

APPENDIX A

Community Collaboration Process, Timeline, and Supporting Documentation

Community Health Assessment/Community Service Plans Collaborative Planning Meetings Timeline

10-10-12 – Meeting with BSC Communications department to design survey, develop deployment plan for tool when developed

10-22-12 – Consumer survey tool piloted in paper format with D'Youville college students, comments collected, revisions to tool made, tool loaded into Google Docs

10-27-12 – Consumer survey deployed at Bidwell Farmers Market

10-30, 10-31, 11-1, 11-2-13 – Consumer survey intake sites (paper) at Erie County HEAP, Social Services Waiting Room, Child Support Waiting Room

11-1-12 – Consumer survey tool deployed by BSC Communications students using electronic methods such as email links, Facebook, Twitter, and other avenues

11-30-12 – Consumer survey pilot distribution by BSC Communications Department completed

12-3-12 – Survey sent out via email to list serves and contacts internally

Dec 2012 and Jan 2013 Paper surveys ongoing at Senior Centers (Cheektowaga, Alden, Amherst, Mosher, West Seneca, Town of Tonawanda)

2-26-13 – Joint Meeting #1 for hospitals, academia, and health department

2-26-13 – Consumer survey link shared with CHS for distribution on their website

2-26-13 – Consumer survey link tweeted out by CE, link to survey on home page of Erie County, New York

3-25-13 – Joint Meeting # 2 for hospitals, academia, and health department

4-24-13 – Living Healthy Task Force meeting scheduled to host town meeting for professional input

4-24-13 – Community Health Forum held with membership of Living Healthy Task Force and other community partners at Main Library, facilitated by Buffalo State College, Center for Health and Social Research

4-26-13 – mass email blitz of consumer survey link to Erie County Employees

7-26-13 - Joint Meeting for hospitals, academia, and health department

8-9-13 – Joint Meeting for hospitals, academia, and health department

8-14-13 – Breast feeding investigation meeting with Mary K Comtois from United Way

8-23-13 – Joint Meeting for hospitals, academia, and health department

8-28-13 – Breastfeeding meeting with partners

9-16-13 – Joint meeting with hospitals, academia and health department. Joint areas finalizes as increasing breast feeding rates specifically and something to do with addressing cardiovascular issues. This will include and comprehensive approach by partners with hospitals looking at readmission data for an array of cardiovascular events, and community education to increase awareness of stroke and decrease complications by addressing early recognition of signs and symptoms and receipt of timely intervention/treatment.

10-4-13 – Prevention Agenda meeting with Kaleida administration to solidify joint objectives for CHIP

10-16-13 – Breastfeeding objective team meeting

10-22-13 – prevention agenda meeting with Prevention Focus, Erie County Mental Health service provider

10-26-13 – NYS Health Foundation grant opportunity planning meeting to address breastfeeding objective

Community Health Assessment/Community Service Plans
Joint Planning Meeting
2/26/13
2:30 – 4:30 pm
Rath Building Room 904

1. Welcome and Introductions
2. Why are we here?
 - Document issued 12-10-12 asks local health departments and hospitals to collaborate on the development of Community Health Improvement plans and Community Service Plans
3. 5 priority areas as defined by NYSDOH Prevention Agenda (potential objectives)
Must pick 2 priority areas, at least one must address a disparity
 - Prevent Chronic Disease (Tobacco, Physical Activity, Nutrition)
 - Promote a Healthy and Safe Environment (Clean Air, Water, Injury Prevention, Violence)
 - Promote Health Women Infants and Children (Family Planning, Maternal Child Health)
 - Promote Mental Health and Prevent Substance Abuse
 - Prevent HIV,STDs, Vaccine Preventable Diseases and Healthcare Associated Infections (ESAP, STDs, PNAP, IAP, TB)
4. Data sources and plan development resources:
 - Federal – CDC, NIH,
 - State – NYSDOH Prevention Agenda, NYS Health Indicator Reports, NYSDOH
 - Local – ECDOH, YRBS data (BPS), local needs assessments (United Way, BPPN, Foundations, P2, Colleges and Universities, Hospitals, Insurers, Department of Mental Health, others?)
 - Consumer Surveys
<https://docs.google.com/spreadsheets/viewform?formkey=dGRxSEVQOUwzWkpWQWVnM3dfYIBFT1E6MQ>
 - www.TheCommunityGuide.org best practice
5. Joint priority and focus area identification
6. Next steps
 - Community collaboration meeting to present identified priority areas and solicit input on plan development to reach desired goals as identified in the Prevention Agenda
 - Necessary partners?
 - Monthly working group meetings till submission
 - Format – face to face, teleconference, mixture?

THANK YOU!

COMMUNITY HEALTH ASSESSMENT/COMMUNITY SERVICE PLANS
JOINT PLANNING MEETING
2/26/13
MINUTES

Meeting Participants:

Gale Burstein, M.D., Commissioner of Health, Erie County
Cheryll Moore, Medical Care Administrator, Erie County Dept. of Health
Angela Hastings, Intern, Erie County Dept. of Health
Gregory Young, M.D., Associate Commissioner, New York State Dept. of Health
Melissa Golen, Kaleida Health
Bonnie Polakoff, Catholic Health
Christine Kemp, P2 Collaborative of WNY
Kate Ebersole, P2 Collaborative of WNY
Maria Foti, Catholic Health
Laurene Tumiel Berhalter, Family Medicine, University at Buffalo
Alan Delmerrico, Center for Health & Social Research, Buffalo State College

All of the participants introduced themselves. Dr. Burstein thanked everyone for their attendance at the meeting. She went on to say that there is a great opportunity to address what the health needs are of the community. As well as our biggest challenges. What can be done collaboratively to develop a plan to address these health needs, and what can be done to make this a healthier place to live?

Cheryll Moore said that Bertrand Chaffee Hospital was contacted, however, we had no response from them. Dr. Young suggested following up with them. As they are an Erie County hospital and must be involved in the plan. Ms. Moore said she had attended a meeting with Catholic Health System where they are developing information for their community services plan. She was not sure where Kaleida stood on this. She said this was the first planning meeting here. At the County level a community health assessment and a community health improvement plan need to be done. This is different from what has been done in the past. We used to do a Community Health Assessment and then develop a Municipal Public Health Services Plan; and do yearly reporting based upon that. Hospitals do community services plans. This year they are on the same schedule.

Ms. Moore passed out information which was the guiding document for the community health assessment community services plan. The requirements and/or priorities are five instead of ten. One area that is chosen is addressing disparities. She felt that disparities are the cause of many of our issues. Getting to the underlying socio-economic, ethnic, language that underlies health. The five priorities are listed: preventing chronic disease, there are potential objectives listed within the priority areas. Physical activity, nutrition, tobacco issues, which are also part of the hospitals' daily issues. Healthy and safe environment, clean air, water, injury prevention, violence, healthy women, infants and children. Maternal infant child health initiative funding is available, which is being applied for currently, as well as nurse family partnerships.

The network, family planning, promoting mental health and preventing substance abuse. Underlying root cause of this is mental health behaviors. Internally we have met with our Dept. of Mental Health that have been charged with collaborating. Also mentioned are preventing STD's, HIV, vaccine preventable diseases, and health care associated infections. At the county level we have an STD clinic, PNAP grant, IAP, TB and ESAP controlling disease spread. Ms. Moore asked if anything had been done in the hospitals regarding this. A plan by Sisters will move forward to see what they have done and what will be planned. Kaleida answered that they have many programs. Dr. Burstein asked if everyone will have the same prevention priorities. Dr. Young answered that yes the group must, there are two. Of the two priorities we can select one that happened to be the same throughout the region. P2 can provide data with this. Dr. Young explained that he is just introducing the format for the plan, but will no longer be involved. The hospitals and the counties reimbursement both depend on the plan. Disparities need to be addressed, and indicators, with an explanation of how the indicators were found. Also performance measures to gauge how you do over the next 3 to 5 years. The intent is not to just put something on paper, this must be a has to happen document. There is much involved and it will be more of a challenge than previous years.

As a group there must be two out of five initiatives selected. A question was raised regarding clarification by Kaleida Health; say that we as a group choose tobacco prevention, does Kaleida then have to have this as their same priority, or can they choose something else as diabetes, and or cardio-vascular diseases as their priority. Must they tie in with the County? Dr. Young said that they must come together as a group and decide upon priorities to work together. A whole community improvement process is desired, where all are working on the same initiatives. There must be collaboration on two priorities. Dr. Young suggested that one of those two would be good if they would be the same as hospitals and other counties in the region did. P2 could then come to their aid with data. This is their strength; as this is a major undertaking.

Dr. Burstein asked when we would know when the other counties initiatives would be. It was mentioned that the other counties are in different phases. Mid April would probably be the time frame we would have an idea of what across the board the counties are looking at.

Cheryll Moore said that there are five main areas. In the priority areas there are focus areas. There are different goals and objectives. One agreed upon priority area and two focus areas within can be worked on. The handouts were very descriptive regarding this. As far as consolidating our efforts this might be the way to go to focus in one area. Resources down the road (5 yrs.) as opposed to 3 yrs. for the hospitals. We can plan out to a point.

Ms. Moore has been pulling data, such as the last community health assessment and local data. Surveys were done last time, consumer surveys are presently being done as opposed to professional surveys. We worked with the Communications program at Buffalo State College; they developed the survey which was based on the prior survey. Survey results were distributed. There are different questions that came from students involved in the Communications program. There were 280 returns that went out through social networking. This was a project of the communications program that is very technically oriented. Facebook, Pinit, etc. were utilized. After that we went into social services waiting rooms. Paper surveys with clients were done. There was a cross section in this environment. The County Executive tweeted the survey, and it

is now on the County website. Angela Hastings, an intern for the ECDOH commented that she has been reaching out to the local colleges to see if the survey could be posted on their respective websites. She is waiting for responses. Ms. Moore said that the Catholic Health System has posted the survey on their website. She also said that she would share the data with everyone. She compared the present survey with the past survey; participants in the last survey did not know how many fruits and vegetables were supposed to be consumed on a daily basis. Presently they are stating that they know the amount but are not eating them. We have increased knowledge but we need to change behaviors. Our population is 64% overweight and obese in Erie County. We asked questions regarding eating patterns, perception and choices; how they shopped, how they made choices at restaurants. We have a restaurant program that will give us a way to work with menu labeling.

The next focus will be on senior citizen centers getting the older population's input. This will be Angela Hastings' new task. We need at least one thousand surveys completed. Christine Kemp asked if the survey could be completed via mobile phones. Ms. Moore said yes that it could be as it is google.doc. Ms. Kemp suggested that publicizing this in waiting rooms at social services could have people complete them on their phones while waiting.

Dr. Young asked what the hospital's thinking on this is. He asked if they had areas of the five in which they would be interested on focusing in. They said that they are working on their own prioritization process presently with each of the hospitals. They came up with a scoring tool from the focus area putting some criteria on the priority impact feasibility. The first hospital felt strongly about providing input to this. They will be continuing the process over the next couple of weeks, so that they will actually have some feedback. Chronic disease will probably be the area of focus. So much of the prevention agenda and all of the assessments from NYS focus on cardio-vascular, with the GVI this is an organizational focus for Kaleida as well. If the County does not have chronic disease and cardio vascular as a subset if this something they could still focus on as an organization; and what level they would have to put to the County agenda versus what they would put into their individual plan. Dr. Young said that the plans need to be an individual county and hospital which is the opposite of what was done three years ago. Dr. Young mentioned that mental health is also a huge issue of concern. Ms. Moore said that internally at the County level we have met with our Mental Health Dept. and they are willing to work with us on this. She said that if a person's mental health is not in order their physical health suffers. It was mentioned that if you look at mental health as a focus area, if substance abuse is not provided the person's well-being cannot be accomplished as an objective. An outcome would be difficult to arrive at without markers.

Ms. Moore said that there is an area that we could work collaboratively on as a region hospital which would have a huge impact on that is prescription drugs. Working on policy changes within the facility as far as prescribing practices, and referral practices, the Emergency Department. She said that the County's focus would be STD, HIV and Maternal Child Health as well as Chronic Disease. Obesity prevention and nutrition also. Based on data would be cardio vascular under chronic disease; obesity prevention. Underlying factors such as these which would affect hypertension, diabetes, cancer etc. If chronic disease is selected, two priority areas would not necessarily have to be picked, two focus areas could be selected within chronic disease. This might be a more streamlined approach for a collaborative group.

A question was asked that in terms of a workable document how would it be evaluated as to yes we have made progress or no we did not? We might want to think about it in terms of what data we have, what things that we might be able to move the most. She thought that some of the metrics may be difficult to shift in three years. Dr. Young commented that they are not expecting to see any major outcome change, but progress in whatever is selected. The group must decide what the measures are; what the group comes up with as measures that are reproducible. This is the difficult part.

There are two types of data, the assessment data and the trackable data. The trackable is part of the chip. The chip is a work plan written with smart objectives. Cheryll Moore said that she would send out data from recent grant application associating local prevention agenda and Healthy people 2020 indicators. This actually showed where indicator movement could occur.

There was discussion regarding the Maternal Child Health grant that is currently being applied for. Chronic diseases and Maternal Child Health, should we choose two areas within those or one in each area. One in each area seems to make more sense. A question was asked if everyone needed to identify exactly what we will be doing within them. Ms. Moore said that if we get our priority areas identified and then at the next meeting we can focus down as to exactly what will be done.

A question was asked regarding the hospital PCMH dollars that were just awarded; if they came from New York State. Does this tie in at all? Resources and systems change and approach if this is part of it. The deliverables that primary care have to make, as they are doing their PCMH recognition which ties into maternal child health that ties into chronic disease etc. There is a lot of alignment with chronic disease about where the pieces fit in. Is this contributing to data and where we can extract data from?

A matrix was suggested in some key areas showing what initiatives that we already have going. What are the potential big ones, as the Pre-natal Peri-natal grant etc. Could we possibly tie them into the other things. PCMH applies to ECMC and Kaleida, it does not apply to the Catholic Health System.

Ms. Moore said that she could pull together from the resources in the community for maternal child health. As far as chronic disease she thought that Kate Ebersole had the best hold. Ms. Ebersole replied that with the UB information from Laurene plus their different coalitions that she could provide a list of all that they are aware of as being grant funded. As well as what other foundations are focused upon.

The two priority areas will be Maternal Child Health and Chronic Disease. Cheryll Moore will put together information on the Maternal Child Health end and Kate will pull together information on chronic disease for a March 8 deadline. On March 11 Ms. Moore will e-mail the information to the other meeting participants. A Community Partner meeting needs to be scheduled. She is going to pull together a meeting of the Living Healthy Task Force in Erie County. This engages many partners in the community from businesses, pharmaceuticals, community health workers etc. She asked the others if they could think of any participants for

the community meeting to let her know. This will be happening concurrently while we are meeting. This meeting will be held the 2nd week in April. Ms. Moore also suggested that there be a push of the consumer surveys. She will send out the on-line link for the survey. There were suggestions made to send the survey out to insurance companies, banks, i.e. large employers.

There were two dates given out for the next meeting either March 20 or March 25, 2-4 PM. based upon Dr. Burstein's schedule as she wants to involved in the process.

CHA/CSP Joint Planning Meeting
3-25-13
2-4pm

1. Welcome and Introductions
2. Update on consumer surveys
3. Local programs and services
4. Living Healthy Task Force Meeting April 24th
 - 3 questions for professionals in the community
 - Town Meeting format
5. Next Steps

COMMUNITY HEALTH ASSESSMENT MEETING

MARCH 25, 2013

RATH BUILDING

Those in Attendance:

Maria Foti – Catholic Health
Bonnie Polakoff – Catholic Health
Melissa Golen – Keleida Health
Christine Kemp – P2 Collaborative of Western New York
Alan Delmerico – CHSR at Buffalo State College
Cheryll Moore – ECDOH
Mary Walawander – ECDOH

The meeting participants identified themselves. Cheryll Moore thanked everyone for attending the meeting. Some information was also passed out.

Update on Consumer Surveys

Ms. Moore handed out survey results as well as CD's with raw data from the latest run of the surveys. The BMI's and the formulas were run by our intern. We are starting to look at the demographics as they are starting to really replicate Erie County as a whole. With census data in one area, we will have data from consumers stating what the problems are. The surveys will be run through April 30th. Surveys will be provided to the outreach clinics through the Catholic Health System. Ms. Moore thought that by May 15th hard final data should be available. She said that the County as a whole is looking very similar. When we pull out the zip codes it will be interesting to see what the breakdown will be. The surveys have been done in senior citizen centers, local malls as well as the public libraries (in this instance tear off sheets with the web address were placed alongside the computers). We will also do a push out to all users in Erie County. Ms. Moore asked if any of the participants could also do a push out to their employees. She also asked if this was accomplished to let her know what date a push would occur on. There was conversation on perhaps doing a blast e-mail as part of a healthy living initiative for organizations involved.

Our intern has also been working with the local school systems. Many of them have a reverse 911 system, or an e-mail to parents system. However this has proved to be frustrating to accomplish.

Dr. Young said that we all needed to agree upon the same priority; however this is not truly what the language is. There needs to be clarification on this of what the language is versus what we are being asked to do. The County has to choose two priorities; the hospitals do not necessarily have to follow these same two. We are charged with collaborating with others within our community to agree upon two measures one with disparities that we would work on collaboratively. It does not have to be two measures but two areas. If we do two focus areas and

there are three objectives, the Dept. of Health could be doing one thing, and the hospitals another, but we work collaboratively to move the indicator. Do the individual plans have to mirror the County plan? Cheryll Moore thought that they should not mirror each other. We should not be doing the exact same things. We should be doing different things to move the same indicator. i.e. if we choose breastfeeding, someone would work on WIC, and someone else on zip codes. The question becomes how specific are the counties if what we agree upon is the collaborative going to be? There is the guidance and the chart. It's the reality of what we will accomplish in setting targets and goals. Christine Kemp that said these issues were addressed in the webinar. Two priority areas must be the same within the CSP and CHA. The priority areas must be the same, it doesn't have to be the exact same process to get to what you want to achieve, such as tobacco cessation, you would do the five A's. The community could have more funding for the split liners. Erie County does direct one on one cessation. We would be both addressing the focus area of tobacco within the priority area of chronic disease. The way we go about it can be totally different. It is ambiguous if we have to address the same focus area within the priority area of chronic disease. It could be obesity and tobacco cessation, as they both fall under chronic disease. Of the overarching of the five priority areas, those two must be the same. Melissa Golen said that as long as we agree to chronic disease we could each select a focus. As a county would you say chronic disease tobacco or would you just say chronic disease and then let Catholic Health select a focus area? It must be a focus area. If we all agree to something and then Kaleida doesn't do something within that where is the collaborative? It depends upon the level of specificity. Kaleida can participate in the process but what level of agreement is then needed.

Cheryll Moore reiterated that we reside in a County with problems that can be addressed easily from many different areas. There are not a lot of resources to accomplish things. We must figure out how we can do this together and move the indicators. If we are all addressing something different this will not happen. We kind of talked about the area of chronic disease because our obesity rates are off the charts. 64% of adults are overweight and obese. There are many things that can be done to address this. At the last meeting we came to this conclusion.

The priority area should be selected. At the last meeting the two priority areas chosen were Maternal Child Health and Chronic Disease. Ms. Moore asked if we could move ahead tentatively with these two areas. A focus area needs to also be determined and agreed upon; and or priority areas. Kaleida questioned what level do we all have to come on board. Would it be the focus area, and then within the focus area we can then branch out. Or do we have to have to move a single metric or a multiple metric? Objectives do not have to be agreed upon. We each can individually define the focus areas. We can agree on focus areas, and then each organization within can define the objectives. We all have to have the same objectives. The goals and objectives are metrically linked. The highest area that must be agreed upon is the focus area. We need to know what Kaleida is looking at as far as priority and focus areas. What has been chosen previously has been based on data. These are high risk indicators that need to be moved.

Alan Delmerico commented that we are choosing focus areas within priority areas that we can all agree upon. The goals might be dispersed amongst the different groups around the table. Under preventing chronic disease and reducing illness and death related tobacco use. The goals within are much more distinctively community oriented and might be something that falls

within the domain of the Dept. of Health as opposed to hospital systems. Whereas some of the much more politically oriented would align much better as goals for the hospital systems. We would be agreeing upon a focus area and then essentially divvying up the goals and each working on the ones that best align with our subset capacities to achieve the objectives. These objectives are tied to the goals. We should narrow it down and then branch off specifically to our need focus.

Cheryll Moore said that we may agree to disagree with each other. If however we agree to agree we will be able to move the indicators in a better fashion. She said that we need to know that in the two areas chosen are these areas that you are interested in working in. Ms. Moore suggested that Ms. Golen bring this back to her executive board to find out if this is agreeable to move forward. To reiterate we agreed upon two priority areas, and are going toward focus areas.

At the County level we will be looking at pre-conception reproductive health, we are reopening family planning. We can fill this gap. We are looking at increased access to high quality chronic disease preventive care and management in both clinical and community settings. This was agreed upon as our first focus area. Moving onto Healthy Women, Infants and Children, Maternal and Infant Health, Ms. Moore asked if the hospitals were looking at anything specifically be it clinical or community. They responded that breastfeeding and premature births were the two areas that they are interested in.

Mary Walawander told the group that she could provide data for them. Cheryll Moore said that caution needed to be exercised in accessing the PQI data. There was conversation regarding data and reporting regarding publically available sources.

Ms. Moore said that we need to obtain information from our community partners. A Healthy Living Task Force meeting has been scheduled for Erie County specifically on April 24, from 8:30 – 11:30 A.M. This will be held at the Main Library. The Healthy Living Task Force is comprised of community based organizations, businesses, health professionals, pharmaceutical companies and payers. It is Erie County specific. She asked what we want to know from them regarding their perceptions of health issues in the community. Ms. Moore asked the group for three questions we could ask. There was conversation including the following areas: What issues do you see in your population the most? (What issues are unique to the type of people that they work with)? Health related issues? Transportation. Getting health care, receiving health care, accessing health care. Social determinants? Is it easy for your clientele to access health care? This will be a town meeting format (30 or 40) people. What is preventing your clients from accessing health care? What are the barriers to good health in general? What is one thing that you could change to help your clients live a healthier lifestyle? What motivates people to change behavior? What is the biggest health issue facing your clients? Is there a service that has been unavailable for your client recently? Ms. Moore said that she would send an e-mail out to everyone with these to pick out the top three. We are looking to get professionals that deal with consumer's perception of health care in the community, or lack thereof. We might be able to tie together that the consumer is saying one thing and the professional is unable to refer the consumer. If it links together it will all make sense. We are safer in trying to characterize the

County as a whole countywide issue. The subset will be the City. We will come up with three pertinent questions for the Healthy Task Force meeting.

**Erie County Community Health Forum
Community Health Assessment**

**Buffalo & Erie County Public Library
Wednesday April 24, 2013
8:30-11:30am**

Agenda

Welcome and overview of meeting

Purpose:

- 1) Elicit perceptions of health issues affecting our community from businesses, health professionals, community based organizations, and pharmaceutical companies and payers.
- 2) Discuss and provide overview on County Health Assessment

Forum Format

Each of the four main topics (Chronic, Infectious, Disease Prevention/Health Promotion and Elder Care) will be allotted 36 minutes. Example breakdown as follows

Introduction and Overview	– 3 minutes
Question 1	– 10 minutes
Question 2	– 10 minutes
Question 3	– 10 minutes
Transition	– 3 minutes
	36 minutes

Forum Questions

Infectious Diseases – Pneumonia, Flu, Tuberculosis, HIV, STIs, etc. (36 minutes)

- 1) What are the challenges/issues/barriers related to the prevention of infectious diseases that you see in your community? (10 min)
- 2) What changes in your community would best help to improve overall health? (10 min)
- 3) Are there specific communities or population groups that resources should be focused on? (10 min)

Chronic Diseases – Diabetes, Mental Health, Cardiovascular Disease, Obesity, etc. (36 minutes)

- 1) What are the challenges/issues/barriers related to the prevention of chronic diseases that you see in your community? (10 min)
- 2) What changes in your community would best help to improve overall health? (10 min)

3) Are there specific communities or population groups that resources should be focused on? (10 min)

Health Promotion/Disease Prevention – Nutrition, Physical Activity, Access to care, Smoking, Drugs, etc. (36 minutes)

- 1) What are the challenges/issues/barriers related to implementing health promotion that you see in your community? (10 min)
- 2) What changes in your community would best help to improve overall health? (10 min)
- 3) Are there specific communities or population groups that resources should be focused on? (10 min)

High Risk Populations – Elders, youth, disparities (36 minutes)

- 1) What are the challenges/issues/barriers related to the prevention for high risk populations that you see in your community? (10 min)
- 2) What changes in your community would best help to improve overall health? (10 min)
- 3) Are there specific communities or population groups that resources should be focused on? (10 min)

Overview of consumer survey results to date

Any additional Items from audience – (Remaining time)

THANK YOU!

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LIVING HEALTHY TASK FORCE

4/24/15

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LIVING HEALTHY TASK FORCE

4/24/15

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ERIE COUNTY COMMUNITY HEALTH FORUM

WEDNESDAY APRIL 24, 2013
BUFFALO & ERIE COUNTY PUBLIC LIBRARY
8:30-11:30AM

Erie County



Department of Health

In partnership with:

Center for Health & Social Research
CHSR
at
Buffalo State

West Side Youth
Development
Coalition

MEETING PURPOSE

- Elicit perceptions of health issues affecting our community from businesses, health professionals, community-based organizations, and pharmaceutical companies and payers
- Discuss and provide an overview on County Health Assessment



Erie County

Department of Health

DR. ALAN DELMERICO

- Dr. Alan Delmerico is a Research Scientist at the Center for Health and Social Research where he conducts spatial and statistical analyses, maintains geographic databases, and prepares scientific presentations, reports, and publications. He holds a PhD in Geography and some of his research interests include diabetes, patterns of alcohol and substance use, aging populations, and neighborhood on health.

Center for Health & Social Research
CHSR
at
Buffalo State

MR. JONATHAN LINDNER

- Mr. Jonathan Lindner is a Health Educator and Research Analyst at the Center for Health and Social Research, where he focuses on projects to improve community health through prevention programs directed at changing individual behaviors and community-level factors. He is an Undergraduate lecturer, Certified Health Education Specialist, and National School Health Trainer for the Centers for Disease Control and Prevention.

Center for Health & Social Research
CHSR
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Buffalo State

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INFECTIOUS DISEASE

Erie County



Department of Health

INFECTIOUS DISEASE

QUESTION ONE

■ What are the challenges/issues/barriers related to the prevention of infectious diseases that you see in your community?



Erie County

Department of Health

INFECTIOUS DISEASE

QUESTION TWO

- What changes in your community would best help to improve overall health?



Department of Health

INFECTIOUS DISEASE

QUESTION THREE

■ Are there specific communities or population groups that resources should be focused on?

Erie County



Department of Health

CHRONIC DISEASE

Erie County



Department of Health

CHRONIC DISEASE

QUESTION ONE

- What are the challenges/issues/barriers related to the prevention of chronic diseases that you see in your community?



Erie County

Department of Health

CHRONIC DISEASE

QUESTION TWO

- What changes in your community would best help to improve overall health?

Eric County



Department of Health

CHRONIC DISEASE

QUESTION THREE

- Are there specific communities or population groups that resources should be focused on?



Erie County

Department of Health

HEALTH PROMOTION/ DISEASE PREVENTION

Erie County



Department of Health

HEALTH PROMOTION/DISEASE PREVENTION

QUESTION ONE

- What are the challenges/issues/barriers related to implementing health promotion that you see in your community?



HEALTH PROMOTION/DISEASE PREVENTION

QUESTION TWO

- What changes in your community would best help to improve overall health?

Erie County



Department of Health

HEALTH PROMOTION/DISEASE PREVENTION

QUESTION THREE

■ Are there specific communities or population groups that resources should be focused on?

Erie County



Department of Health

HIGH RISK/SPECIFIC POPULATIONS

Erie County



Department of Health

HIGH RISK/SPECIFIC POPULATIONS

QUESTION ONE

- What are the challenges/issues/barriers related to the prevention for high risk populations that you see in your community?

Erie County



Department of Health

HIGH RISK/SPECIFIC POPULATIONS

QUESTION TWO

- What changes in your community would best help to improve overall health?

Erie County



Department of Health

HIGH RISK/SPECIFIC POPULATIONS

QUESTION THREE

- Are there specific communities or population groups that resources should be focused on?



Erie County

Department of Health

ERIE COUNTY CONSUMER HEALTH SURVEY

Erie County



Department of Health

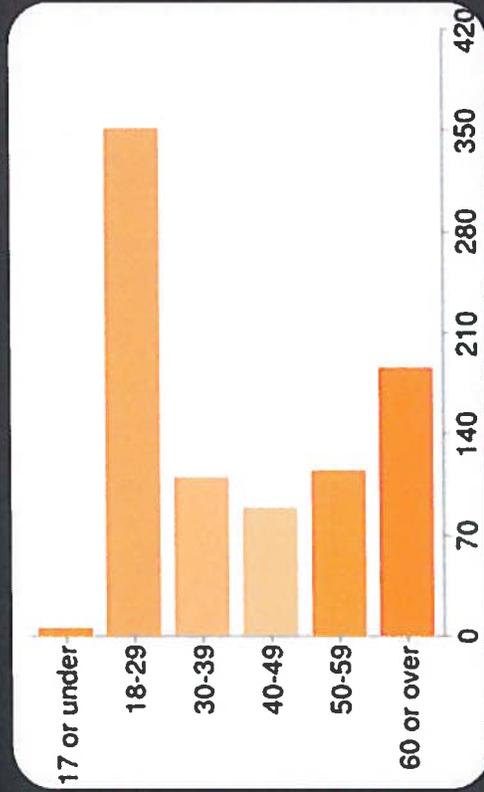
2012-2013

Current Results

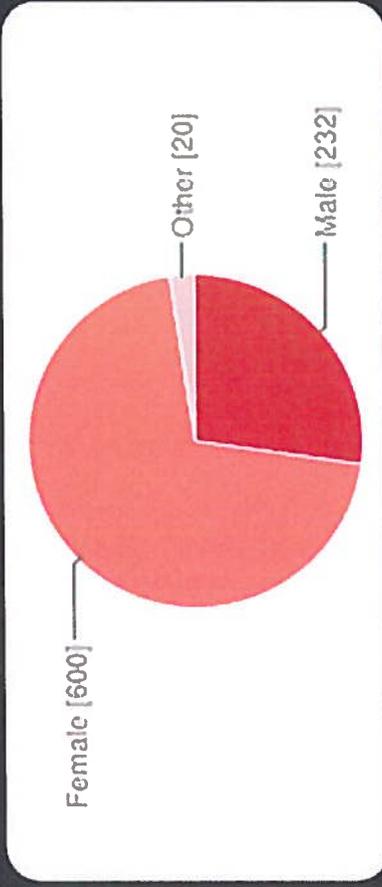
852 Participants

DEMOGRAPHICS REACHED

■ Age

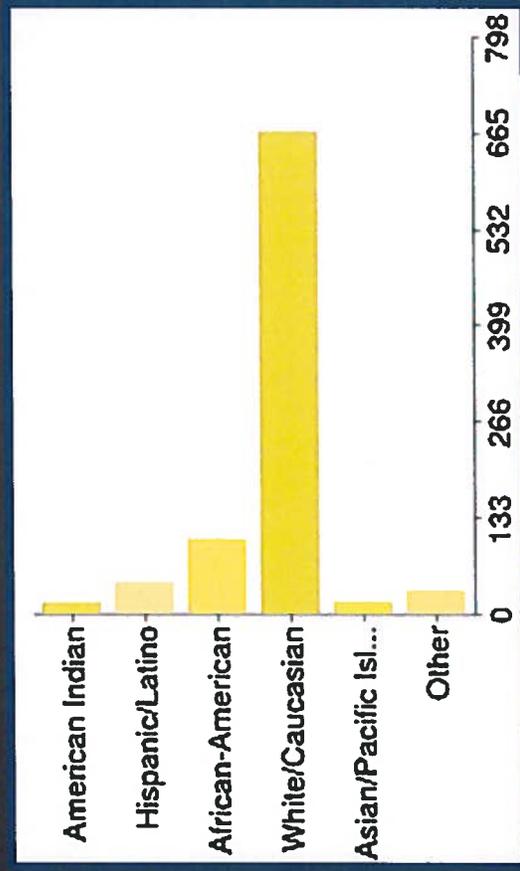


■ Gender

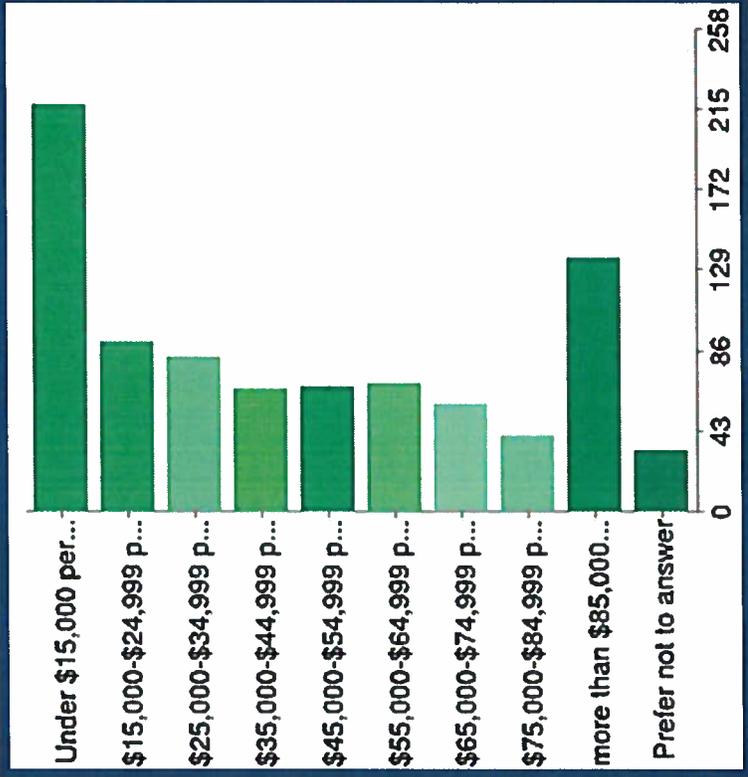


DEMOGRAPHICS REACHED CONTINUED

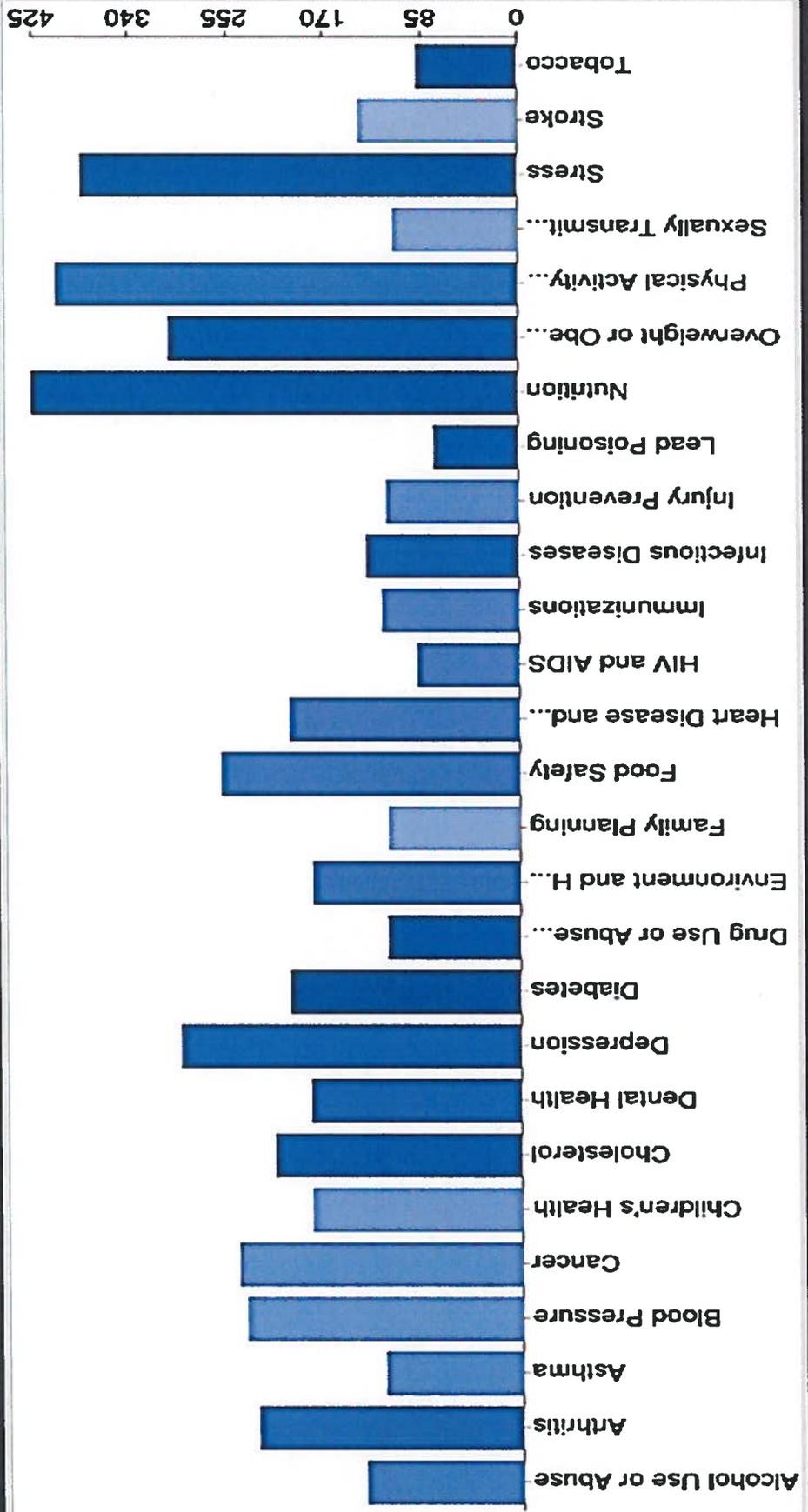
■ Race/Ethnicity



■ Income

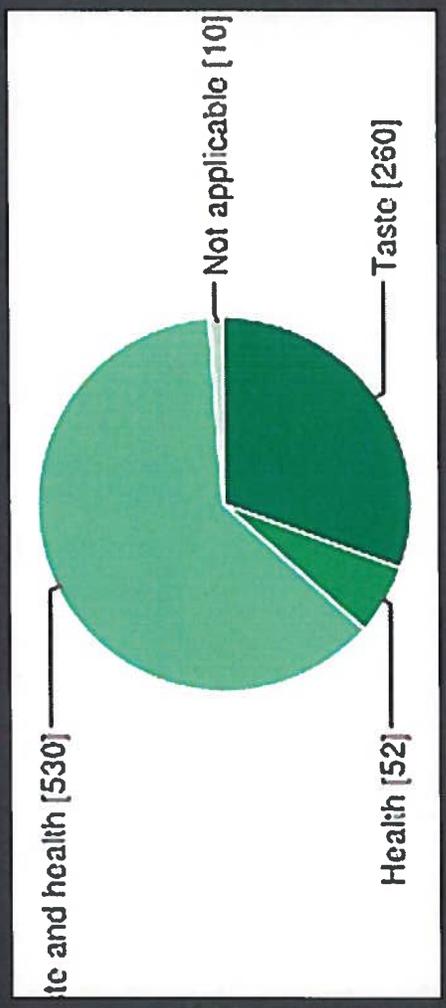
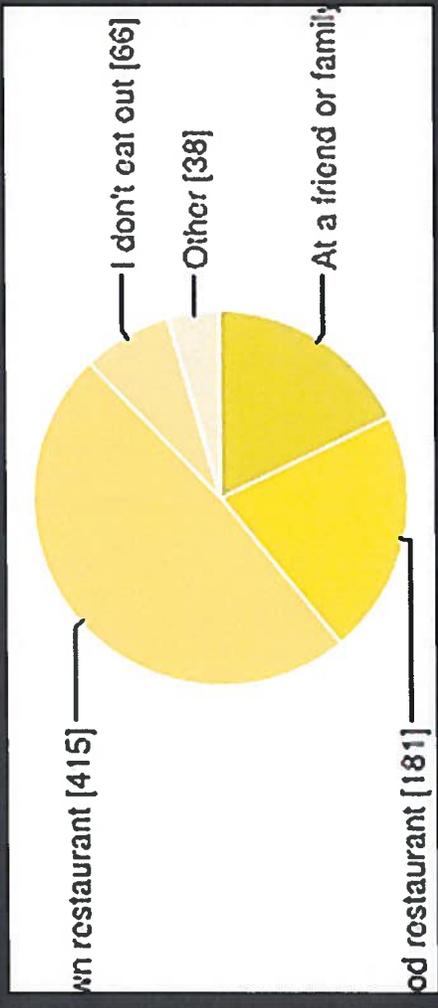


HEALTH TOPIC CONCERNS



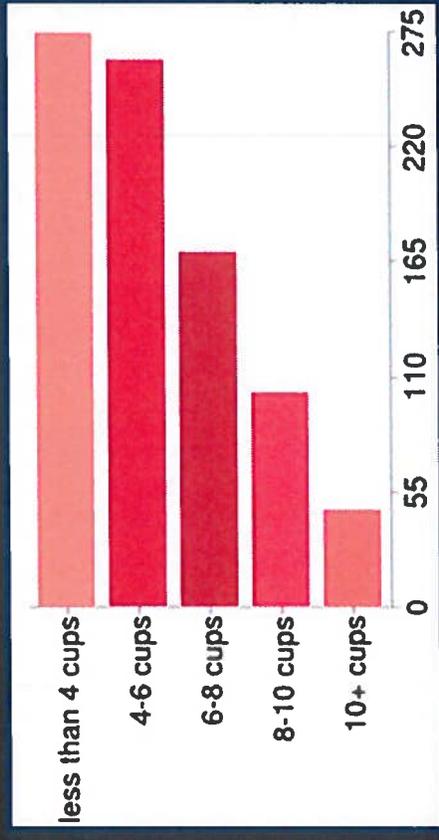
INTERESTING FINDINGS

■ Restaurant Behaviors

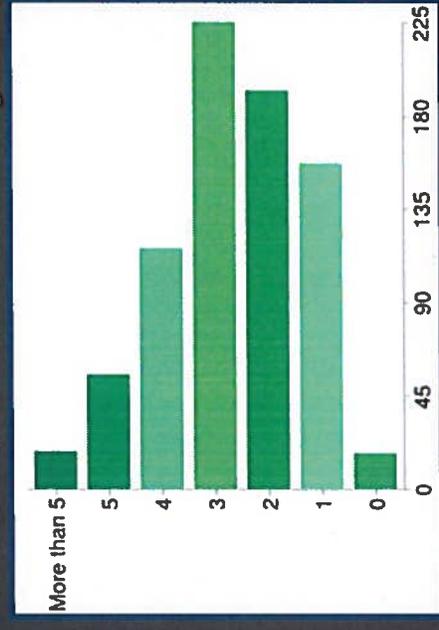


AREAS WHERE CHANGE IS NEEDED

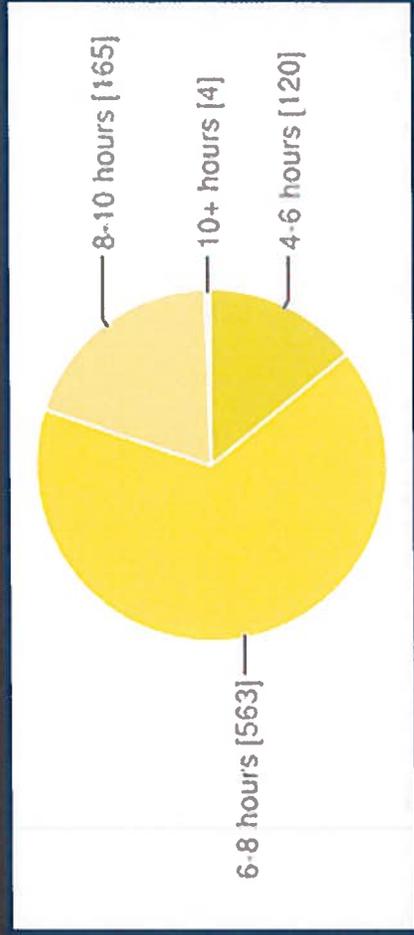
Amount of Water Consumed Daily



Amount of Fruits & Vegetables Consumed Daily



Perception of Needed Amount of Sleep Daily



CONCLUSION

- The Erie County Department of Health has a goal of reaching over 1,000 participants by the end of April to conclude the data.
- Please assist in spreading the survey so that our data can be as accurate as possible, in order to provide the greatest benefits to the community.

ANY ADDITIONAL ITEMS FROM AUDIENCE

Erie County



Department of Health

ERIE COUNTY COMMUNITY HEALTH FORUM

COMMUNITY HEALTH ASSESSMENT

BUFFALO & ERIE COUNTY PUBLIC LIBRARY

WEDNESDAY, APRIL 24, 2013

8:30 – 11:30 A.M.

MINUTES

Cheryll Moore introduced the Buffalo State team, comprised of Alan Delmerrco and Jonathan Lindner, who were facilitating the meeting. She went on to explain that the Community Health Assessment is done every five years with data from national, state and local sources from surveillance obtained from consumers with what is going on in Erie County and to identify problems and needs in health care. We are currently at the end of the five year cycle, and we are developing for the next five years. The survey is on the Erie County website. The information must be submitted by November 15th, and will be up on the website by January 1st.

Question #1 Infectious Diseases

Barriers seen recently is the misinformation that gets out to the community. Also pregnant teens are not concerned with STD's. It was questioned regarding the way the message is being given out and who is giving the message. Thought needs to be given to those who are giving and creating the message. It was mentioned that focus groups could be set up in the community. Buffalo Pre-natal Peri-natal mentioned that there is a problem with girls getting into the system, such as the Dept. of Social Services. We need to work with them. Once they get into the system and they get numerous denials for no reason, they get frustrated and do not want to go back. A dialogue should be started with Social Services. When Buff. Pre-natal accompanies a client to a social service appt. and reiterates that the person is in need, they are able to get services and are surprised that they are not being denied again.

An educational campaign combined with navigational services for assistance with utilizing services needs to be established. This would include coordination with M.D. appointments such as physicals, family planning etc. It was also mentioned that this kind of coordination could be implemented in schools.

Phil Haberstro commented that breaking down silos, and being strategic towards environmental policy changes and positive choices towards infectious diseases.

Another point was to educate young men regarding STD's. Getting to appointments is also a very important factor. As well as coordination of services. There is also a large portion of the community that is uninsured that need to be pre-certified. Is there a coalition that is looking

Services should work together to assist people in accessing health insurance. The Dept. of Social Services is trying to recertify clients as soon as possible. However this is a difficult endeavor. Should we be looking at pulling together to work more effectively.

Specific community or population groups that these resources should be focused on. The male and refugee populations were mentioned. What groups should these resources be focused on specifically? You must look at those who are disproportionately affected in a negative way by the outcomes. The overall picture must be looked at. It is also important to look at gender specific issues; and to focus at preventive and ongoing medical care to help people get connected to resources and understand the necessity of care. Literacy is also important among the refugee population. Lack of resources is also a huge problem.

Educating foundations was mentioned by Phil Haberstro.

Question #2 - Chronic Diseases

Stigma was thought to be one of the largest challenges with promoting health and wellness specifically to chronic disease. Even though there may be services and people are aware of them they may not access those services for fear of any kind of retaliation. Even to themselves or their own mental health. When dealing with chronic diseases one of the core pieces we need to be mindful of is substance abuse. There are issues that are related to stigma and how we can address them.

Phil Haberstro said that that are two critical groups here. The Boards of Education for all of our schools in Erie County should understand how the rule of health education plays in the prevention of chronic disease. Also the employers across Erie County, and the leadership in those groups needs to understand the cost benefits of employee health promotion programs for them.

Maintenance on individuals that know that they have a diseases, i.e. asthma, inhalers that break, and then medication is not taken. Education needs to identify this problem so that the individuals maintain taking their medication.

Another of the major issues of barriers is the utilization of preventive health care. Knowing that annual physicals be done, and then referral to a place for care. Transportation and child care are also barriers to accessing care. Education on an almost personal level needs to take place regarding where to go to get help.

The Diabetes Coordinator from Catholic Health System wanted to focus on an increase in the 30 day rate admissions for patients that come in with an 1800 blood sugar level. This has occurred multiple times due to no access for diabetic care. They are sending patients home with prescriptions. For diabetes alone the cost could be up to \$600, the patients are people with no money. They are continually looking for grants, but this needs to be looked at in a coordinated, collaborative way so that they can put a program in place to get them immediately into health care follow-up. So that they do not rebound into the hospitals and have the services that they need.

Prevention for a lot of population groups is not an option. Many do not have access to fresh fruits and vegetables resulting in a healthier diet for prevention of chronic diseases in the first place.

Also one of the challenges for prevention of chronic diseases is behavioral changes. You need to actively be involved. One of the biggest issues about prevention is that much of the prevention discussed is good prevention. We will never be able to treat our way out of disease. The big issue is how to get the major systems of insurers and hospitals to actively invest in a primary universal kind of correction.

The word is starting to get out to the community about some of these issues such as cardio vascular disease and even mental health. One of the challenges is where does it go from it being an issue to actually make changes that may be prevented by their socio-economic status. We have gathered a lot of information and know how bad things are, the community knows that there is an issue but there is a gap between what people know are a problem and effective interventions that make a difference, instead of interventions that are not producing results.

Someone spoke of evaluating mental health issues of city and specific demographic areas. They are mapping resources and gaps. The gaps of 70-80% are easily filled with multiple programs. The mental health patient is not treated as any other patient in the health care system. Once they are in as mental health patients there is no way out. As a physician when a patient is seen you give them a way out, there is a diagnosis and a prognosis. With mental health patients once you are in, it is a life sentence. The patient often times does not have the drug to get better to pursue treatment.

Businesses must be encouraged to come into Buffalo in order for anyone to advance to do outside activities. We need to invest in the population to get them active. In private schools you are mandated to take a sport. This in turn makes for a healthier population. We need to focus on trying to get our community to engage kids in activities.

A consequence of poverty can be poor health. We need to incorporate activities to bring about positive changes in targeted populations. Groups need to be engaged to evaluate physical health. There must be access to physical activity in the schools.

There must be an integration of physical and mental health services.

Diana Monaco a Dietician from the FDA, who also teaches at Buffalo State, said that involving Educators that try to teach nutrition goes hand in hand with avoiding chronic disease. Getting advice from the experts regarding nutrition education is integral for getting the correct information.

One of the important populations is the child bearing female. She should have access to a healthy environment. This is the starting point for the health of the child. Gestational development and having babies born on time is one of the most important points in going forward, and this begins with the mother's health.

African-American infants born in the City of Buffalo are two and a half times more likely to die than their Caucasian counterparts. The Hispanic populations are also disproportionately high in terms of poor outcomes after birth. There is a new campaign to increase the number of African-American women who breast feed because of the positive benefits of breastfeeding; Pre-conception care also needs to be looked, Buffalo Prenatal is attempting to get the women to do some preventive medicine activities before they decide to get pregnant.

The Erie County Dept. of Senior Services recently completed a needs assessment and health behaviors came up near the top. They did a lot of focus groups and they surveyed seniors. We need to be focusing on the elderly, also young mothers, others who are of child bearing age and their young children. There is a great return on investment when we focus there.

Resources should also be focused on educating individuals on family history. If the parents had heart disease and diabetes what was the reason. Can you do anything to avoid chronic diseases?

MS rates in the area were discussed. People with disabilities in general need to be a focus, just based on the cost of the medical system. There are issues with needing more physicians that are aware of the medical needs of the disabled population. Both on the health side and the physical disabilities side.

It was also mentioned that there are people employed with health insurance where the employers are going to high deductible plans. People are not willing to go for treatment because of this. Over the next five years we could possibly be seeing employees who are covered having less access to health care.

An employee from Independent Living stated that he represented people with physical disabilities but also the health component. He felt that a barrier to health care is due to a lack of coordinated training regarding health issues for disabled people. The barrier involves the fact that the systems do not cross over too well. We are seeing many more instances where people with disabilities are being sub diagnosed. They are diagnosed with small things that are actually larger because they assume that the disability is the cause of the symptom. We need to get something in place where people with disabilities specifically recipients of mental health services can get those needs met by people that are trained to know the difference. The cost for people with chronic disease is very high. We need to get the prevention rates up.

Question #3 – Health Promotion/Disease Prevention – Nutrition, Physical Activity, Access to care, Smoking, Drugs, etc.

Health literacy is a huge issue. We need to think about how we are sending the message. If internet access is not available there is no point in attempting to reach the community in that manner. We need to optimize community block clubs, the faith based community, and word of mouth to be able to reach the community.

Erie Niagara Tobacco Free Coalition was in agreement of the previous comments and suggested doing train the trainer programs so that it also becomes peer to peer. There have been discussions with the Buffalo Board of Block Clubs attempting to build experts into block club citizens as becoming trained advocates for the different health behaviors that we trying to help improve. Using health economists to send advocates into the largest employers to make commitments around these behaviors similar to the Wegmans model.

Traditional issues, problems, concerns, challenges with implementing health promotion programs

A grass roots movement to remove stigma would be very effective. We all have boundaries providing services that are supposed to provide a health promotion, or disease prevention. High risk populations must be targeted the most, general health promotion doesn't necessarily resound with them. Doing some work to make health a value that everyone embraces and celebrates as a community.

There must be more collaboration between organizations. As a health insurer they have a model. Somehow plans could all come together for any organization. There is duplication, using a best practice approach and have insurers get together to brainstorm.

For best practices a continuum of primary universal prevention through continuing care and after care, as well as private care management. We need to get cross cutting to get information so that we are not duplicating. A health social network would be helpful.

Social media could also be an outlet to get input from the community and also to promote people's resources. This would be a way to connect to health promotion.

What changes in your community would best help to improve overall health?

We need to look at our community as a complete community. Not city versus suburbs vs. rural. We need to build a sense of that work and build a totally connected community here in Erie County.

We should look to extend local research studies that are happening at Roswell and probably more at the universities that are using local folks in the testing. Such as screenings, perhaps the local community could then support such endeavors.

It was felt that the community coalitions that we have with information are under-utilized at this point and time. All community health matters, we are a collection of individuals, we must address the community to recover individual's health. This is not true of us presently.

There should be more focus on primary care. There is a lack of primary care physicians. Individuals are utilizing urgent care and emergency rooms. Physician offices are not open in the evenings.

Are there specific communities or population groups that resources should be focused on?

Health promotion and prevention need to be reiterated. Focus on the elderly to keep them healthy also needs to be accomplished. More resources in the senior centers to keep them as healthy as possible. This is a big population that needs to be focused on.

Refugees and immigrants also need to be addressed. There are not a lot of resources available for them. There are cultural and language barriers.

Health promotion among employers also needs to be focused on. Incentives or employers who build in employee health options, i.e. gym options. If employers were rewarded for these options if would be an incentive to raise the value of health.

Looking for small gains in high risk population, young age, urban, poor, trauma exposed or middle aged who have not developed chronic disease as of yet; and to keep them from developing any chronic disease.

High Risk Populations – Elders, youth, disparities

What are the challenges/issues/barriers related to the prevention for high risk populations that you see in your community?

Baby boomers would not necessarily go to senior centers (where there is a lot of health promotion going on), but possibly to centers that have inter-generational programs or perhaps to a coffee establishment. We need to think about how we will get health promotion out to them.

Encouraging more peer to peer support. We encounter people about smoking, when gun violence and walking into the house safely is certainly a priority. When health promotion is done by peers in this instance it will certainly become more valuable.

Urban minority young men were brought up. We only have roughly 20% of them graduate from high school; this is a population that needs to be engaged in health literacy and focused upon.

What changes in your community would best help to improve overall health?

We need to have programs that address the urban risk male population. They need to be focused and oriented that they need to finish school early on in their lives. As well as the parents-school relationship.

If there is a school district that is suspending kids on the average of 45 school days per offense and they are not in school learning about the things that they need to; they are out in the community engaging in behaviors that puts their health at risk. There are a lot of systems that reach out into people's homes for various reasons, i.e. case management or county employees, CPS. All of these people need to have health education given to them as part of their jobs and working in the impact of health when they are out dealing with these folks.

Better workplace wellness and increased funding needs to be reiterated. Health behavior needs to be encouraged.

50% of children in the community show up in kindergarten not ready to learn, and wind up behind in school. There needs to be early childhood school readiness put into place. There is a coalition addressing this problem.

If parents are working, children may be in day care centers or some other setting that may or may not have any health information presented to them either by modeling or program engagement for youth. More importantly it becomes a cost for the parent as well. If the parents are not comfortable where the child is, but that is what they can afford, going back to the poverty issue or the hours provided. The quality of those providers needs to be looked at as well.

Are there specific communities or population groups that resources should be focused on?

An educational system where students are suspended or because they choose not to participate. Home schooling trends also come into play.

Health needs to become a value that means something to everyone in our community. The fact that our educational system recognizes one semester or half a semester for health is not enough. Gym and health need to remain in the curriculum.

We need to get physicians back in the practice of counseling patients on health issues that are brought to them. As opposed to a computerized response to the issue that brings them into the doctor's office. Spinning off pages of information and the patient being told to read it. The relationship with the physician is key. The physician and the practices should be understanding of the issues that affect these populations.

Cheryll Moore gave an update of the consumer surveys.

**Erie County Department of Health:
Data and Technical Support to Develop Dashboards (draft 1.0, 8/15/13)**

Alan M. Delmerico, Ph.D. (Principal Investigator)
William F. Wieczorek, Ph.D. (Co-Investigator)
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Buffalo, NY 14222-1095
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Facsimile: 878-5905
E-mail: delmeram@buffalostate.edu

2013 DRAFT Work Plan

Process Overview

The Center for Health and Social Research (CHSR) has been collaborating with the Erie County Dept. of Health (ECDOH) to provide data and analytical support for ECDOH funded programming across a variety of areas. The focus of this agreement is on the data information and evaluation systems that will allow for measuring the impact of the maternal and child health programs on the community. This work provides a framework and working relationship between ECDOH and CHSR that ensures a longer term (5 year) commitment for data system and evaluation processes.

Drs. Delmerico and Wieczorek will manage the project through their direct involvement and through the oversight of other CHSR staff, as needed.

I. Dashboard conceptual development process.

Background: The CHSR in collaboration with the ECDOH will develop a series of dashboard instruments for use in public reporting and for program-level continuous quality improvement. The goal is to utilize facilitated meetings to drive the development of these instruments, specifically aligning them with goals and objectives for the 2013-2017 New York State Prevention Agenda as part of the County Health Assessment planning process. The dashboards will be designed to be conceptually and functionally aligned with the prevention activity logic models currently being developed. The dashboard will include specific process and outcome metrics from the logic models. The CHSR will facilitate a series of meetings between all necessary parties involved in the dashboard development, including but not limited to representatives of the CHSR, ECDOH, Erie County Division of Information and Support Services (DISS), and health agencies.

Deliverables:

- Dashboard structure developed that conceptually and functionally aligns with logic models
- Specific process and outcome metrics identified that integrate with the components of the logic models

Estimated Cost \$7,500 (100 hours at \$75/hr).

2. Development and implementation of dashboard template.

Background: The CHSR in collaboration with the ECDOH and DISS staff will develop a web-based interface for the dashboards allowing easy access to metrics identified in Task 1 above as well as the supporting information that indicates how those process and outcome metrics align with the components of the logic models. The dashboard template will be designed to feature an overview screen offering a visual summary of dashboard metrics. From this overview screen, users will be able to access individual metric screens that can be examined in greater detail, including comparison data and outcome targets. The online system will be designed to offer multiple levels so that identified groups (e.g. ECDOH staff, health agency staff, the public) can have access to specific content appropriate to their group categorization. In order to achieve this task, the CHSR will facilitate a series of meetings between all necessary parties involved in the online dashboard template development, including but not limited to representatives of the CHSR, ECDOH, DISS, and health agencies.

Deliverables:

- An attractive online dashboard system template to visualize the identified process and outcome metrics that integrate with the components of the logic models including:
 - Overview screen template designed to visually integrating the various metrics
 - Individual metric screen template with integrated display of comparison and target data
 - Supporting information that indicates how those process and outcome metrics align with the components of the logic models
- The dashboard system will allow categories of users to access various levels of information
 - The county-level dashboard will be available to all users and will facilitate public reporting on outcomes
 - Sub-county level data will be restricted to staff of relevant Erie County health agencies, the Center for Health and Social Research (CHSR), and the Erie County Dept. of Health (ECDOH)

Estimated Cost \$15,000 (200 hours at \$75/hr).

3. Acquisition, processing, and publishing of data for dashboards

Background: The CHSR anticipates utilizing data from multiple existing sources (e.g., SPARCS/PQI, ECDOH sources, and local data from agencies). However, some local data may need to be created (e.g., surveys or other sources) in the long-run to create more robust dashboards. Existing archival data will be obtained and processed along with appropriate matching metadata for each metric. We envision acquiring and processing data at multiple geographic scales (e.g. county-level, municipal, ZIP code). Sub-county level data will be used to assess whether programs are targeting and impacting areas of high need and the system can be designed to track impacts over time. Dashboard metrics at the county-level will be aligned with NYS Prevention Agenda objectives, goals of Healthy People 2020, and other applicable targets. Comparison data will be obtained for NY State as well as similar counties (e.g. Monroe) and included in the dashboard interface. Finally, the dashboard templates designed in Task 2 above

will then be populated with data. Updates to the system will be made on an ongoing basis when updated data become available.

Deliverables:

- Obtained and processed data elements aligned with the specific metrics identified in Task 1 published to the dashboard template
- Appropriate metadata for each metric, prepared and published to the dashboard in concert with the matching data element
- Comparison data for each metric from NY State and others as appropriate
- Aligned goals and targets from the NYS Prevention Agenda, Healthy People 2020, or other applicable sources collected and displayed on the dashboard

Estimated Cost \$9,500 (120 hours at \$75/hr).

Work Plan Summary - 2013

Section 1: Dashboard conceptual development process: 100 hrs, \$7,500.

Section 2: Development and implementation of dashboard template: 200 hrs, \$15,000

Section 3: Acquisition, processing, and publishing of data for dashboards: 120 hrs, \$9,500

Total 2013 Work Plan \$32,000

Cost of the December 2012-May 2013 Work Plan

Total costs for these services are estimated at \$32,000, based on an estimated 420 hours of effort at \$75 per hour. These are only estimates; CHSR has the flexibility to allocate effort to achieve the goals of the work plan for the estimated total cost. If the scope of the work is substantially greater or less than anticipated, CHSR will notify ECDOH as soon as this situation is recognized so that a revised agreement can be negotiated. This agreement can also be amended to expand the scope of work with the approval of both ECDOH and Research Foundation of SUNY/Buffalo State College. This agreement may be terminated by written notice by either party, provided such notice is given 30 days prior to the proposed date of termination and only in the failure of good faith efforts by ECDOH and the Center for Health and Social Research to resolve outstanding issues and concerns relating either to its content or implementation.

Agenda
CHA/CSP Joint Meeting Conference Call
8/23/13

1. Welcome
2. Confirmation of joint focuses
3. Inventory of Breastfeeding activities in the community occurring to increase rates in Erie County – update to plans, possible dashboard creation for indicator ([Healthy Marin](#))...example, proposal from Buffalo State College
 - Data links in meeting notice email
 - Baseline? How to best obtain
 - Subcommittee/workgroup meeting
4. Inventory of Chronic Disease (Hypertension or colorectal?) in the community
 - What specific indicators do we want to monitor/move?
 - CHS/ECDOH – increase age appropriate colorectal cancer screening rates at 1500 Broadway site
 - Baseline data/ - links sent in meeting email
 - Stroke Heroes act FAST campaign – links provided -
 - Kaleida -
5. Next meeting ?

Thanks and have a great weekend!

NYS Prevention Agenda 2013-2017 – Erie County Community Health Assessment planning

Key:

Priority Area

- Focus Area
 - o Goal
 - Potential relevant grant/project/agency in Erie County

Prevent Chronic Disease:

- Reduce obesity in children and adults
 - o Create community environments that promote and support healthy food and beverage choices and physical activity
 - o Prevent childhood obesity through early child care and schools
 - Breastfeeding-Friendly Erie County (P2/United Way)
 - o Expand the role of health care and health service providers and insurers in obesity prevention
 - o Expand the role of public and private employers in obesity prevention
- Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure
 - o Prevent initiation of tobacco use by NY youth and young adults, especially among low SES populations
 - Erie-Niagara Tobacco-Free Coalition
 - o Promote tobacco use cessation, especially among low SES/poor mental health
 - NYS Smokers Quitline (Roswell Park)
 - Erie-Niagara Tobacco-Free Coalition
 - o Eliminate exposure to secondhand smoke
 - NYS Erie County Asthma grant (pending)
 - Erie-Niagara Tobacco-Free Coalition
- Increase access to high-quality chronic disease preventive care and management in both clinical and community settings
 - o Increase screening rates for cardiovascular disease, diabetes, and breast/cervical/colorectal cancer, especially among disparate populations
 - AF4Q 3.0 (P2)
 - Meeting the Mark: Diabetes Recognition Program
 - NYS/CDC Diabetes Prevention Program
 - Jericho Road Hope Refugee Drop-In Center (United Way funded)
 - o Promote use of evidence-based care to manage chronic diseases
 - AF4Q 4.0 (P2)
 - BEACON (P2) – Health IT for population health management
 - NYS Erie County Asthma grant (pending)
 - P2 Chronic Disease Self-Management initiatives
 - o Promote culturally relevant chronic disease self-management education
 - P2 Chronic Disease Self-Management initiatives

Promote Healthy Women, Infants, and Children

- Maternal and Infant Health
 - o Reduce premature births in NYS
 - Buffalo Prenatal-Perinatal Network CHW program (United Way)
 - Jericho Road Ministries (Refugee outreach - Priscilla Project) (United Way)
 - o Increase the proportion of NYS babies who are breastfed
 - Breastfeeding-Friendly Erie County (P2/United Way)
 - Buffalo Prenatal-Perinatal Network CHW program (United Way)
 - Jericho Road Ministries (Refugee outreach - Priscilla Project) (United Way)
 - o Reduce the rate of maternal deaths in NYS
- Child Health
 - o Increase the proportion of NYS children who receive comprehensive well child care in accordance with AAP guidelines
 - NYS Erie County Asthma Grant (pending)
 - Buffalo Prenatal-Perinatal Network CHW program (United Way)
 - o Reduce the prevalence of dental caries among NYS children
- Preconception and Reproductive Health
 - o Reduce the rate of adolescent and unplanned pregnancies in NYS
 - o Increase utilization of preventive health services among women of reproductive age to improve wellness, pregnancy outcomes, and reduce adverse birth outcomes

Agenda
CHA/CSP Joint Meeting
7/26/13

1. Welcome
2. Consumer survey data presentation – Al Delmerico
3. Confirmation of joint focuses
4. Inventory of Breastfeeding activities in the community occurring to increase rates in Erie County
5. Inventory of Chronic Disease (Diabetes or colorectal?) in the community
 - What specific indicators do we want to monitor/move?
 - Baseline data/
6. Next meeting – 8/9/13 9am, room 904 Rath Building

Thanks and have a great weekend!

CHA/CSP – Breast Feeding Collaboration to decrease obesity

% babies fed breast milk exclusively in delivery hospitals

% babies continued to be fed breast milk exclusively at 2 and 4 month pediatrician visits

Work with large select practices to create model – potential low hanging fruit

- UBMD – Jericho, Cleve Hill, Jefferson, Linwood Peds
- Buffalo Pediatrics
- Tonawanda Peds
- Delaware Peds
- Towne Gardens
- CHS/1500 Broadway

Develop dashboard for posting on ECDOH website for tracking movement of indicators, hosting of data (local prenatal/ perinatal indicator data and local programs associated with moving them)

Agenda
CHA/CSP Joint Meeting Conference Call
8/9/13

1. Welcome
2. Confirmation of joint focuses
3. Inventory of Breastfeeding activities in the community occurring to increase rates in Erie County – update to plans, possible dashboard creation for indicator ([Healthy Marin](#))...example
4. Inventory of Chronic Disease (Hypertension or colorectal?) in the community
 - What specific indicators do we want to monitor/move?
 - Baseline data/
 - Stroke Heroes act FAST campaign
5. Next meeting ?

Thanks and have a great weekend!

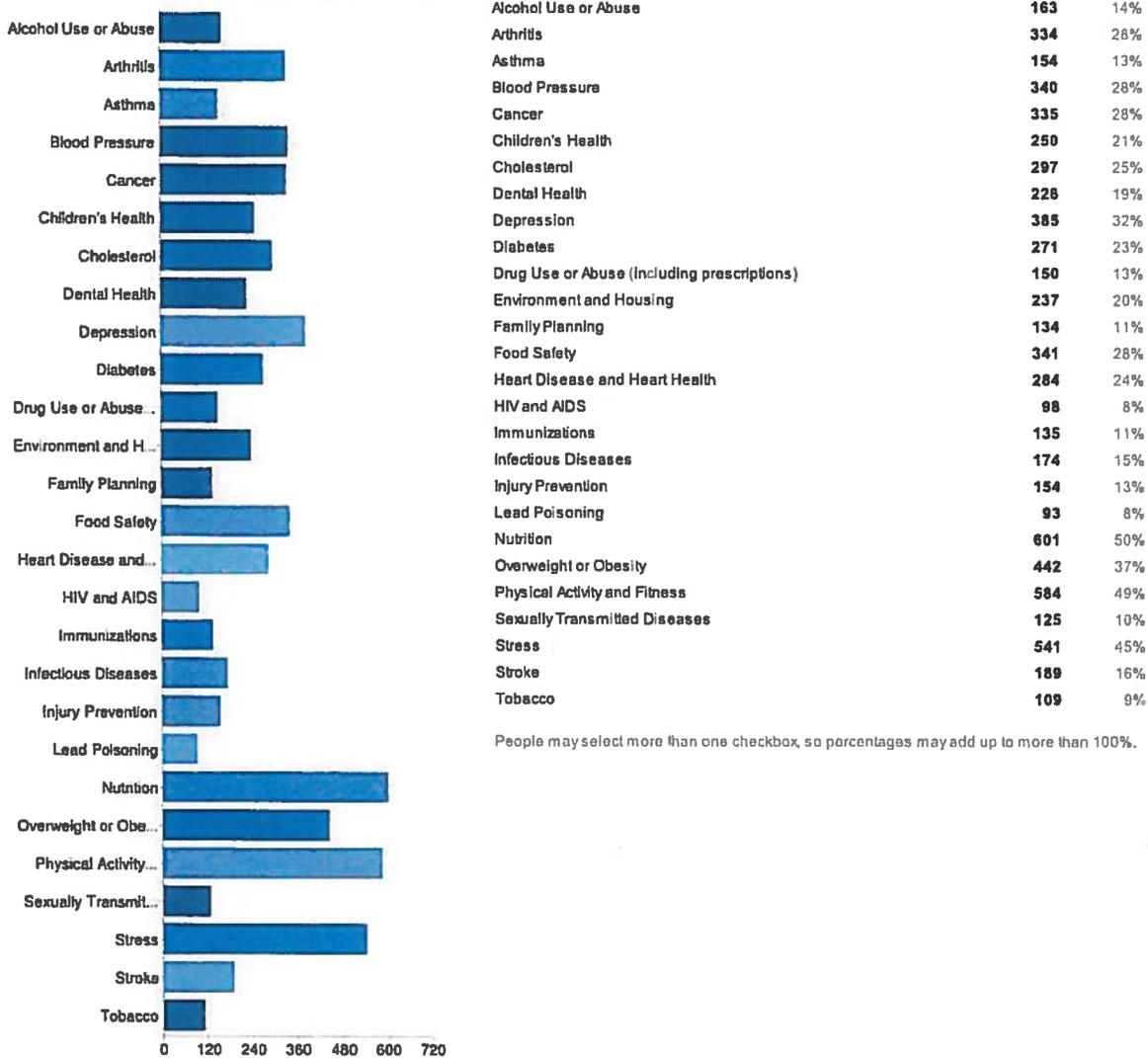
1198 responses

Summary [See complete responses](#)

A. Introduction

Please be honest, we guarantee that your identity will never be known or sought. Only take this survey once.

A1. What health topics are you interested in learning more about?:

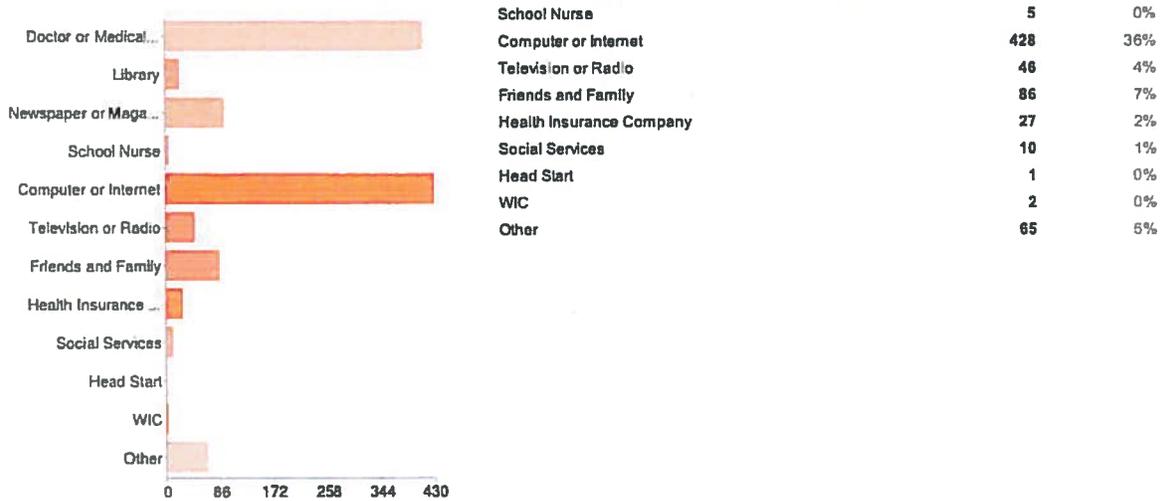


A2. If there are other health topics you are interested in, what are they?

Mental Health topics
 Mental health such as Anxiety, borderline personality disorder, bipolar, etc...
 Epilepsy
 Autism
 ALS
 None that I can think of,
 N/A
 Canker Sores - Prevention of
 Preventive medicine
 kidneystones
 Birth Control
 Headaches (migraines, cluster, tension) and ideas for helping ease them. Also, the use of vitamins and homeopathic remedies.
 How pollution from surrounding areas effect our health, and what we can do to reduce our exposure to toxic pollutants. Of particular concern is the Huxley Coal Powered Generating Plant, the public should be educated about how the emission from th ...

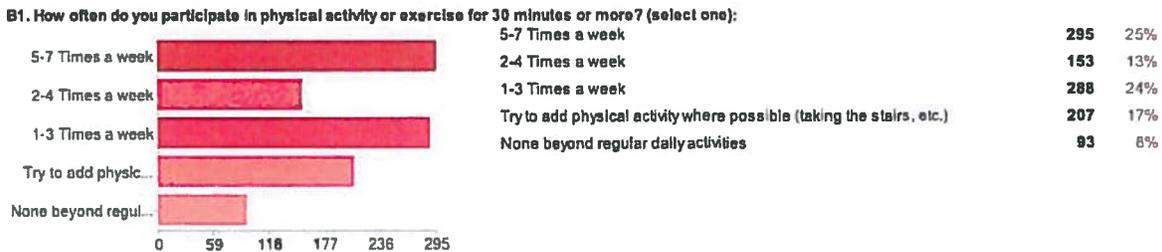
A3. Where do you get most of your health information? (select one):

Doctor or Medical Provider	411	34%
Library	22	2%
Newspaper or Magazine	95	8%



B. Your habits and your health

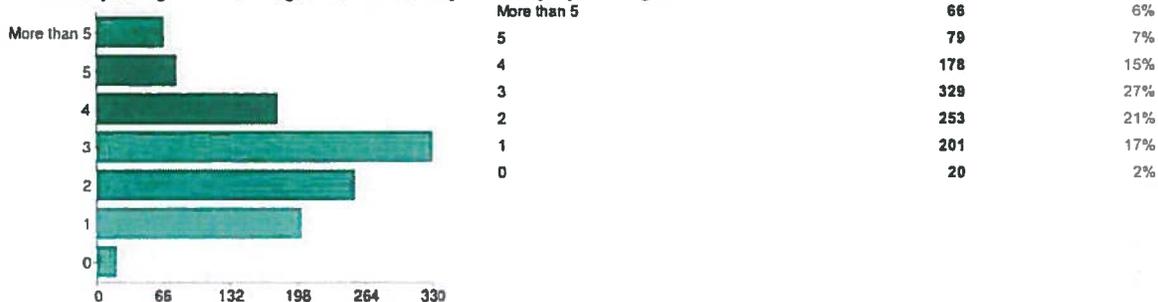
In this section we want to learn about the perceptions and behaviors associated with your individual health status.



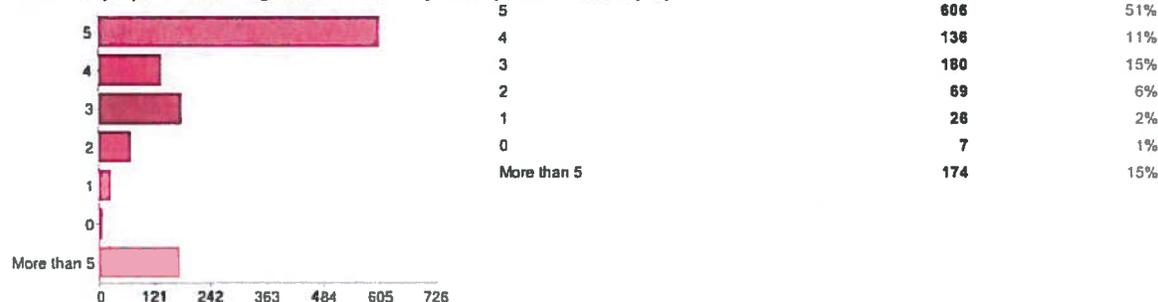
B3. Is there anything else that would help you become more active? If yes, what?

More affordable personal training at home gym Outdoor activities, such as biking, canoeing, white water rafting trips, sport games, etc...
 Having more time available to me. Right now I have class, work and an internship plus homework on top of that. group sports no not
 really no None N/A Cheaper exercise classes activities, a wider spread of times when activities were available. Motivation and less stress from work, school, etc. If I didn't experience my daily pain in my fingers, back, neck, and foot. Better gym equipment at the schools facilities as well as more space for each sport team to practice
 I ...

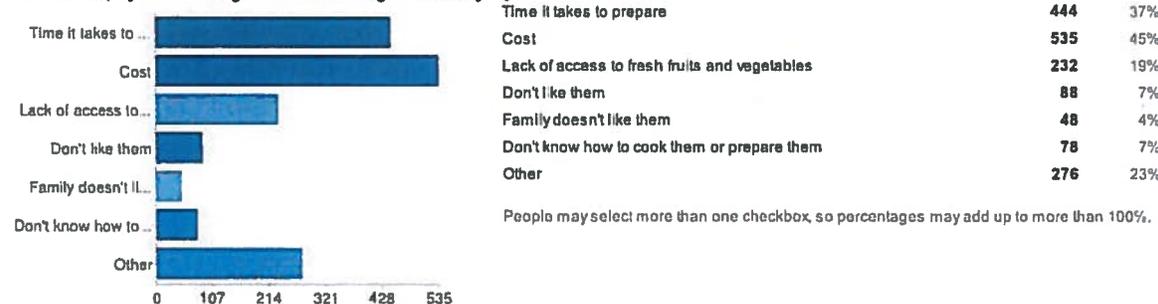
B4. How many servings of fruits and vegetables combined do you eat every day on average?



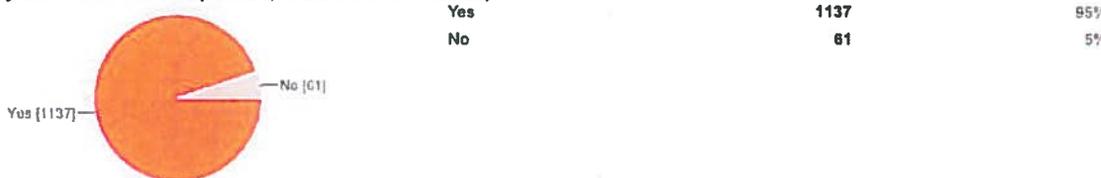
B5. How many cups of fruits and vegetables combined do you think you should eat every day?



B6. What keeps you from eating more fruits and vegetables every day?

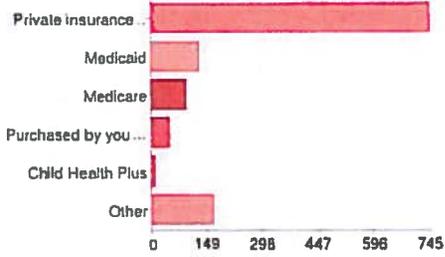


B7. Do you have health insurance (Medicaid, Medicare or other insurance)?

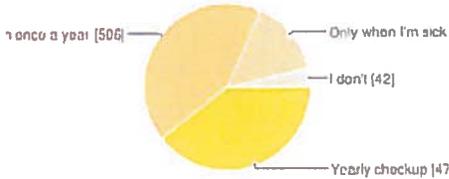


B8. If you do have health insurance, is this insurance...

Insurance Type	Count	Percentage
Private insurance from you or your spouse's work	745	62%
Medicaid	131	11%
Medicare	95	8%
Purchased by you directly from the insurance company	49	4%
Child Health Plus	11	1%
Other	167	14%

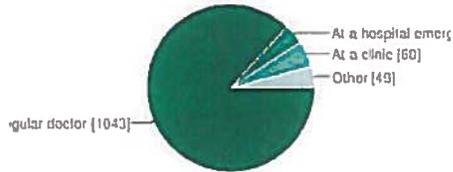


B9. How often do you see a doctor or medical professional?



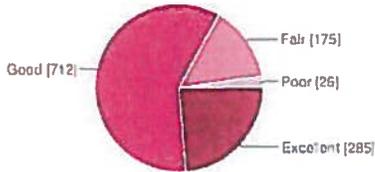
Yearly	473	39%
More than once a year	506	42%
Only when I'm sick	177	15%
I don't	42	4%

B10. Where do you usually seek medical care?



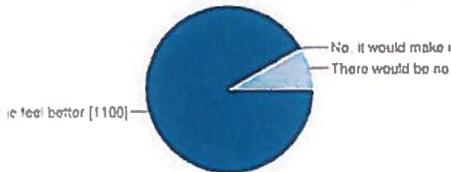
At your regular doctor	1043	87%
At a hospital emergency room	46	4%
At a clinic	60	5%
Other	49	4%

B11. How would you rate your overall health?



Excellent	285	24%
Good	712	59%
Fair	175	15%
Poor	26	2%

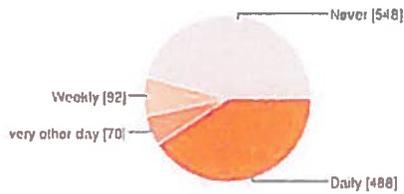
B12. If you were to eat healthier and exercise more, do you think that it would make a difference in how you feel?



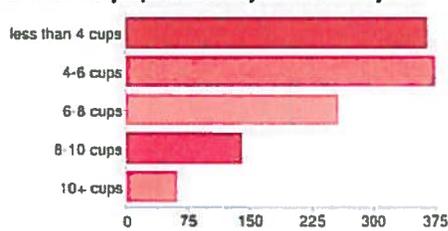
Yes, it would make me feel better	1100	92%
No, it would make me feel worse	3	0%
There would be no change in how I feel	95	8%

B13. How often do you take a multi-vitamin?

Daily	488	41%
Every other day	70	6%
Weekly	92	8%
Never	548	46%

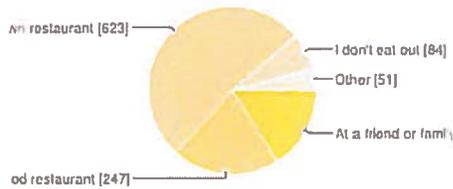


B14. How many cups of water do you drink each day?



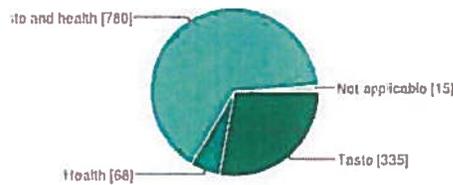
Number of cups	Count	Percentage
less than 4 cups	365	30%
4-6 cups	375	31%
6-8 cups	257	21%
8-10 cups	140	12%
10+ cups	61	5%

B15. When away from home, where do you normally eat?



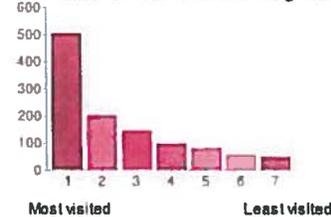
Location	Count	Percentage
At a friend or family member's house	193	16%
At a fast food restaurant	247	21%
At a sit-down restaurant	623	52%
I don't eat out	84	7%
Other	51	4%

B16. When eating out, do you order based on taste or health?



Basis	Count	Percentage
Taste	335	28%
Health	68	6%
A combination of both taste and health	780	65%
Not applicable	15	1%

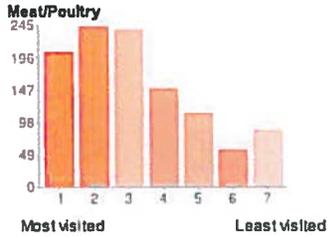
B17. Please rank each section of the grocery store from most frequently shopped to least frequently shopped (Don't repeat numbers).



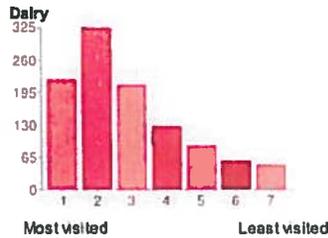
Rank	Count	Percentage
1 - Most visited	501	42%
2	200	17%
3	142	12%
4	95	8%
5	78	7%
6	54	5%
7 - Least visited	45	4%

Snack

Rank	Count	Percentage
1 - Most visited	61	5%
2	102	9%
3	125	10%
4	160	13%
5	128	11%
6	188	16%
7 - Least visited	273	23%



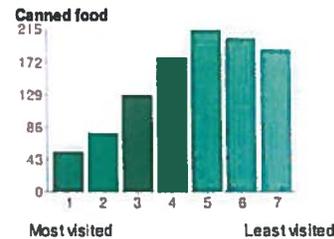
1 - Most visited	204	17%
2	244	20%
3	239	20%
4	150	13%
5	112	9%
6	56	5%
7 - Least visited	86	7%



1 - Most visited	221	18%
2	325	27%
3	210	18%
4	127	11%
5	88	7%
6	56	5%
7 - Least visited	50	4%



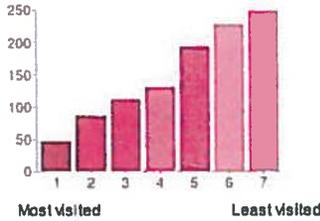
1 - Most visited	113	9%
2	139	12%
3	188	16%
4	259	22%
5	153	13%
6	117	10%
7 - Least visited	85	7%



1 - Most visited	52	4%
2	77	6%
3	127	11%
4	177	15%
5	214	18%
6	203	17%
7 - Least visited	188	16%

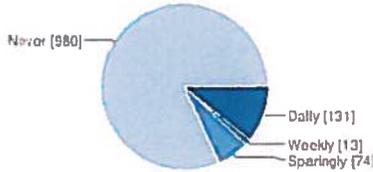
Baked food

1 - Most visited	45	4%
2	85	7%
3	111	9%
4	130	11%
5	193	16%



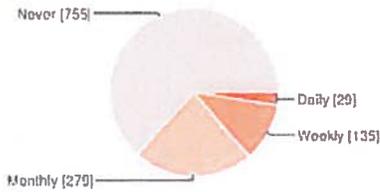
6	228	19%
7 - Least visited	249	21%

B18. How often do you use tobacco products?



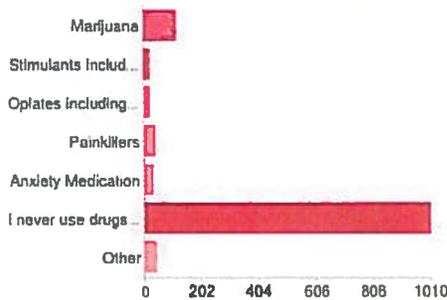
Daily	131	11%
Weekly	13	1%
Sparingly	74	6%
Never	980	82%

B19. How often do you drink 4 or more alcoholic drinks at one setting?



Daily	29	2%
Weekly	135	11%
Monthly	279	23%
Never	755	63%

B20. What drugs do you use recreationally (Please be honest, we guarantee your anonymity)?



Marjuana	118	10%
Stimulants including prescription drugs	21	2%
Opiates including prescription drugs	19	2%
Painkillers	38	3%
Anxiety Medication	29	2%
I never use drugs recreationally	1009	84%
Other	40	3%

People may select more than one checkbox, so percentages may add up to more than 100%.

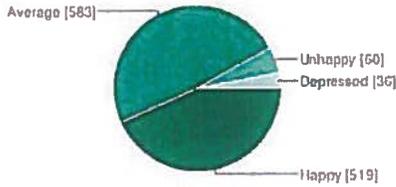
B21. How many hours of sleep do you think the average adult needs per night?



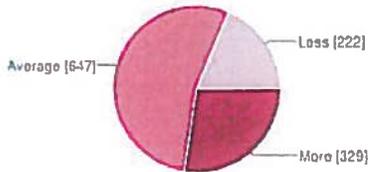
4-6 hours	167	14%
6-8 hours	803	67%
8-10 hours	224	19%
10+ hours	4	0%

B22. I would consider my average mood to be:

Happy	519	43%
Average	583	49%
Unhappy	60	5%
Depressed	36	3%



B23. I would say that I have _____ energy compared to the average person:

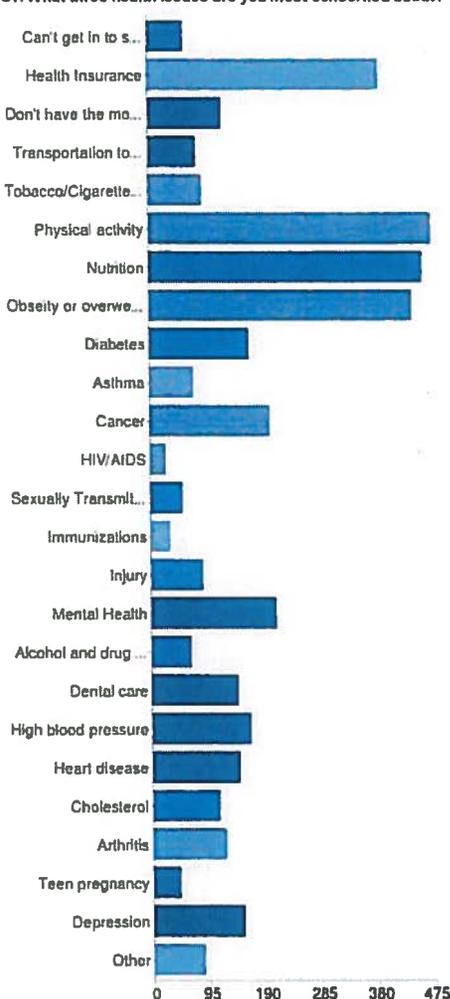


More	329	27%
Average	647	54%
Less	222	19%

C. Health needs in your community

In this section we are interested in knowing what you think are the most important issues related to health in your community.

C1. What three health issues are you most concerned about?



Can't get in to see a doctor/Can't get an appointment	60	5%
Health Insurance	389	32%
Don't have the money to go to a doctor	123	10%
Transportation to the doctor	79	7%
Tobacco/Cigarettes/Cigars	89	7%
Physical activity	474	40%
Nutrition	459	38%
Obesity or overweight	442	37%
Diabetes	167	14%
Asthma	73	6%
Cancer	202	17%
HIV/AIDS	25	2%
Sexually Transmitted diseases	53	4%
Immunizations	32	3%
Injury	87	7%
Mental Health	211	18%
Alcohol and drug abuse	66	6%
Dental care	145	12%
High blood pressure	166	14%
Heart disease	147	12%
Cholesterol	112	9%
Arthritis	123	10%
Teen pregnancy	45	4%
Depression	152	13%
Other	85	7%

People may select more than one checkbox, so percentages may add up to more than 100%.

C2. What do you think needs to be done to deal with the health issues you are concerned about?

more info should be available Exercise and Nutrition I don't know X Eat better and exercise more, exercise Research continue to watch diet People need to be aware of their health condition and understand how to live a healthy lifestyle. Early intervention More time spent on information It is not so much of a concern for myself because I am in elite shape, but for most of the people in this county their either overweight due to lack of physical activity or due to improper diet. Mentally health is always important because mental health needs to be balanced with physically health. When these are balance ...

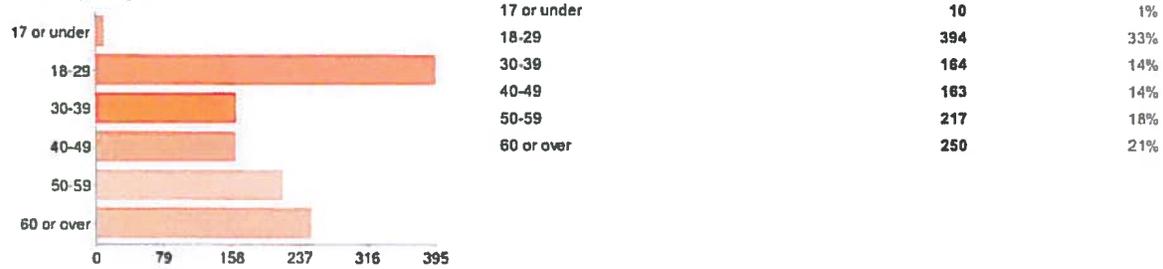
C3. Have you had difficulty finding a particular healthcare service for you or your family? If yes, please explain:

no No Yes...access to eating disorder/body image support groups No No. no No no No No No I am 22 years of age and I still live with my parents. I work regular part time at a job and could have healthcare provided for me via that company but I am still under my parents at this time. So no. No I will have no health care once in turn 26. Not really, it's mostly cost that is a factor. No, No no NO no No, No, no. No no No no no sort of it's all expensive no no. No Most doctors do not take my particular insurance and going on the website to find a doctor can be difficult if you don't have Internet access like I do. Also th ...

D. Demographics

Tell us about yourself

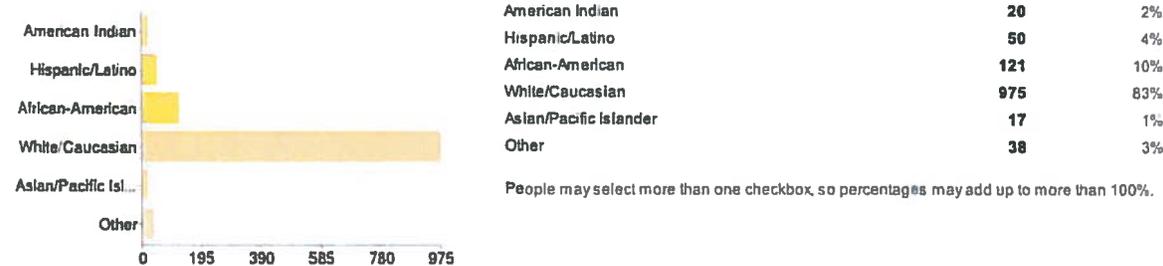
D1. Your age range:



D2. Gender



D3. Race/Ethnicity



D4. Zip code where you live:

14212 14207 14222 14221 14226 14075 14068 14086 14223 14220 14228 14221 14221 14226 14150 14212 14222 14224 14224 14150 14220 14220

D5. County where you live:

Erie Erie US Erie Erie erie Erie ene Erie Erie Erie Erie county Erie Erie ERIE Erie Erie Erie erie Erie Erie USA Erie Erie Erie Niagara Erie ene Erie Niagara Nassau ene united states Erie USA Wayne Niagara Monroe erie Erie Erie Erie er ...

