

# WCA Hospital Comprehensive Community Service Plan 2013-2015

## 1. WCA Hospital Our Mission

The mission of the WCA Hospital is to improve the health and well being of the people of Chautauqua County and the surrounding area in a way that includes compassion, dedication, and a commitment to quality, while maintaining economic viability and a vision for the future. **WCA's Goals and Objectives** are to continuously meet the healthcare and socio-economic needs of the population we serve through ongoing community health improvement planning and prevention programs, the development and enhancement of clinical services with state of the art diagnostic equipment, recruitment and placement of primary care physicians, and creating access to quality care through our Charity Care Program initiatives.

## 2. DEFINITION AND BRIEF DESCRIPTION OF THE COMMUNITY SERVED

### Describe the method (s) used to determine the service area (e.g. zip codes, census data etc.)

The organization's service area is reviewed periodically as part of the organization Strategic Plan. The review includes market share data of services provided by zip codes along with population and demographic data. Generally, any zip code where 75% of the admissions are at WCA are considered to be primary service areas. WCA designs our community service plan around our community's needs. The present plan extends to cardiology, cancer treatment, general surgery, orthopedic care, women's services, behavioral health, community preventative services, and primary and emergency department care.

### Brief description of the community served

WCA provides service to an economically challenged, rural population of approximately 160,000 people in Chautauqua County, NY and areas of Western Cattaraugus County, NY and in Northwestern Warren County, PA. We operate two inpatient facilities - WCA Hospital, a 254-bed full-service community hospital, and Jones Memorial Health Center, an 88-bed facility. WCA is classified as a large community hospital that delivers coordinated medical services to provide a multi-specialty approach to patients presenting with complex acute and chronic problems. In particular, we provide specialty care for people with chronic illnesses such as diabetes, cancer, heart disease, respiratory disease, neurologic disorders, renal disease and digestive disorders.

Chautauqua County is made up of two cities, Dunkirk and Jamestown.

The vast geographic area of the County coupled with the fact that almost half of its residents are sparsely populated throughout the rural area lends itself to **transportation and access to healthcare challenges.**

Chautauqua County is one of the poorest counties in the state. **14.5%** of all county residents live **below the federal poverty level.**(U.S. Census Bureau 2007 – 2011)

Hispanics are the fastest growing ethnic group in the County and in the nation, currently making up 5.9% of the County's population. **Language and cultural differences** can create barriers to the provision of health knowledge, health education and service delivery. **57.1% primarily speak Spanish.**

Other populations residing within the county that WCA also serves are the migrant families, Seneca Nation reservations, the Amish and the homeless

### 3. PUBLIC PARTICIPATION

#### **Identifies the participants involved in assessing community health needs and their roles**

The Chautauqua County Health Planning Team (CCHPT) partners involved along with WCA Hospital in the joint planning sessions for the Chautauqua County Community Health Assessment (CHA) the Community Health Improvement Plan (CHIP) and individual Community Service Plan (CSP) processes are: Chautauqua County Health Department, Chautauqua County Health Network, Chautauqua County Mental Health, Lake Erie regional Health System of New York ( Brooks and TLC), The Chautauqua Center, and Westfield Hospital and P2 Collaboration of WNY

#### ***CCCHPT Participating Organizations***

- The Woman's Christian Association (WCA Hospital) of Jamestown, NY is a not-for-profit acute care hospital which provides service to an economically challenged, rural population of approximately 160,000 people in Chautauqua County, Western Cattaraugus County, NY, and Northwestern Warren County, PA. WCA operates two inpatient facilities: WCA Hospital, a 277-bed full-service community hospital, and Jones Memorial Health Center, an 40-bed facility. Services provided include cardiology, cancer treatment, general surgery, orthopedic care, women's services, behavioral health, community preventative services, and emergency department care.
- Established in 1898, Brooks Memorial Hospital provides a wide range of health care services to the communities surrounding Dunkirk and Fredonia, NY with an emphasis on quality and caring. Current offerings include Acute Care, Cardiac Rehabilitation, Cardiopulmonary, Diagnostic Imaging, Dialysis, Emergency Care, Gastroenterology, Laboratory Services, Obstetrics, Physical Therapy, Short Term Rehabilitation, Sleep Studies, Surgical Care, and Women's Imaging. Brooks Memorial Hospital is also a member of Lake Erie Regional Health System of New York.
- The Chautauqua County Department of Health and Human Services (CCDHHS) protects and promotes the health, safety and self-reliance of Chautauqua County residents and provides essential human services, especially for those who are least able to help themselves. Divisions of the CCDHHS include: Administrative Services, Public Health, Family and Children Services, Temporary Assistance, Medical Assistance, Legal Affairs, and Youth Bureau. The Public Health Division...
- The Chautauqua County Department of Mental Hygiene provides accessible, comprehensive, integrated and outcome based mental hygiene services to Chautauqua County residents in a cost effective manner.
- Chautauqua County Health Network (CCHN) is comprised of the three hospital organizations, their governing boards and medical staff and is known for its proactive approach and participation in cutting edge projects. CCHN also has two sister-organizations, the Integrated Delivery System and Chautauqua Region Associated Medical Partners (AMP).
- TLC Health Network is comprised of Lake Shore Health Care Center - a full service hospital in Irving - and various outpatient facilities throughout Chautauqua and Cattaraugus Counties. Combined, these facilities offer a wide range of services to the people of Western NY, including Acute Care, Behavioral Health, Cardiac Rehabilitation, Cardiopulmonary, Chemical Dependency Counseling, Diagnostic Imaging, Emergency Care, Gastroenterology, Home Health Care, Laboratory Services, Long Term Care, Physical Therapy, Primary Care, Short Term Rehabilitation, Surgical Care, Urgent Care, and Women's Imaging. TLC Health Network is also a member of Lake Erie Regional Health System of New York.
- P<sup>2</sup> Collaborative of Western New York is a Robert Wood Johnson Foundation Aligning Forces for Quality organization which works to improve the health of Western New Yorkers. Efforts focus on quality improvement, community health planning, and health engagement programs. For the CHIP process, P2 provided extensive facilitation, oversight and guidance to the CCCHPT.
- The Chautauqua Center (TCC) is a federally qualified health center that provides family medicine and wellness outpatient services to individuals of all ages.

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- Westfield Memorial Hospital (Westfield, NY) As an affiliate of Saint Vincent Health System in Erie, Pa., Westfield Memorial Hospital offers direct access to highly specialized care, including the convenience of on-site physician specialists. Staffed by the area's finest physicians and medical professionals, we are committed to meeting the health care needs of area families for years to come
- P2 Collaborative of Western New York- P<sup>2</sup> (Pursuing Perfection) is a not-for-profit corporation, incorporated on August 22, 2002. The official name of the organization is P<sup>2</sup> Collaborative of WNY. Together with our multi-stakeholder partnerships: We work with communities to determine how to make their neighborhoods healthy places to live and work. We help to improve services to underserved patient populations. We help physicians, practices, and hospitals to improve the quality of care they deliver. We help coordinate programming to inspire Western New Yorkers to live healthier every day. P<sup>2</sup> works with individuals and organizations in Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming counties to improve the health of Western New Yorkers.

**Includes the dates and a brief description of the outcomes of the public input process describes how public notification of these sessions was accomplished.**

Public outreach for the community health planning process began with a **web-based survey**. The link for the survey was shared through Facebook, the CCDHHS website, was featured in a press release to local newspapers, and sent electronically to a number of email distribution lists. Paper copies of the survey were distributed in emergency rooms, reproductive health clinics, the federally qualified health center, Social Services Temporary Assistance offices, mental health clinics, Cancer Services Program clinics (to capture the Amish population) and the Chautauqua County Jail. In the survey, the CCCHPT asked respondents what issues they considered to be community problems, what health issues were most concerning, about their personal health, and also requested demographic information. The survey also asked residents which medical services they leave the county for and why.

From March 28 to June 2, 2013, 1,170 survey responses were collected: 1,027 responded electronically; 143 paper responses were collected. The majority of the respondents self-identified as Female (73.99%) and White/Caucasian (95.34%) and reported having some form of private health insurance (76.67%). The top three family and/or community problems identified on the survey were jobs (79.20%), not enough money (52.39%), and transportation (34.19%). The top three health issues individuals were more concerned about were health insurance (41.32%), obesity or overweight (37.43%), and cancer (23.24%).

Community members' perceptions of health issues were also gathered at three **"Community Conversations"** held in Dunkirk, Jamestown, and Westfield sponsored by the P2 Collaborative of WNY and the Chautauqua County Health Network. Community members were asked to give their perspective on community health and wellness issues and offer solutions in an open discussion facilitated by P2 Collaborative representatives

Following are each of the community conversations summarizing the discussions concerning barriers to care or gaps in services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### **4. ASSESSMENT AND SELECTION OF PUBLIC HEALTH PRIORITIES**

##### **Describe the collaborative process and criteria that were used to identify the priorities**

##### **Chautauqua County CHA/CHIP/CSP 2013** **Timeline of Events**

##### ***Planning Meetings- all CCHPT members and specific priority agenda focus groups***

- March 22<sup>nd</sup> 2013
- July 9<sup>th</sup> 2013
- August 5<sup>th</sup> 2013
- September 6<sup>th</sup> 2013
- September 13 Stakeholders Meeting
- September 24<sup>th</sup> 2013
- October 12 – Maternal Child Health Meeting

##### ***Outreach Events***

- Chautauqua County Community Health Survey (n = 1,170)
- Jamestown Community Conversation (WCA Hospital) – June 13<sup>th</sup> 2013
- Dunkirk Community Conversation (LERHSNY) – June 20<sup>th</sup> 2013
- Westfield Community Conversation (Westfield Hospital) – June 26<sup>th</sup> 2013
- Chautauqua County Community Health Input Meeting – September 13<sup>th</sup> 2013

## ***Prevention Agenda Priority Area Selection***

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

**1) Prevent Chronic Diseases**

**Focus Area(s): Reduce Obesity in Children and Adults**

**Disparity: Low-income residents**

**2) Promote Healthy Women, Infants, and Children**

**Focus Area(s): Preconception and Reproductive Health, Maternal and Infant Health**

**Disparity: Pregnant mothers who use drugs/drug addicted newborns**

**(Not including TLC Health Network or Westfield Memorial Hospital)**

**3) Promote Mental Health and Prevent Substance Abuse**

**Focus Area(s): Strengthen Infrastructure Across Systems**

### ***Stakeholder sessions that were held:***

The CCCHPT also held a meeting with local content area experts for the three identified priority areas. Professionals working in the fields of chronic disease prevention, mental health and substance abuse, and prenatal care were in attendance to observe outstanding statistics, and provide specific guidance for the CHIP. Twenty-seven community partners were in attendance. Another specific meeting held was with the health department and hospitals participating in the disparity area of newborn drug related discharge. Maternal and physician education and standardized tox screens to identify all drug addicted newborns were discussed along with breastfeeding

### ***The data and information used to select priorities***

***Data and Information*** Demographic data for Chautauqua County was gleaned from the United States Census Bureau website. Specifically, data from Census 2010 and the American Community Survey 2007-2011 were used to develop the demographic profile for the Community Health Assessment. Local level data that was not captured by the U.S. Census Bureau was requested from local agencies. For example, the migrant population figures were obtained from the SUNY Fredonia Migrant Outreach Program and information about the homeless population was provided by Chautauqua Opportunities Incorporated, The New York State Department of Health's Community Health Indicator Reports and Tracking Indicators for Public Health Priority Areas were extensively used to identify health issues in Chautauqua County. NYS Vital Statistics Data, Expanded Behavioral Risk Factor Surveillance System, and the Student Weight Status Category Reporting System were also referred to throughout the planning process. Additional data was provided by the NYSDOH through the Community Transformation Grant, "Community Transformation in Small Communities Grant (CTG) Population Survey Preliminary Frequencies from Baseline Data. Local data sources that offered information included: Chautauqua County Department of Mental Hygiene.

Supporting Data for Top 3 Prevention Agenda Priority Areas

**Promote Mental Health and Prevent Substance Abuse**

*Community Health Survey*

24% of respondents ranked Mental Health as a top priority

12% of respondents ranked alcohol and drug abuse as a top priority

Mood most of the time

18% said worried, tense, or anxious

7% said sad, blue, depressed

*Community Conversations*

Listed specifically as an area of need at Dunkirk and Westfield conversations. Mentioned in Jamestown but did not top the list as a priority.

*Secondary Data- NYSDOH*

**Injury Indicators - Chautauqua County 2008-2010**

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
<b>Suicide mortality rate per 100,000</b>								
Crude	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	42	10.4	7.1	Yes	8.4	No	3rd
Age-adjusted	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	42	9.7	6.8	No	8.1	No	3rd
Ages 15-19 years	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	2	6.2*	4.0	No	4.9	No	3rd
<b>Alcohol related motor vehicle injuries and deaths per 100,000</b>	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	216	53.7	36.2	Yes	50.0	No	2nd

**Tobacco, Alcohol and Other Substance Abuse Indicators - Chautauqua County 2008-2010**

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
<b>Drug-related hospitalization rate per 10,000</b>								
Crude	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	740	18.4	27.3	Yes	21.2	Yes	2nd
Age-adjusted	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	740	20.1	27.2	Yes	21.8	Yes	3rd
Newborn drug-related hospitalization rate per 10,000 newborn discharges	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	63	157.1	64.0	Yes	78.4	Yes	4th
Alcohol related motor vehicle injuries and deaths per 100,000	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	216	53.7	36.2	Yes	50.0	No	2nd
Age-adjusted % of adults who smoke cigarettes (2008-2009)	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	26.0	17.0	Yes	18.9	Yes	4th
Age-adjusted % of adults living in homes where smoking is prohibited (2008-2009)	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	74.5	80.9	No	79.3	No	3rd
Age-adjusted % of adults who binge drink (2008-2009)	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	20.5	18.1	No	19.8	No	3rd

Newborn drug-related hospitalization rate per 10,000 newborn discharges, 2009-2011

ICD -9 groups	Description	Chautauqua		NYS
		Count	Rate	Rate
76070	Unspecified noxious substance Fetus or newborn affected by:...	0	0	1.90
76072 and 76073	Narcotics and Hallucinogenic agents	9	22.40	13.90
76075	Cocaine	9	22.40	10.13
76079	Fetus or newborn affected by: immune sera transmitted via placenta or breast milk medicinal agents NEC transmitted via placenta or breast milk toxic substance NEC transmitted via placenta or breast milk	25	62.30	23.64
7635	Maternal anesthesia and analgesic reactions and intoxication	0	0	1.73
7795	Drug withdrawal syndrome in newborn	27	67.20	20.37
Total		70	174.30	72.60
# Births for Chautauqua		4016		

**Prevent Chronic Diseases**

*Community Health Survey*

Priority ranking:

37% listed overweight/obesity

23% listed cancer

22% listed physical activity

19% listed nutrition

13% listed diabetes

11% listed high blood pressure

10% listed heart disease

14% were daily tobacco users, 1% weekly, 5% sparingly

*Community Conversations*

Listed as an area of need at all 3 conversations. Dunkirk- food options and education; Jamestown- motivation, lack of fitness programs, access to healthy food; Westfield- obesity, diabetes, motivation

*Secondary Data- NYSDOH*

## Obesity and Related Indicators – Chautauqua County 2008-2010

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
<b>All students (elementary – PreK, K, 2<sup>nd</sup> and 4<sup>th</sup> grades, middle – 7<sup>th</sup> grade and high school – 10<sup>th</sup> grade)</b>								
% overweight but not obese (85 <sup>th</sup> -less than 95 <sup>th</sup> percentile) #	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	11.3	N/A	N/A	14.7	N/A	1 <sup>st</sup>
% obese (95 <sup>th</sup> percentile or higher) #	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	17.8	N/A	N/A	16.5	N/A	3 <sup>rd</sup>
% overweight or obese (85 <sup>th</sup> percentile or higher) #	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	29.2	N/A	N/A	31.3	N/A	2 <sup>nd</sup>
<b>Elementary students (PreK, K, 2<sup>nd</sup> and 4<sup>th</sup> grades)</b>								
% overweight but not obese (85 <sup>th</sup> -less than 95 <sup>th</sup> percentile) #	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	9.0	N/A	N/A	13.3	N/A	1 <sup>st</sup>
% obese (95 <sup>th</sup> percentile or higher) #	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	14.9	N/A	N/A	15.2	N/A	3 <sup>rd</sup>
% overweight or obese (85 <sup>th</sup> percentile or higher) #	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	24.0	N/A	N/A	28.5	N/A	2 <sup>nd</sup>
<b>Middle and high school students (7<sup>th</sup> and 10<sup>th</sup> grades)</b>								
% overweight but not obese (85 <sup>th</sup> -less than 95 <sup>th</sup> percentile) #	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	14.7	N/A	N/A	16.6	N/A	2 <sup>nd</sup>
% obese (95 <sup>th</sup> percentile or higher) #	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	22.1	N/A	N/A	18.3	N/A	4 <sup>th</sup>
% overweight or obese (85 <sup>th</sup> percentile or higher) #	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	36.9	N/A	N/A	34.9	N/A	3 <sup>rd</sup>
% of pregnant women in WIC who were pre-pregnancy overweight but not obese (BMI 25-less than 30) ~	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	678	23.2	26.6	Yes	26.3	Yes	1 <sup>st</sup>
% of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher) ~	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	873	29.9	23.4	Yes	26.7	Yes	3 <sup>rd</sup>
% obese (95 <sup>th</sup> percentile or higher) children in WIC (ages 2-4 years)	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	703	13.2	14.5	Yes	15.2	Yes	1 <sup>st</sup>
% of WIC mothers breastfeeding at 6 months	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	306	14.5	39.7	Yes	28.7	Yes	4 <sup>th</sup>
Age-adjusted % of adults overweight or obese (BMI 25 or higher) (2008-2009)	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	61.6	59.3	No	60.6	No	2 <sup>nd</sup>
Age-adjusted % of adults obese (BMI 30 or higher) (2008-2009)	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	27.4	23.1	No	24.3	No	2 <sup>nd</sup>
Age-adjusted % of adults who did not participate in leisure time physical activity in last 30 days (2008-2009)	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	77.9	76.3	No	78.9	No	2 <sup>nd</sup>
Age-adjusted % of adults eating 5 or more fruits or vegetables per day (2008-2009)	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	24.9	27.1	No	27.7	No	3 <sup>rd</sup>
Age-adjusted % of adults with physician diagnosed diabetes (2008-2009)	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	11.2	9.0	No	8.5	No	4 <sup>th</sup>
Age-adjusted % of adults with physician diagnosed angina, heart attack or stroke # (2008-2009)	<a href="#">(Table)</a> <a href="#">(Map)</a>	N/A	9.1	7.6	No	7.2	No	4 <sup>th</sup>
<b>Age-adjusted mortality rate per 100,000</b>								
Cardiovascular disease mortality	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	1,498	263.0	250.9	No	244.7	Yes	3 <sup>rd</sup>
Cerebrovascular disease (stroke) mortality	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	230	40.0	26.7	Yes	31.9	Yes	4 <sup>th</sup>
Diabetes mortality	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	124	23.4	16.6	Yes	14.9	Yes	4 <sup>th</sup>
<b>Age-adjusted hospitalization rate per 100,000</b>								
Cardiovascular disease hospitalizations	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	4,981	95.4	165.6	Yes	157.5	Yes	1 <sup>st</sup>
Cerebrovascular disease (stroke)	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	994	19.0	25.1	Yes	25.3	Yes	1 <sup>st</sup>

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

#### *Community Health Survey*

4% ranked unplanned pregnancy as a priority

## Community Conversations

Listed peripherally as a subset of other problems at each of the conversations. Family support, education children and parents about healthy lifestyles listed as a priority.

## Secondary Data- NYSDOH

### Family Planning/Natality Indicators - Chautauqua County 2008-2010

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
% of births within 24 months of previous pregnancy	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	1,056	25.1	18.0	Yes	21.1	Yes	3rd
<b>Percentage of births to teens</b>								
Ages 15-17 years	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	156	3.7	1.9	Yes	1.9	Yes	4th
Ages 15-19 years	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	547	13.0	6.6	Yes	6.8	Yes	4th
% of births to women 35 years and older	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	364	8.6	19.4	Yes	19.0	Yes	1st
<b>Teen pregnancy rate per 1,000 #</b>								
Ages 10-14 years	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	11	0.9	1.4	No	0.8	No	3rd
Ages 15-17 years	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	232	28.1	31.1	No	20.4	Yes	4th
Ages 15-19 years	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	740	46.0	53.5	Yes	37.4	Yes	3rd
Ages 18-19 years	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	508	65.1	84.1	Yes	60.3	No	2nd
<b>Abortion ratio (induced abortions per 100 live births) #</b>								
Ages 15-19 years	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	160	29.3	116.3	Yes	75.7	Yes	1st
All ages	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	751	17.8	46.6	Yes	27.7	Yes	2nd

### Maternal and Infant Health Indicators - Chautauqua County 2008-2010

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
<b>Percentage of births</b>								
% of births to women 25 years and older without a high school education	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	257	10.8	14.8	Yes	10.3	No	3rd
% of births to out-of-wedlock mothers	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	2,048	48.7	41.4	Yes	37.6	Yes	4th
% of births with early (1st trimester) prenatal care	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	2,747	68.8	72.8	Yes	75.2	Yes	4th
% of births with late (3rd trimester) or no prenatal care	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	284	7.1	5.9	Yes	4.3	Yes	4th
% of births with adequate prenatal care (Kotelchuck)	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	2,488	62.8	66.0	Yes	68.2	Yes	4th
<b>WIC indicators</b>								
% of pregnant women in WIC with early (1st trimester) prenatal care	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	2,495	84.2	85.6	No	86.3	No	3rd
% of pregnant women in WIC who were pre-pregnancy underweight (BMI less than 18.5)	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	150	5.1	4.6	No	4.1	Yes	3rd
% of pregnant women in WIC who were pre-pregnancy overweight but not obese (BMI 25-less than 30) ~	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	678	23.2	26.6	Yes	26.3	Yes	1st
% of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher) ~	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	873	29.9	23.4	Yes	26.7	Yes	3rd
% of pregnant women in WIC with anemia in 3rd trimester	<a href="#">(Table)</a> <a href="#">(Map)</a>	225	37.6	37.3	No	35.4	No	3rd
% of pregnant women in WIC with gestational weight gain greater than ideal	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	1,470	51.3	41.8	Yes	47.1	Yes	3rd
% of pregnant women in WIC with	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	205	7.5	5.5	Yes	5.7	Yes	4th

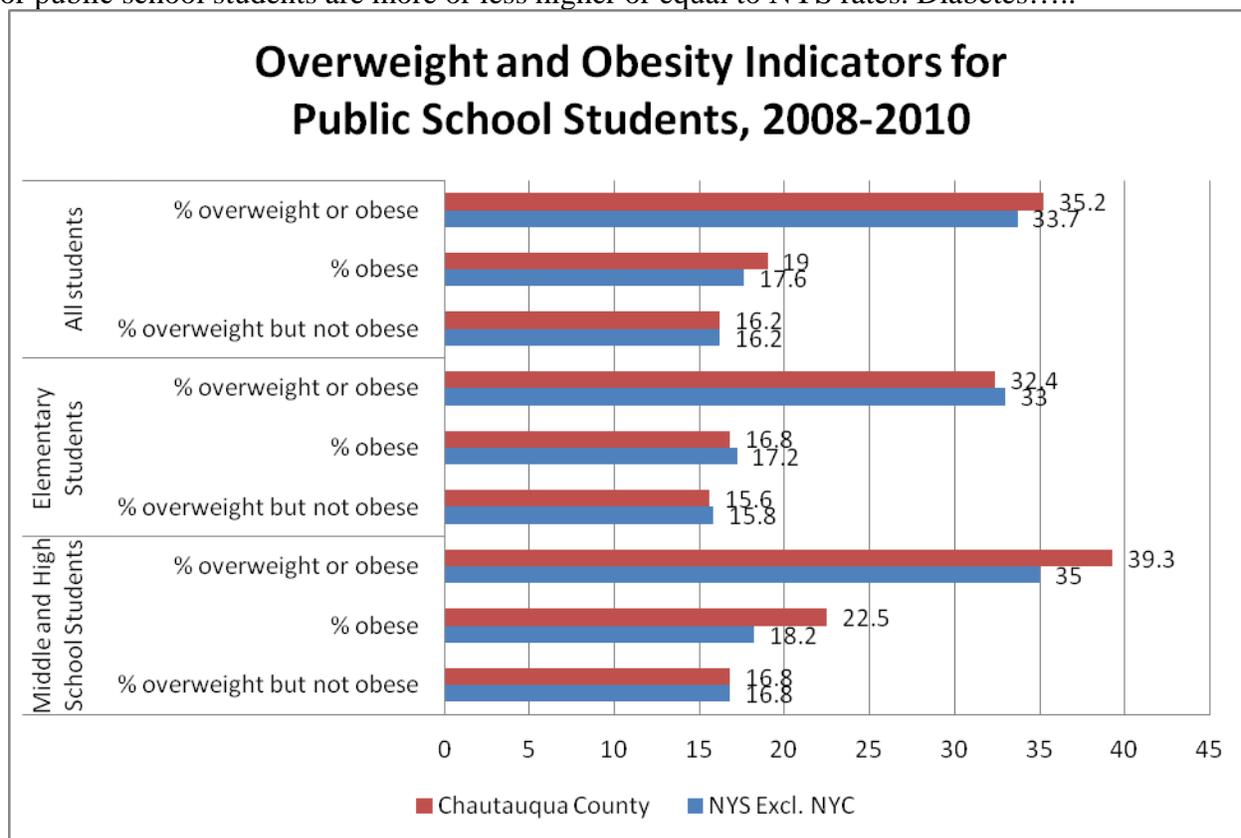
gestational diabetes									
% of pregnant women in WIC with hypertension during pregnancy	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	366	13.3	7.2	Yes	9.0	Yes	4th	
% of WIC mothers breastfeeding at least 6 months	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	306	14.5	39.7	Yes	28.7	Yes	4th	
% of infants fed any breast milk in delivery hospital	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	2,573	64.2	78.3	Yes	73.5	Yes	4th	
% of infants fed exclusively breast milk in delivery hospital	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	2,180	54.4	42.5	Yes	52.1	No	3rd	
% of births delivered by cesarean section	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	1,486	35.3	34.4	No	36.1	No	3rd	
<b>Mortality rate per 1,000 live births</b>									
Infant (less than 1 year)	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	36	8.6	5.3	Yes	5.7	Yes	4th	
Neonatal (less than 28 days)	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	23	5.5	3.6	No	4.0	No	4th	
Post-neonatal (1 month to 1 year)	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	13	3.1	1.7	No	1.7	No	4th	
Fetal death (>20 weeks gestation)	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	37	8.7	6.9	No	4.8	Yes	4th	
Perinatal (20 weeks gestation - 28 days of life)	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	60	14.1	10.4	Yes	8.8	Yes	4th	
Perinatal (28 weeks gestation - 7 days of life)	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	39	9.2	5.7	Yes	5.7	Yes	4th	
Maternal mortality rate per 100,000 live births +	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	0	0.0*	23.3	Yes	17.6	Yes	2nd	
<b>Low birthweight indicators</b>									
% very low birthweight (less than 1.5kg) singleton births	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	41	1.0	1.1	No	1.0	No	3rd	
% low birthweight (less than 2.5 kg) births	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	352	8.5	8.2	No	7.7	No	4th	
% low birthweight (less than 2.5kg) singleton births	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	271	6.7	6.2	No	5.7	Yes	4th	
<b>% of premature births by gestational age</b>									
less than 32 weeks gestation	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	81	2.0	2.0	No	1.9	No	3rd	
32 - less than 37 weeks gestation	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	387	9.7	9.9	No	9.3	No	3rd	
less than 37 weeks gestation	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	468	11.8	12.0	No	11.2	No	3rd	
<b>Newborn drug-related discharge rate per 10,000 newborn discharges</b>	<a href="#">(Table)</a> <a href="#">(Trend)</a> <a href="#">(Map)</a>	63	157.1	64.0	Yes	78.4	Yes	4th	

## THREE YEAR PLAN OF ACTION

**The Need: Chronic Disease: Obesity:** Consistent with New York State as a whole, statistics from the NYSDOH Vital Statistics and the Chautauqua County Health Assessment 2014-17 indicated that in 2011, the leading cause of death in Chautauqua County was heart disease. There were 452 deaths to heart disease in Chautauqua County, resulting in a rate of 231 per 100,000 residents. (NYS Vital Statistics Leading Causes of Death by County, NYS, 2011)

Stroke, or cerebrovascular disease, was the fourth leading cause of death in Chautauqua County in 2011. In total, 82 deaths were caused by stroke, with a rate of 43 deaths per 100,000 residents. (NYS Vital Statistics Leading Causes of Death by County, NYS, 2011)

Premature mortality rates which account for deaths to residents aged 35 to 64 years were significantly higher than both New York State excluding New York City and New York State for diseases of the heart and coronary heart disease. For all subgroups, the rates in Chautauqua County were greater than the state comparison groups. Overweight and Obesity Indicators for public school students are more or less higher or equal to NYS rates. Diabetes.....



NYS Overarching Objective 1.0.1: By December 31, 2017 reduce the percentage of public school children reported to the Student Weight Status Category Reporting System who are obese by 5% to 12.8% (Baseline: 17.8%; Target: 12.8%; Years: 2008-2010; Source: NYS Student Weight Status Category Reporting System)

NYS Overarching Objective 1.0.2: By December 31, 2017, reduce the percentage of adults ages 18 years or older who are obese by 5% to 22.3% (Baseline 27.3%; Target: 22.3%; Years: 2008-2009; Source: NYS BRFSS)

**Chautauqua County Goal 1:** Create community environments that promote and support healthy food and beverage choices and physical activity. (NYS Action plan Goal 1.1)

**Objective 1.1.** By December 31, 2017 decrease the percentage of adults ages 18 years and older who consume at least one soda or sugary drink per day by 5% (Baseline: 25%; Target: 20%; Year: 2013; Source: Community Transformation Grant Population Survey Preliminary Frequencies from Baseline Data Collection)

<i>Activities/Interventions</i>	<i>Date</i>	<i>Partner(s) Responsible</i>
Educate county residents (special low-income target areas: Dunkirk, Jamestown, Silver Creek) about healthy beverage choices through media campaign (radio, television, social media), utilizing Community Transformation Grant resources	1/14-9/14	CCDHHS
Provide presentations regarding healthy beverage choices to organizations throughout Chautauqua County and technical assistance for healthy beverage policy development (Tracking Indicator: number of new policies developed; Goal: 14 buildings by September 2014)	1/14-9/14	CCDHHS
Provide presentations to appropriate staff/boards representing hospitals and County buildings	3/14	CCDHHS
<b>Pass healthy beverage policy at each hospital and Chautauqua County buildings (Tracking Indicator: number of policies passed; Goal: 4 policies)</b>	3/14-9/14	BMH, CCDHHS, TLC, WCA, WMH
Work with local media outlets to highlight new policies (Tracking Indicator: number of earned media hits (radio, television, newspaper); Goal: 4 media hits)	3/14-9/14	CCDHHS
<b>Carry out specifications of healthy beverage policies</b>	9/14-1/15	BMH, CCDHHS, TLC, WCA, WMH
<b>Representative at each agency will inspect vending/sales to ensure standards set in policy are being met</b>	6/15, 12/15, 6/16, 12/16, 6/17, 12/17	BMH, CCDHHS, TLC, WCA, WMH
<b>Tracking Indicators:</b> Track sales data to identify increase or decrease in sales; if decrease is detected, work with vendors to identify new healthy products that will sell (Tracking Indicator: Sales figures before change, sales figures after change; Goal: no decrease in sales)	6/15, 12/15, 6/16, 12/16, 6/17, 12/17	BMH, CCDHHS, TLC, WCA, WMH
Continue to work with community organizations to develop healthy beverage policies	9/14-9/17	CCDHHS

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**Chautauqua County Objective 1.2:** By December 31, 2017, increase the number of adults who have been diagnosed with pre-diabetes that have participated in the National Diabetes Prevention Program by 300% (Target: 17.6%; Baseline: 22.6%; Year: 2008-2009; Source: NYSBRFSS)

**Tracking Indicators:** % population diagnosed with pre-diabetes

<i>Activities/Interventions</i>	<i>Date</i>	<i>Partner(s) Responsible</i>
Identify funding streams to expand NDPP in Chautauqua County	9/13-1/14	CCHN
Obtain funding to train 7 new National Diabetes Prevention Program Lifestyle Coaches in Chautauqua County	9/13-1/14	CCHN

7 employers in Chautauqua County will have staff person trained to offer DPP to employees and community at large	2/14-6/14	BMH, CCDHHS, CCHN, Cummins, TCC, TLC, WCA, WMH
Target primary care practices with high Medicaid populations to encourage referrals to NDPP for persons diagnosed with pre-diabetes (Tracking Indicators: Number of high Medicaid practices referring patients)	6/14-6/15	BMH, CCDHHS, CCHN, Cummins, TCC, TLC, WCA, WMH
Initiate at least 6 DPP programs for employees and community members (including lessons and follow-up sessions) (Tracking Indicators: number of programs initiated, number of participants)	6/15	BMH, CCHN, CCDHHS, Cummins, TCC, TLC, WCA, WMH
Collaborate to identify methods to increase sustainability of DPP in Chautauqua County	6/14-6/16	BMH, CCHN, CCDHHS, Cummins, TCC, TLC, WCA, WMH
Complete at least 6 DPP programs in Chautauqua County (Tracking Indicators: number of participants who completed program, pounds lost by participants individually and collectively, minutes of moderate to vigorous physical activity conducted each week by participants, participants' changes in A1C)	6/16	BMH, CCHN, CCDHHS, Cummins, TCC, TLC, WCA, WMH
Identify next steps	1/16-7/16	BMH, CCHN, CCDHHS, Cummins, TLC, TCC, WCA, WMH
<i>Objective 3: By December 31, 2017 increase availability of fresh and local produce to Chautauqua County residents.</i>		
Collaborate with Chautauqua Health Action Team and Cornell Cooperative Extension of Chautauqua County to identify ways to expand local food system (Farm to School, Farm to Table, Local Foods Coalition, Food Hub efforts)	1/14-12/17	BMH, CCDHHS CCHN, TLC, WCA, WMH
Plan hospital gardens, start seeds	2/14-	BMH, CCHN, WCA
Along with designated patients, plant starters	4/14-5/14	BMH, CCHN, WCA
Maintain and care for gardens; educate patients on how to care for gardens (Tracking Indicators: number of patients who help maintain gardens)	4/14-9/14	BMH, CCHN, WCA
Offer produce from gardens and produce from external farmers for sale to Chautauqua County residents	6/14-10/14	BMH, CCHN, WCA
Refer low-income patients and residents to local farmers; markets that accept SNAP benefits, WIC Vegetables and Fruits Checks, and Senior Farmers' Market Nutrition Program Coupons (Tracking Indicators: Number of WIC, SNAP, and Senior vouchers or dollars spent at markets)	1/14-12/14	BMH, CCDHHS CCHN, TCC, TLC, WCA, WMH
Donate produce from garden to low-income residents (ex/cancer treatment patients, Meals on Wheels, local soup kitchens)	6/14-10/14	BMH, WCA
Evaluate impact and success of healthy foods work through feedback from patients, employees, and visitors (satisfaction surveys, anecdotal evidence)	11/14-2/15	BMH, CCDHHS CCHN, TLC, WCA, WMH
Replicate step to identify new opportunities to expand program	3/15-	BMH, CCDHHS CCHN, TLC, WCA, WMH

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

NYS Goal 3.2: Promote use of evidence-based care to manage chronic diseases.

Tracking Indicators: (Baseline: 378.6 deaths per 100,000 residents; Target: 359.67 deaths per 100,000; Year: 2009-2011; Source: NYS Vital Statistics Mortality Data)

*Activities/Interventions*

Establish work group to coordinate *Million Hearts™* Initiative activities  
**SEE Chautauqua County Department of Health and Human Services / Community Health Improvement Plan (CCDHHS CHIP 2014-2017 )for full details of partnership activities and interventions pages 17 and 18.**

**Description of WCA Hospital Strategies – Prevention Agenda – Chronic Disease – Obesity Disparity**

**WCA Hospital What We Know:** Obesity - Having a body mass index (BMI) status that indicates overweight or obese (BMI > 30) conditions is a risk factor for several chronic diseases e.g. heart disease, stroke, cancer and especially the rise in Type 2 Diabetes in children and teenagers. Increasing education opportunities regarding healthy food and drink options, creating easy access to fresh, local produce, and physical activity are proven ways to reduce risk factors. The use of aspirin for those at risk for heart disease, blood pressure monitoring, cholesterol management and smoking cessation all have been noted to reduce risk factors especially to those in low income neighborhoods, working long shifts, or helping to prevent co-morbidities in those suffering from chronic disease.

**WCA Hospital What We Did:** From 2010-2012 CSP, WCA incorporated and increased its' healthier choice entrees in to our full service cafeteria as well as our patient dining experience. In 2011 we increased our sales by 5% of fruits and vegetables to employees through our WCA Farmers Market Express which travels to each department for easy access to locally grown produce. The establishment of a lush herb garden in the cafeteria during season has brought an increased

awareness of seasoning foods with fresh herbs. Our WCA chef uses the herbs from the garden in the cafeteria entrees and salad bar options. WCA's three raised vegetable garden beds (funded by Creating Healthy Places, Live, Work and Play) have not only harvested produce for our employee cafeteria but for outreach organizations such as Meals on Wheels. The gardens are also used as therapeutic gardens and tended by our in-patient adolescent behavioral health patients as part of their daily therapy sessions.

**WCA Hospital Next Steps:** Healthy Beverage Policy and Sustaining WCA Gardening Project

Evidence based research shows that people who drink one or more sodas or other sugary drinks per day are more likely to be overweight or obese than those who do not consume these drinks. WCA Hospital employs over 1100 people and offers cafeteria service and vending for 24 hours a day for all shifts and community members

**CCCHPT Goal 1:** Create community environments that promote and support healthy food and beverage choices and physical activity. (NYS Action plan Goal 1.1)

**Objective 1.1.** By December 31, 2017 decrease the percentage of adults ages 18 years and older who consume at least one soda or sugary drink per day by 5% (Baseline: 25%; Target: 20%; Year: 2013; Source: Community Transformation Grant Population Survey Preliminary Frequencies from Baseline Data Collection)

**WCA Hospital Goal:** By September, 2017 WCA will sustain a healthy beverage policy for all of its purchased beverages in the WCA cafeteria and vending with a plan for extension to patient nutrition services.

**Objective 1:** 70 % of items in beverage vending machines will be unsweetened, lightly sweetened (less than or equal to 80 calories per bottle or can) or artificially sweetened.

**Objective 2: If available sweetened beverages will be placed on the bottom row and will be offered at a cost greater to that of all other items**

**Strategies:**

- By December, 2013, WCA will invite Chautauqua County Community Transformation Grant Educators to come and discuss the benefits of providing healthy beverage choices in the WCA and JMHC Cafeteria and Vending to Nutrition Services Director.
- By January, 2014 WCA Wellness and Nutrition Services will work with setting up policy guidelines for healthy beverage choices to present to WCA Board/Strategic Affairs for approval.
- By April 2014, National Nutrition Month, healthy beverage choices will be promoted to all WCA employees through the HR Communicator, signage on vending and cafeteria beverage. Punch cards will be given to employees who purchase healthy choices with monthly prize drawings for the employees who purchase healthy beverages.
- From April 2014 to 2016 vending and cafeteria beverages will be tracked for compliance to policy.

**Next Steps:** Plan to expand healthy beverages to bedside patient nutrition services will also be researched.

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**Tracking indicators:**

Sales increase or decrease , Number of punch cards a month, number of sugary drinks sold over 6 months

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

**CCCHPT Goal 3.2:** Promote use of evidence-based care to manage chronic diseases.

**WCA Hospital Objective CD 2.1.** By December 31, 2017 reduce cardiovascular disease mortality rate by 5% in Chautauqua County.

**Activities/Interventions**

Work with the CCCHPT to establish work group to coordinate *Million Hearts™* Initiative activities See Evidence based strategies defined on page 28 .

**Also see Chautauqua County Department of Health and Human Services / Community Health Improvement Plan (CCDHHS CHIP 2014-2017 )for full details of partnership activities and interventions pages 17 and 18.**

**Description of WCA Hospital Strategies – Prevention Agenda – Chronic Disease –  
Obesity- Pre-Diabetes**

**WCA Hospital What We Know:** WCA participated and offered a National Diabetes Prevention Program (DPP) and had 10 people start the DPP core class, 6 completed it. These 6 lost a total of 60 lbs. Of the 6, 3 reached their goal of 5-7% body weight loss and reached their exercise goal of 150 mins per week. Post core sessions continue. On a side note, 4 class members say how much better their lab values are now to date.

**WCA Hospital What We Did:** In 2013, WCA was able to train a DPP health coach who is a WCA Nutrition Technician (NT) through funding from P2 of WNY.

**WCA Hospital Next Steps :** The NT position is a fulltime position at WCA and to further serve the community another WCA employee needs to be trained so they can alternate classes with their already full time job responsibilities.

WCA is in the partnership with CCHN grant award for the DPP program through the New York Health Foundation

NYS Overarching Objective 1.0.2: By December 31, 2017, reduce the percentage of adults ages 18 years or older who are obese by 5% to 22.3% (Baseline 27.3%; Target: 22.3%; Years: 2008-2009; Source: NYS BRFSS)

**WCA Hospital Goal 1:** WCA DPP program will increase the number of referred prediabetic patients seeing up to 24 prediabetic patients each year in 2013, 2014, and 2015.

**Objective 1:** WCA will facilitate 6 DPP programs from 2013, 2014, 2015, two programs a year targeting primary care practices with high Medicaid populations to encourage 5% more referrals for persons diagnosed with pre-diabetes that are underinsured and/or Spanish Speaking.

**Strategies:**

- Visit primary care offices and federally qualified health centers promoting the DPP program regarding referral of their patients to the national program.
- Identify all of the DPP health coaches in the county who facilitate DPP programs and coordinate class efforts with them throughout the county.
- Work with CCHN to identify prediabetic patients in primary care and clinic settings through the NDPP.
- Work with faith based groups and outreach organizations with high population of Hispanic or African Americans who would benefit from DPP. (Disparity underserved/underinsured)
- Offer DPP to pregnant women identified as prediabetic in the NY OB/GYN Hospitalist Delphi clinic at WCA

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**Tracking Indicators: (2013 -2015)**

- Number of high Medicaid practices referring patients
- Number of private pay or self pay participants in the programs
- Number of Medicaid patients that participate in the WCA DPP program from community and Delphi clinic. .
- Number of trained DPP Health Coaches and DPP sites in the county
- Spanish Speaking DPP Health Coaches available in Chautauqua County
- Number of participants who complete the programs
- Pounds lost individually and collectively
- Minutes of moderate to vigorous physical activity weekly
- Changes in A1C Hemoglobin

**WCA Goal 2: By December 31, 2017:** Increase availability of fresh and local produce to Chautauqua County residents and WCA Employees

**WCA Objective 1 :** Increase participation in hospital gardens to include employees and rehabilitation patient by 10%

**Strategies:**

- Maintain and care for existing vegetable gardens at WCA and JMHC campus. (Creating Healthy Places Live

Work and Play 2012-2013)

- Educate patients on how to care for gardens especially to include Behavioral Health Patients and Cardiac Rehab Patients.
- Continue to sustain gardens through incorporating gardening in to Behavioral Health Rehabilitation and expand it to Cardiac Rehabilitation Patients as part of their Living Healthy Workshops

**Tracking Indicators:** number of patients who help maintain gardens

**WCA Objective 2** – Increase options for harvest distribution from the WCA/JMHC gardens to employees and low income, and immunosuppressed patients.

**Strategies:**

- Provide free produce from garden to low-income residents (ex/cancer treatment patients, Meals on Wheels, local soup kitchens)

**Tracking Indicators:**

- Amount of produce donated to local low income residents or patients

**WCA Objective 3** – Increase access of fresh fruits and vegetables to WCA employees and families through weekly WCA Farmers Markets and cafeteria specials featuring garden harvest foods.

**Strategies:**

- Continue the Mobile Farmers Market Express to all departments in the hospital
- Continue the herb garden in the Cafeteria ( Creating Healthy Places Live/Work/Play 2012-2013)

**Tracking indicators:**

- Number of employees and community members who purchase from the WCA Farmers Markets
  - Number of employees who purchase healthy choices in the WCA Cafeteria ( punch card)
- Survey of all employees regarding Farmers Market easy accessibility and if it has changed their purchasing habits

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

CCCHPT Partners: Brooks Memorial Hospital, CCDHHS, WCA Hospital

#### **The Need: Early Prenatal Care**

NYSDOH Maternal and Infant Health Indicators indicate that from 2008-2010, 68.8% of mothers who gave birth sought out prenatal care during the first trimester. This figure is significantly lower than the NYS rate of 72.8% and the NYS excluding NYC rate of 75.2%. The percentage of mothers seeking out prenatal care during the third trimester is significantly higher than the rest of the state at 7.1%. Additionally, only 62.8% of births during 2008-2010 were designated as having adequate prenatal care. The rate of prenatal care use during the first trimester is greater among mothers who participate in the WIC program with 84.2% during 2008-2010.

The percentage of births within 24 months of a previous pregnancy 2008-2010 is significantly higher in Chautauqua County as compared to both New York State and Upstate New York. During that time period, 25.1% of births were within 24 months of a previous pregnancy in Chautauqua County. In New York State, this figure was only 18% and 21.1% for Upstate New York. Western New York saw 21.8% of births within 24 months of a previous pregnancy during the same time range. (NYSDOH Family Planning/Natality Indicators 2008-2010)

As indicated by the NYSDOH Maternal and Infant Health Tracking indicators, many Chautauqua County mothers are not seeking out prenatal care early enough during pregnancy.

**Drug Addicted Newborns:** During the time frame 2008-2010, sixty-three infants less than 28 days old were discharged from a hospital with a drug-related ICD-9 code, resulting in a rate of 157.1 infants per 10,000 newborn discharges. This rate was significantly higher than the New York State rate of 64 and the New York State excluding New York City rate of 78.4.

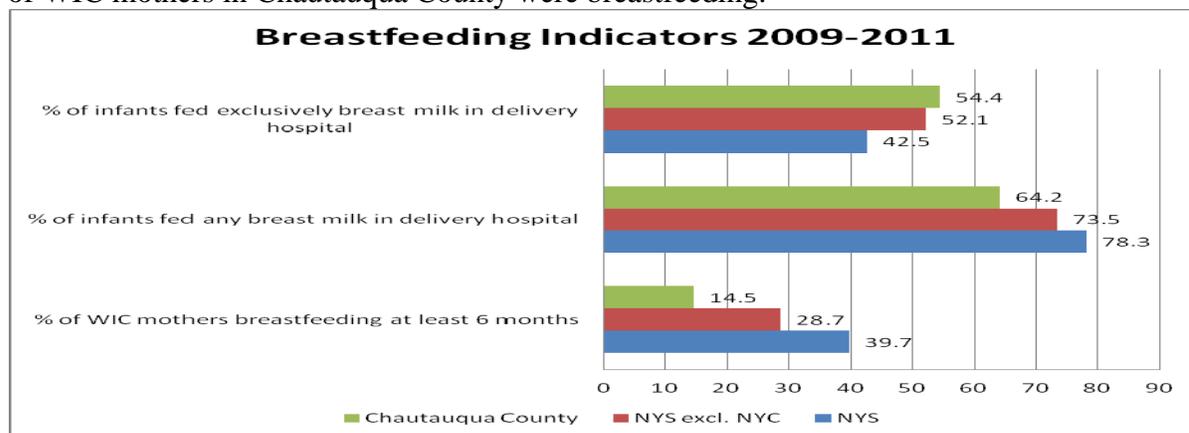
Table... Newborn drug-related discharge rate per 10,000 newborn discharges, 2008-2010

	3-Year Total	Chautauqua County	NYS	NYS excl. NYC
Newborn drug-related discharge rate per 10,000 newborn discharges	63	157.1	64	78.4

NYSDOH Maternal and Infant Health Indicators 2008-2010

Examination of Chautauqua County newborn drug-related hospitalization rates from 2001 to 2010 reveals that this rate was relatively stable around 50 cases per 10,000 discharges until 2007 when the rate began to rise rapidly. A breakdown of ICD-9 codes for these figures was requested from NYSDOH. The rates of newborn hospitalizations due to narcotics and hallucinogenic agents and cocaine in Chautauqua County were nearly double the state rate. (See Chaut. Co. DOH Health Assessment 2014-2017)

**Breastfeeding:** A greater percentage of infants are exclusively fed breast milk in delivery hospital in Chautauqua County (54.4%) than New York State excluding New York City (52.1%) and New York State as a whole (42.5%). However, the percentage of infants who were fed any breast milk in the delivery hospital was less in Chautauqua County than the two comparison geographies. The disparity between these entities was much greater when examining the percentage of WIC mothers still breastfeeding their babies at 6 months. As displayed in Chart XXX below, only 14.5% of WIC mothers in Chautauqua County were breastfeeding.



**Focus Area: Preconception and Reproductive Health**

**Goal 1:** Increase utilization of preventive health services among women of reproductive age to improve wellness, pregnancy outcomes and reduce recurrence of adverse birth outcomes. (NYS Action plan Goal 7)

**Chautauqua County Objective HWIC 1.1.** By December 21, 2017 increase the percentage of pregnant women who access prenatal care during the first trimester by at least 10%

**Tracking Indicators:** Percentage of births with early (1<sup>st</sup> trimester) prenatal care. (Target 78.8%; Baseline: 68.8%; Year 2008-2010; Source: NYS Vital Statistics Data)

Activities/Interventions	Date	Partner(s) Responsible
Form Maternal Child Health Coalition	1/2015	CCDHHS
See CCDHHS CHIP 2014-2017 for detailed partner activities		

**Chautauqua County Objective HWIC 1.2:** By December 21, 2017 decrease the newborn drug-Related discharge rate per 10,000 newborn discharges by at least 10 %

**Tracking Indicators:** (Target 156.9 per 10,000); Baseline 174.3 per 10,000, year 2009 -2011; SPARCS NYSDOH Bureaus of Biometrics and Health Statistics

**Activities/Interventions** – Maternal and Infant Community Health Collaboration Coalition establishes workgroup to address newborn drug-related discharge rates.

Partners: BMH CCDHHS, MICHC partners, WCA

See CCDHHS CHIP 2015-2017 for detailed partner activities

<b>Objective 7-3</b> By December 31, 2017 improve birth spacing by at least 10%		
Tracking Indicators: Percentage of live births that occur within 24 months of a previous pregnancy. (Target 15.1%; Baseline: 25.1%; Year 2008-2010; Source: NYS Vital Statistics Data)		
<i>Activities/Interventions</i>	<i>Date</i>	<i>Partner(s) Responsible</i>
To be determined by CCHPT focus groups and the Maternal Child Health Coalition		CCHPT (except Westfield as they have no Maternity ward)
<b>See CCDHHS CHIP 2014-2017 detailed activities</b>		

<b>Focus Area: Maternal and Infant Health</b>		
<b>Chautauqua County Goal 1:</b> Increase proportion of NYS babies who are breastfed. (NYS Action plan Goal 2)		
<b>Chautauqua County Objective HWIC 1.4:</b> By December 31, 2017 improve racial, ethnic and economic disparities in breastfeeding rate by 10%		
<b>Tracking Indicators:</b> Percentage of infants exclusively breastfed in the hospital:		
<ul style="list-style-type: none"> <li>• All Infants (Target: 64.4%; Baseline: 54.4%; Year: 2008-2010; Source: NYS Vital Records)</li> <li>• (Disparity) Ratio of Black non-Hispanic to White non-Hispanic infants exclusively breastfed in the hospital (Target: 0.57; Baseline: 0.34; Year: 2008-2010; Source: NYS Vital Records)</li> </ul>		
<i>Activities/Interventions</i>	<i>Date</i>	<i>Partner(s) Responsible</i>
MICHC Coalition develops survey to learn reasons why mothers are not breastfeeding at 6 months	2/14	BMH, CCDHHS, MICHC partners, WCA
Identify opportunities to recruit new lactation consultant for WCA Hospital.	1/14-12/14	CCDHHS, MICHC partners, WCA
<b>See 2014-2017 CCDHHS/CHIP detailed activities</b>		

**Description of WCA Hospital Strategies – Prevention Agenda Priority**  
**Promote Health Women, Infants and Children**

**WCA Hospital What We Know:** In 2012 WCA delivered 675 newborns. NYSDOH indicators show an increased need for early prenatal education and care to increase 1<sup>st</sup> trimester OB/GYN visits, breastfeeding education to increase breastfeeding at 6 months and standardized drug toxicity screening of newborns within the hospital, prenatal clinics and physician offices to identify and navigate new mothers and newborns to proper early treatment interventions.

**WCA Hospital What We Did:** Partnership with New York OB/GYBN Hospitalists at WCA - Delphi Prenatal Clinic providing 7 healthcare providers to accept low income/uninsured or underinsured mothers, prenatal education and case management after birth through WCA Hospital Case Management and the Chautauqua County Department of Health newly funded Maternal Child Health grant strategies.

**WCA Hospital Next Steps:** Increase access to prenatal care and sustain partnership and implementation with the Chautauqua County Health Department and Maternal Infant Child Health Collaborative (MICHC) grant strategies

**Focus Area: Preconception and Reproductive Health**

**CCCHPT/WCA Hospital Goal 1:** Increase utilization of preventive health services among women of reproductive age to improve wellness, pregnancy outcomes and reduce recurrence of adverse birth outcomes. (NYS Action plan Goal 7)

**WCA Objective 1.1:** *By December 31, 2017 increase the percentage of pregnant women who access prenatal care during the first trimester by at least 10%.*

**Strategies:**

- Meeting with NY Ob/GYN Hospitalists at WCA Delphi Prenatal Clinic providers, Chautauqua County Health Department Coordinator of the Maternal Child Health grant to discuss available Delphi prenatal services and

Maternal Infant Community Health Collaborative ( MICHC) grant –Community Health Worker Program( CHW) completed Oct 2013)

- Connect all uninsured/underinsured women and other high risk populations who test positive at the Chautauqua County Health Department for pregnancy and want to continue their pregnancy to clinic resources making the initial phone call for the clinic appointment at time of testing. ( Implemented October2013 )
- Provide a trained Community Health Worker from the MICHC to be established in the Delphi Clinic for prenatal, to work alongside the healthcare providers to educate, form a relationship with, assist with navigating families to develop the necessary skills and resources to improve their health status, family functioning and self sufficiency.
- WCA Marketing will promote services of the Delphi Clinic to all healthcare providers, OB/GYN offices, schools and outreach organizations with low income/high risk populations.

**-Tracking indicators:**

- Delphi will track referrals to the clinic from the health department.
- Delphi will track how many patients see a Community Health Worker
- MICHC will track outcome measures of the CHW program
- Percentage of births with early (1<sup>st</sup> trimester) prenatal care. (Target 78.8%; Baseline: 68.8%; Year 2008-2010;

**Focus Area: Maternal and Infant Health**

**CCCHPT/WCA Hospital Goal 1:** Increase proportion of babies at WCA that are breastfed for longer than 6 months (NYS Action plan Goal 2)

**WCA Hospital Objective 1.1:** By December 31, 2017 improve racial, ethnic and economic disparities in breastfeeding rate by 10%

**Strategies:**

- Seek for opportunities to obtain a certified/trained lactation consultant to be available 7 days a week

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- WCA maternity staff to continue to educate new mothers on the importance and benefits of breastfeeding and call in existing lactation consultants from Jamestown Pediatrics when needed.
- Community Health Workers at the Delphi Clinic to educate on breastfeeding benefits and techniques at the Delphi prenatal visits. ( underinsured/uninsured women)
- Work with P2Collaborative and their “Breast Feeding Friendly” education materials and education sessions to offer at WCA as a community presentation in 2014.
- Investigate opportunity to provide a Breast Feeding Café where WCA could provide a comfortable setting for moms to come in to discuss breast feeding issues and “milk hotline” where moms could call already trained WCA Maternity staff about breast feeding questions and concerns.
- See CCCHSS CHIP page 24 for detailed CCCHPT partnership strategies

**Tracking Indicators:**

- Percentage of infants exclusively breastfed in the hospital:
- Percent of mother breastfeeding at 6 months

All Infants (Target: 64.4%; Baseline: 54.4%; Year: 2008-2010; Source: NYS Vital Records)

(Disparity) Ratio of Black non-Hispanic to White non-Hispanic infants exclusively breastfed in the hospital (Target: 0.57; Baseline: 0.34; Year: 2008-2010; Source: NYS Vital Records)

**WCA Hospital Goal 2:** Decrease the percent of drug addicted newborns at WCA by 10 %s

**Objective** Standardize drug toxicity screening of newborn for early intervention programming and treatment

**Strategies:**

- 2013 Research OB/GYN practices and participating CSP hospital regarding their policies for drug screening of mothers/ babies
- 2014-2015 Educate OB/GYN office, PCP’s and Prenatal clinic health care providers about the high incidence of

drug addicted newborns in a WCA Medical Education Program and through the relationships that CCHN has with medical practices offer a county wide education program.

- 2014 Focus groups among OB/GYN practices and clinics to standardize screening at mothers point of entry into the system
- 2013-15 WCA Prenatal classes will continue to educate mothers to be on the risks of taking drugs during pregnancy for the mother and the baby.

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

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

<b>Focus Area: Strengthen Infrastructure Across Systems</b>		
Goal 1: Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment and recovery. (NYS Action plan Goal 3.1)		
<i>NYS Objective 1.2: Support efforts to integrate MEB disorder screening and treatment into primary care.</i>		
CC Objective 1.1: Support efforts to integrate MEB disorder and substance abuse screenings and referral to treatment in primary care, clinic, and emergency room settings throughout Chautauqua County. (Tracking Indicators: Number of people screened in primary care and emergency care settings, Number practices using screen)		
<i>Activities/Interventions</i>	<i>Date</i>	<i>Partner(s) Responsible</i>
Research MH/SA screening tools currently being used in health care settings in Chautauqua County	3/14	BMH, CCDHHS, CCHN, TLC, WCA, WMH
Assist Chautauqua County Department of Mental Hygiene in developing connections with health care practices to expand reach of Early Identification and Recognition Program; Inform physicians and support staff at annual meetings, provide CCDMH with contact information for affiliated physicians (Tracking Indicator: number of practices that work with CCDMH)	3/14-3/15	BMH, CCDHHS, CCHN, TLC, WCA, WMH, CCDMH
Survey health care providers to determine willingness to implement a screening tool, understand current mechanisms for providing or referring mental health/substance abuse care, and barriers (Tracking Indicator: number of practices that respond to survey)	5/14	BMH, CCDHHS, CCHN, TLC, WCA, WMH, CCDMH
Research reimbursement options for integrating screening or mental health care into practice	6/14-9/14	BMH, CCDHHS, CCDMH, CCHN, TCC, TLC, WCA, WMH
Convene primary care and mental health/substance abuse providers to identify best evidence-based screening tool or practice to ensure patients are receiving appropriate care	8/14	BMH, CCDHHS, CCHN, TLC, WCA, WMH, CCDMH
	9/14-11/14	BMH, CCDHHS, CCHN, TLC, WCA, WMH, CCDMH
Identify care settings in hospitals where patients should be screened (e.g. emergency rooms, inpatient services)	9/14	BMH, TLC, WCA, WMH
Develop list of nearby mental health/substance abuse resources for PCPs to share with patients (Tracking Indicator: list developed)	9/14-12/14	BMH, CCDHHS, TLC, WCA, WMH, CCDMH
Identify organization that can provide interviewer training for selected screening tools; if necessary, identify funding source to pay for trainings	9/14	CCDHHS, CCDMH, CCHN
Train appropriate staff at hospitals and primary care settings	1/15-	BMH, CCDHHS, CCDMH, TCC, TLC,

to use screening tools properly	6/15	WCA, WMH, identified agency, primary care practices
Begin implementation of screening tool	2/15-7/15	BMH, CCDHHS, TCC, TLC, WCA, WMH, primary care practices
Track number of practices using screening tool, number of staff people trained to screen, number of patients screened	2/15-2/16	BMH, CCDHHS, TLC, WCA, WMH
Identify issues with screen	2/16-6/16	BMH, CCDHHS, CCDMH, TCC, TLC, WCA, WMH, primary care practices
Work with team of primary care and mental health/substance abuse providers to identify any next steps	7/16-12/17	BMH, CCDHHS, CCDMH, TCC, TLC, WCA, WMH, primary care practices

## **Description of WCA Hospital Strategies**

### **Prevention Agenda Priority: Promote Mental Health and Prevent Substance Abuse**

**What We Know:** According to the Chautauqua County Community Health Improvement Planning meeting held on Sept 13<sup>th</sup> those in Mental Health and Substance Abuse organizations in Chautauqua County expressed the need for better coordination of care in the identification of indicators leading to mental, emotional, and behavioral health issues. Suggestions such as integrating MEB screening in to primary care practices and also in to emergency room visits would alert healthcare screeners to seek early intervention options quickly with referrals to specific individual resources for those in need.

Evidence Based – Patient Navigation Program for MEB – SBIRT ?

#### **What We Did:**

**Focus Area: Strengthen Infrastructure across Systems**

**CCHPT WCA Goal 1:** Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment and recovery. (NYS Action plan Goal 3.1)

**WCA Hospital Objective 1.1:** Support efforts to integrate Mental, Emotional, Behavioral (MEB) disorder and substance abuse screenings and referral to treatment in WCA’s Emergency Room setting.

#### **Strategies:**

- 2013 WCA Hospital will research MEB screening that is already being done within the WCA Emergency Room upon intake
- 2013-2014 WCA will work with CSP/CCHN to survey medical staff physicians and Delphi Clinic regarding screening tools used in their private practices
- 2014-2015 Collaborate with the CSP /CHA/CHIP Strategies to identify a universal research based screening tool, for example (SBIRT) for MEB screening in the county.

#### **Tracking Indicators:**

- Number of people screened in WCA Emergency Room Setting.
- Number of referrals to WCA Behavioral Health for follow up
- Number of practices using the new screening tool

**WCA Hospital Objective 2:** Develop list of Chautauqua County mental health/substance abuse resources for PCPs to share with patients

#### **Strategies:**

- 2013 Identify all of WCA Hospital Behavioral Health and Substance Abuse resources and share with collaborative
- 2014 Collaborate with CSP/CHA/CHIP strategies to develop resource guide for community distribution.

#### **Tracking Indicator:**

- Complete list and guide developed and disseminated to all healthcare and outreach organizations, with links on websites and other media venues.

## 6. DISSEMINATION OF WCA HOSPITAL PLAN TO THE PUBLIC –

- A copy of the WCA Hospital 2013- 2015 Comprehensive Community Service Plan will be available to all community members upon request in written format.
- A Chautauqua County brochure will be created in 2014 that mirrors the new NYS DOH Community Service Plan brochure - Make New York the Healthiest State i.e. *Make Chautauqua County the Healthiest County*, which will outline the impact that the collaborative CCCHPT strategies have on our county. ( CCCHPT initiative to be discussed)
- WCA will provide a written summary or brochure format of the CSP in the WCA Hospital Annual Report to the community which is distributed county wide through the Jamestown Post Journal in May.
- WCA will also report on the WCA CSP strategies at WCA’s Annual Meeting of the Corporations where community stakeholders are invited to come to hear about all of WCA’s accomplishments and successes in the delivery of healthcare to our public. (See WCA Website [www.wcahospital.org](http://www.wcahospital.org) Annual report publication “High Tech Meets High Touch”.
- WCA’s 1100 employees will be given a copy of the developed brochure and it will be a feature story in WCA’s HR Communicator. ( See [www.wcahospital.org](http://www.wcahospital.org) click on Latest News and see WCA News Links publications )

### 6. Plan for Monitoring

#### ***Maintaining Engagement***

By committing to collaborate on the initiatives described above, the Chautauqua County Community Health Planning Team (CCCHPT) will maintain close contact over CSP 2015-2017 CSP. CCCHPT and partners county-wide understand that to make real, long-term change, we must work together. This fact, in combination with the reality of budget cuts and staffing shortages, fosters collaboration in Chautauqua County.

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

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

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

#### ***Description of Evidence-Based Interventions***

The strategies chosen to address the selected Prevention Agenda priority areas are a combination of existing and new strategies for Chautauqua County. Some strategies specify evidence-based programs, policies, or environmental changes.

In many cases, additional research and planning was deemed necessary before moving forward. Other strategies reflect concepts that make sense for our community, but are not necessarily proven methods. The evidence-based strategies that were selected are described below.

## **Reducing Access to Sugary Drinks**

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

## **Million Hearts Program**

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

- Improving access to effective care
- Improving the quality of care for the ABCS (Aspirin for those at risk, Blood pressure and cholesterol monitoring and smoking cessation.)
- Focusing clinical attention on the prevention of heart attack and stroke
- Activating the public to lead a heart-healthy lifestyle
- Improving the prescription and adherence to appropriate medications for the ABCS

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

## **National Diabetes Prevention Program**

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

## **Access to Professional Support for Breastfeeding**

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

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

The CCCHPT proposes to identify evidence-based mental health and substance abuse screening tools to adopt and implement in local hospitals and health care practices. The Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an integrated and comprehensive public health approach to delivery of early intervention and treatment services for people with substance abuse disorders, as well as individuals who are at risk. Hospital emergency rooms,

primary care practices, health clinics, and other community settings provide opportunities to identify at-risk substance users and offer intervention services before more serious consequences occur. This tool assesses the severity of substance abuse and identifies appropriate levels of treatment, provides a brief intervention that aims to increase awareness and motivate behavior change, and provides referral to appropriate treatment when necessary. (Screening, Brief Intervention, and Referral to Treatment (SBIRT), 2012)