Memorial Hospital: <https://www.ahn.org/locations/saint-vincent-hospital/westfield-memorial-hospital>
- Developing a press release and distributing to all local media outlets
- Posting links to the Executive Summary and Report on social media outlets
- Sharing documents and links to documents with community partners at various coalition and workgroup meetings
- Forwarding links 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 CCCHPT will additionally respond to any earned media requests generated from this outreach.

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