2019
COMMUNITY HEALTH NEEDS ASSESSMENT FOR
NIAGARA COUNTY

2020 - 2022
COMMUNITY SERVICE PLAN

DECEMBER 2019 // SUBMITTED BY NIAGARA FALLS MEMORIAL MEDICAL CENTER
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I. Executive Summary

Niagara Falls Memorial Medical Center (NFMMC) is a fully accredited, 171-bed full-service acute care hospital in downtown Niagara Falls. The medical center offers extensive inpatient and outpatient services including a 120-bed skilled nursing and rehabilitation center, six primary care physician practices (Niagara Falls, North Tonawanda, Wheatfield, Grand Island, Town of Niagara and Wellness Center), a suburban outpatient service center (Summit Healthplex/Wheatfield) with laboratory, radiology, rehabilitation, sports medicine and specialty physician services, and a health clinic for members of the nearby Tuscarora Indian Reservation.

Memorial offers several services unique to Niagara County including a wound care center with a multi-specialty medical staff that offers hyperbaric oxygen therapy, a cardiac catheterization laboratory (in partnership with Erie County Medical Center, Catholic Health and Kaleida Health), and the Child Advocacy Center of Niagara, a multi-disciplinary program responding to reports of physical and sexual child abuse.

Additionally, NFMMC's Golisano Center for Community Health, located on the main campus, is the only facility in Western New York that offers specialized primary care, dental and behavioral health care to people with intellectual and developmental disabilities.

Other services unique to Niagara County include adult mental health/psychiatric emergency care, a 54-bed inpatient adult behavioral health unit, and the Niagara Wellness Connection Center, which provides integrated outpatient behavioral health services, primary care and community based social support referral services.

NFMMC has entered into a formal affiliation agreement with the Roswell Park Comprehensive Care Center. A new medical oncology center to be operated in affiliation with Roswell Park Comprehensive Cancer Center is scheduled to open in June 2020 and will provide hematology, immunology, chemotherapy infusion therapy and related support services. The new center will be equipped to provide specialized cancer services to people with intellectual and developmental disabilities.

Beginning in July 2018, Niagara Falls Memorial joined the Niagara County Health Department and the county's other hospitals in implementing a joint health needs assessment. This 18-month long initiative was framed by the 2019-2024 NYSDOH Prevention Agenda and facilitated by representatives from the Population Health Collaborative, a Western New York organization that connects diverse groups of
people to align resources and expertise, actively working to improve population health in Western New York.

The process, which is outlined below, led the county health department and county hospitals to agree to address two broad Prevention Agenda Priority Areas: Preventing Chronic Disease and Promoting Well-Being and Preventing Mental and Substance Use Disorders. At NFMMC, efforts in the first Priority Area will focus on cancer prevention, especially in people with intellectual and developmental disabilities. In the second Priority Area, efforts will focus on the reduction of major depressive disorders. Details are provided in the section titled Implementation Plan.

Niagara County’s hospitals and the Niagara County Health Department will support each other and will meet together on a quarterly basis beginning in Spring 2020 to provide updates and explore further collaboration.

II. Description of Community/Population Served (e.g., geographic, demographic, and Socioeconomic information)

Niagara Falls Memorial defines the community it serves geographically. Its service area encompasses all of western Niagara County and portions of northern Erie County. The zip codes included in this area are 14072, 14301, 14303, 14304, 14305, 14092, 14107, 14109, 14120, 14131, 14132, 14144, 14172 and 14174.

Niagara County is the 18th largest county in New York. According to the U.S. Census Bureau American Community Survey 2013-2017 five-year estimate, the total population of Niagara County is 212,675, making it the second largest county in Western in Western New York by population. It ranks 18th in population size of the 62 counties in New York State. The county is considered to be 75% urban and 25% rural.

In regard to race alone, or in combination with one or more other races, 87.8% of its residents are Caucasian, 7.2% are Black, 1.1% American Indian, 1.1% Asian, 1% Pacific Islander, and 2.7% Hispanic or Latino. 94.5% spoke English, 1.6% Spanish and 1% spoke Italian as their first language.

The service area is a study in contrasts. Niagara Falls (zip codes 14301, 14303, 14304 and 14305), with an estimated 48,976 residents, has some of the highest poverty rates in the region.

The median household income is $33,965 with 28% of its residents living below the federal poverty level and another 21% living between 100% and 200% of the federal poverty level. (Source: American Community Survey, 2017). More than 50 percent of Niagara Falls residents receive some form of government assistance and 75 percent of the city school district’s students qualified for either free or reduced-price meals during the 2019-2020 school year.

Black/African American residents account for 22.4 percent of the city’s population.

The next largest city, North Tonawanda (zip 14120) has 30,752 residents, a median household income of $53,002 and a poverty rate of 8.81%. Its population is 93.5 white. Forty-four percent of the students
in the city’s school district qualified for either free or reduced-price meals during the 2018-2019 school year.

The surrounding towns of Niagara, Wheatfield, Grand Island, Lewiston, Porter and Wilson are predominantly suburban and rural with a significant agricultural presence. All are in Niagara County except Grand Island (zip 14072, population 20,855), which is in adjacent Erie County just south of Niagara Falls.
## Population of area served:

<table>
<thead>
<tr>
<th>Locality</th>
<th>Population</th>
<th>Locality</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barker (village)</td>
<td>754</td>
<td>Cambria (town)</td>
<td>5800</td>
</tr>
<tr>
<td>Gasport (CDP)</td>
<td>1420</td>
<td>Hartland (town)</td>
<td>4038</td>
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<td>Lewiston (village)</td>
<td>2594</td>
<td>Lewiston (town)</td>
<td>15,991</td>
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<td>Lockport (town)</td>
<td>20,222</td>
<td>Lockport (city)</td>
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<td>Middleport (village)</td>
<td>1807</td>
<td>Newfane (town)</td>
<td>9432</td>
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<td>Niagara Falls (city)</td>
<td>48,976</td>
<td>Niagara (town)</td>
<td>8148</td>
</tr>
<tr>
<td>Olcott (CDP)</td>
<td>1014</td>
<td>North Tonawanda (city)</td>
<td>30,752</td>
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<td>Pendleton (town)</td>
<td>6583</td>
<td>Porter (town)</td>
<td>6616</td>
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<tr>
<td>Ransomville (CDP)</td>
<td>1626</td>
<td>Rapids (CDP)</td>
<td>1336</td>
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<td>Royalton (town)</td>
<td>7564</td>
<td>Sanborn (CDP)</td>
<td>1210</td>
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<td>2706</td>
<td>South Lockport (CDP)</td>
<td>7654</td>
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<td>Wheatfield (town)</td>
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<td>Wilson (village)</td>
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<td>Youngstown (village)</td>
<td>1894</td>
<td>Tuscarora Nation Reservation</td>
<td>1048</td>
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</tbody>
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Source: [https://factfinder.census.gov](https://factfinder.census.gov)
III Health Needs Assessment Process

The Community Health Needs Assessment process began in July 2018 and was conducted as a collaborative process involving active participation by the Niagara County Health Department, Eastern Niagara Hospital, DeGraff Memorial Hospital, Mount St. Mary's Hospital & Health Center, Niagara Falls Memorial Medical Center and the Population Health Collaborative, and organization dedicated to improving population health in Western New York by connecting diverse groups and aligning resources and expertise.

Representing their respective organizations in this process were:

Community Health Assessment Steering Committee

Patrick J. Bradley, BA, CHEC, Director of Communications & Emergency Management
Niagara Falls Memorial Medical Center

Fred Caso, Vice President, Community Relations
Mount St. Mary’s Hospital and Health Center

Bernadette A. Franjoine, Senior Director – Operations
Mount St. Mary’s Hospital and Health Center
Karen Hall, MHA, Program Manager  
Population Health Collaborative

Stacy Knott, MSEd, Public Health Educator  
Niagara County Department of Health

Jacquelyn Langdon, AAS, Confidential Secretary to the Public Health Director  
Niagara County Department of Health

Carolyn A. Moore, MSEd, Director of Community Relations  
Eastern Niagara Hospital

Alexandra Murr, DNP, MSN/MHA, RN, NE-BC Nurse Manager  
DeGraff Memorial Hospital

Clement Nsiah, PhD, MS, Project Coordinator  
Population Health Collaborative

Victoria Pearson, MBA, LNHA, Director of Financial Operation  
Niagara County Department of Health

Lauretta Schoenfeldt, BSN, RN, Director of Nursing Services  
Niagara County Department of Health

Daniel Stapleton, MBA, Public Health Director  
Niagara County Department of Health

The process was completed in four phases:

**Phase I (July 2018-September 2018)**

The Community Health Assessment (CHA) Steering Committee was established with representation as above. The team met twice in Phase One and highlights of the meetings can be found below.

- Review Past CHA Survey Questions
  - Revision of questions
- Set Timeline for CHA Process
  - Finalizing Survey Questions
  - Distribution of Surveys areas to target
  - Setting Focus Groups Dates and Location
  - Setting Community Meeting Date
- 2018 Prevention Agenda Update
  - Local Community Coalitions
  - Health Across all Policies
  - Age-Friendly Communities
- Set Future Meeting Dates
From these meeting future dates were established. The following is the listing of LHD and hospital meetings held and facilitated by Population Health Collaborative:

**Planning Meetings – location**
- September 17, 2018 – Mt. St. Mary’s Hospital
- October 23, 2018 – Conference Call
- November 28, 2018 – Conference Call due to winter weather advisory
- January 31, 2019 – Conference Call due to winter weather advisory
- February 27th, 2019 – Eastern Niagara Hospital
- April 1st, 2019 – Eastern Niagara Hospital
- May 17th, 2019 – Mt. St. Mary’s Hospital
- September 4, 2019 – Niagara Falls Memorial Medical Center
- October 10, 2019 – Mt. St. Mary’s Hospital
- December 6, 2019 – Conference Call

**Phase II (October 2018-April 2019)**
- CHA Survey Dissemination
- CHA Survey Data Collection
- Demographic & Secondary Data Analysis
- Focus Group Discussions
- Stakeholder Discussions
- Mid-CHA Survey Data Analysis
- Intercept CHA Survey Dissemination
- Final CHA Survey Data Analysis
- Convene Steering Committee to Review CHA Data
- Identify Priorities for Plans

**Phase III (May 2019-July 2019)**
- Write Report
- Convene Steering Committee to Review Report
- Identify Priorities for Plans

**Phase IV (August 2019-November 2019)**
- Hold Community Stakeholder Meeting
- Establish objectives for focus areas
- Seek Hospital Board Approval — Report
Community Health Assessment Steering Committee partnered in the development of questions for the Community Health Survey that would identify priority areas, health behaviors, facilitators of health, and barriers to health, health care utilization and demographic information.

Two open ended questions were added to the survey to collect anecdotal information directly from the respondents. These questions were reviewed by Population Health Collaborative to ensure the survey’s compatibility with the Survey Monkey tool. Prior to the survey being placed on Survey Monkey and released to the public, all the hospitals were given the draft survey to review and make comments and changes if appropriate.

When the survey was ready for release, Niagara County Public Health Director Daniel Stapleton, composed a press release that was sent to all media outlets. Survey links were provided on the Niagara County Department of Health’s website and Facebook page as well as on social media maintained by some of the participating hospitals, including Niagara Falls Memorial Medical Center.

Niagara County’s Public Health Educator went to various locations throughout the county to offer access to paper copies. Niagara Falls Memorial Medical Center made paper copies of the survey available at its main (downtown) campus and its six primary care sites. Division directors of the Niagara County Department of Health distributed survey flyers to health clinic, rabies clinics and at other community sites.

Appendix A contains a copy of the 2018 Niagara County Public Health Survey. The survey was released to the public in October of 2018 with a closing date of March 31, 2020. Paper surveys were collected and manually entered into the Survey Monkey. There were a total of 1,492 respondents. The chart below summarizes the demographics of the local residents who completed the survey.

Combined, persons in the 50 to 59 age group and in the 60 to 69 age group comprised nearly half of survey takers.
The largest share of survey respondents resides in the eastern end of Niagara County (20.4%), or in zip code 14094. The second largest portion of survey takers (16.7%) live in the City of North Tonawanda or in zip code 14120. Respondents residing in City of Niagara Falls’ zip code 14304 represented 12.8% of respondents. Another Niagara Falls’ zip code, i.e., 14305, ranked fourth in survey participation with a 7.4% share of total respondents.
The above graph rank orders the community health concerns expressed by Niagara County residents in the Public Health survey. Having health insurance was the number one concern followed by ability to seek care from a doctor’s office and having health insurance through an employer. Less than half of respondents, i.e. 43.61%, said they their primary care provider for a yearly check-up. Interestingly, just 2.52% of respondents said they don’t have a primary care provider.

Two questions on the survey offered a write in option. The first stated, “We are interested in what you are proud of in your community. What are some existing services or characteristics in the community that support the health and well-being of you and your family?” Population Health Collaborative highlighted some of the write-in results and placed them into the following categories:

Environment:

- Walkability of neighborhoods
- Plenty of open, green space to utilize farmer’s markets
- Bike paths/hiking trails
- Overall safe neighborhood

Programs:

- Niagara County Office for the Aging-home nutritional meal program
- YMCA
- Adult education classes through the school district
- Yoga/ Tai Chi classes
- Amherst senior center for exercise classes
- Flu shots at local drug stores
- Niagara Falls high school offers use of their walking track for anyone
- North Tonawanda Library
- Food Pantry
- Planned Parenthood
- Summer lunch program for children

Community:
- Sense of “Family”
- Free community dinners
- Churches

Services:
- Health Department
- Niagara County Office for the Aging
- WIC program
- Child Health Plus, Medicaid
- Social service agencies that provide helpful services within the community

Clinical:
- Great local hospitals
- Planned Parenthood/Horizon Health Services
- Variety of local doctors
- McLaughlin Center of DeGraff Memorial Hospital

The second question was “We are also interested in what you believe we are lacking in our community. What are some existing services or characteristics in the community that we do not have that would support the health and wellbeing of your family?

Those results were also analyzed and placed into the following categories:

Environment
- Streets are not safe
- Need more walking paths
- Lack healthier food choice options
- Need lighted paths
- Need inner city parks

Programs
- Need affordable sports programs for children
• Lack recreational transportation for senior citizens
• Lack free/affordable gym membership options
• Need more family health and wellness classes

Services:
• Need more services that assist the homeless population
• Need more services for military veterans

Policy
• Affordable tax rates
• Affordable health care
• Services

Clinical
• Need more reliable hospitals
• Need more local doctors
• Need better mental health services
• Lack clinics and urgent care facilities

Plans to inform the community of the results of the Community Health Survey and Assessment will be directed by the Public Health Director in January of 2020. Copies of the Community Health Assessment and Community Health Improvement Plan will be given to the members of the Board of Health. The Niagara County Community Health Assessment and Community Health Improvement Plan will be available on the Niagara County Department of Health website. Local hospitals will be encouraged to provide this information on their respective websites as well.

**Focus Group Results:** To augment the survey process, focus groups were held throughout Niagara County to further understand the needs of the population as it pertains to health and healthy communities. Focus groups were conducted in February, March and April 2019 at six locations including hospitals, subsidized housing facilities and community/senior centers and a downtown Niagara Falls church.

The focus groups were facilitated by Eastern Niagara Hospital, DeGraff Memorial Hospital, Niagara Falls Memorial Medical Center, Mount St. Mary’s Hospital and the Niagara County Department of Health. The focus group questions were created by Population Health Collaborative and used at all focus groups to maintain consistency.

The majority of the respondents were female and older adults. An exception was the session facilitated by Niagara Falls Memorial Medical Center at which respondents were younger members of the local LGBTQ community. Here are some of the highlights from the focus groups held.
What does a healthy community mean to you?

- Access to health services for everyone
- Safe areas to live in
- Healthy environment
- People taking care of each other
- Neighbors taking care of their property

What resources do you, or your community, need to become healthier?

- A walking buddy
- Exercise programs with seniors in mind
- A Pulmonary Rehab program
- Trusted information on the Internet
- Less expensive drugs

What is the best way for you to get health information?

- Good health care from doctors, hospitals and the insurance companies
- More health education and outreach
- More police
- Transportation to services

What health problems are the biggest concern to you and your community?

- Obesity
- Heart disease
- Loss of health insurance
- Diabetes
- Mental health
- Cancer
- Too many fast food places
- Chemical plants
- Lifestyle choices

What do you think keeps you, or your community, from being healthier?

- Car exhaust
- Power lines
- Underage drinking
- High cost of health care
- The court system
• Smoking
• Not enough exercise
• People living off the government that can be working
• Laziness
• Safety and crime

On August 6, 2019, the Community Health Assessment Steering Committee hosted a Community Partners meeting for representatives of non-governmental organizations (NGOs) and other health-related and social services agencies from across Niagara County.

This community stakeholder meeting effectively brought together partners from key organizations working in Niagara County to review current initiatives and programs that would support the selected priority areas. This meeting engaged a broad spectrum of partners that hold stakes in chronic disease prevention or mental health/substance abuse prevention/awareness.

IV. Prioritized Health Needs to be Addressed

Several community health needs were identified during the Community Health Assessment process. Community needs data were generated from two chief sources, to wit:

Secondary Sources: Secondary data are collected by someone or an entity other than the user of the information. The secondary information used in the Community Needs Assessment includes data collected by the New York State Department of Health (e.g. vital statistics, race/ethnicity data, community health indicators, chronic disease, etc.) U.S. Census, U.S. Department of Labor, Behavioral Health Risk Factor Surveillance System, and National Center for Education Statistics.

Primary Sources: A community survey administered by the Niagara County Department of Health in concert with hospital partners and input received at focus groups were the main source of primary information. A total of 1,492 surveys were completed and six focus group sessions were held.

All information received from secondary and primary sources was carefully analyzed by the Community Health Assessment Steering Committee. In reviewing this information several areas of concern were identified based upon the following criteria:

✓ Prevalence of the disease or healthcare need;
✓ Needs of disparate populations;
✓ The resources required to combat the disease including any existing programs and funding capabilities;
✓ Identification of evidence-based practices to address identified issues;
✓ Impact of social determinants of health;
✓ Ability to quantify and measure the impact of a program to address an identified issue;
✓ Sustainability of programs.
The top two critical health need priorities identified by the steering committee utilizing the aforementioned criteria were:

- Prevent Chronic Disease; and
- Promote Well-Being and Prevent Mental and Substance Use Disorders.

**Prevent Chronic Disease:** Within the Prevent Chronic Disease category, the Community Health Assessment Steering Committee selected the goal pertaining to high rates of cardiovascular disease and the high incidence of risk factors including high blood pressure, diabetes, obesity and smoking. Subsequent to the steering committee’s selection of this goal, NFMMC announced its formal affiliation with Roswell Park Comprehensive Cancer Center and the development of a Medical Oncology Center on NFMMC’s campus that would be administered by Roswell Park. As a result, NFMMC has decided to place its focus on a cancer related goal under the Prevent Chronic Disease category.

The burden of cancer in Niagara County is considerable. Cancer affects not only those afflicted, but their families, caregivers and entire communities. In fact, 31% of Niagara County Public Health Survey respondents identified cancer as a priority health concern.

Cancer trends in Niagara County are worsening. For the most recent reporting period (2013-2015), the New York State Department of Health (NYS DOH) reports a 730.9/100,000 cancer incidence rate for Niagara County compared to a rate of 657.0/100,000 for the prior reporting period. The 11.2% rise in the cancer incidence rate over just a 2-year period places Niagara among the six counties in New York State with the highest cancer prevalence rates.

![Cancer incidence rate chart](chart.png)

*As reported by the NYS DOH, Community Health Indicator Report for Niagara County, 2019

A comparative review of the 38 cancer indicators reported by the NYS DOH tells the story. Niagara’s rates exceed average rates for New York State for two-thirds or 24 of the 38 indicators. Here are some examples:

<table>
<thead>
<tr>
<th>Cancer Indicator/Per 100,000</th>
<th>Niagara Co. Rate</th>
<th>NYS Average Rate</th>
<th>% Increase of Niagara Rate over State Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cancer incidence rate</td>
<td>730.9</td>
<td>564.4</td>
<td>29.5%</td>
</tr>
<tr>
<td>All cancer mortality rate</td>
<td>238.8</td>
<td>176.2</td>
<td>35.5%</td>
</tr>
<tr>
<td>Lung &amp; bronchus cancer incidence rate</td>
<td>86.4</td>
<td>59.2</td>
<td>70.6%</td>
</tr>
<tr>
<td>Lung &amp; bronchus cancer mortality rate</td>
<td>75.9</td>
<td>43.5</td>
<td>74.7%</td>
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<tr>
<td>Female breast cancer incidence rate</td>
<td>182.3</td>
<td>158.6</td>
<td>14.9%</td>
</tr>
<tr>
<td>Prostate cancer incidence rate</td>
<td>187.4</td>
<td>141.2</td>
<td>32.7%</td>
</tr>
</tbody>
</table>

The widespread occurrence of cancer in Niagara County is leading to high cancer death rates. The cancer mortality rate for Niagara is 238.8/100,000. Forty-seven (47) or 76 percent of the counties in New York State have cancer death rates that are lower than the rate reported by the NYS DOH for Niagara County.
As noted above, the lung cancer incidence rate and mortality rate are significantly higher than the New York State average rates for lung cancer incidence and mortality. Further, Niagara County’s cancer incidence rate is the highest for the Western New York region.

New York State Health Department data show stark disparities in cancer incidence and mortality rates between whites and blacks.

The countywide lung cancer incidence rate is 85.7/100,000 for Whites compared to 105.8/100,000 for Blacks. Actual lung cancer rates are significantly higher than expected rates in 3 out of 4 zip codes in the City of Niagara Falls. All 3 of these zip codes have large minority populations and high poverty rates.

The incidence of female late stage breast cancer is another racially-based disparity in Niagara County. The rate is 46.4/100,000 for Whites versus 52.1/100,000 for Blacks.

Premature death rates from cancer are higher among adults with disabilities than among adults without disabilities. People with intellectual and developmental disabilities have proportionally higher rates of gastrointestinal cancer than the general population. People with IDD have decreased access to cancer treatment, and disparities have been found in their cancer screening rates.

As NFMMC wages its chronic disease prevention program in the area of cancer prevention and treatment, special efforts will be made to conduct educational programs in minority neighborhoods and African-American churches, conduct outreach programming to people with IDD and the organizations that serve them, and encourage more minorities to engage in smoking cessation programs. To assure the effectiveness of these outreach approaches, NFMMC will consult community leaders to obtain their feedback and input on the best techniques for providing cancer education to minority residents.

**Promote Well-Being and Prevent Mental and Substance Use Disorders:** There are three indicators featured in the New York State Prevention Agenda that support the steering committee’s selection of “Promote Well-Being and Prevent Mental and Substance Use Disorders” as a priority area. Niagara County’s rates for all three indicators are worse than their respective New York State average rates.

The percentage of adults with poor mental health for 14 days or more in the last month is 10.8% in Niagara County compared to 10.2% for New York State as a whole.

The percentage of adult binge drinking during the last month is 22.4% in Niagara County compared to an 18.1% average rate for New York State.

Moreover, the age adjusted suicide rate per 100,000 in Niagara County is 9.6/100,000 in contrast to an average rate of 6.8/100,000 for New York State. Niagara’s suicide rate is 41% higher than the state rate.

Research indicates that there are significant disparities between ethnic/racial minority patients and non-Latino whites in access and outcomes for mental illness (M. Alegria et al, Psychiatry Services 2009 Nov 9: 11). These disparities are present for depression.

Minorities are more likely than whites to delay or fail to seek mental health treatment (R.C. Kessler et al, British Journal of Psychiatry Supplement 30 (1996)).

Further, it has been found that serious mental illness such as Major Depressive Disorder is frequently untreated or undertreated. The American Psychological Association has highlighted the fact that there are
disparities in the quality of care (i.e. access to comparable care or disparities in the treatment received at the same facility) have found to be related to racial, ethnic, geographic and socioeconomic differences.

Based on these research findings, NFMMC will make extraordinary efforts to screen more minority patients for depression, connect more minorities to depression treatment, involve minorities in more efficient methods for depression screening and ensure that minority patients participate in web-based depression therapy.

V. Implementation Plan

**NFMMC Action Plan:** NFMMC has formulated a detailed plan to address the two selected priorities. Four objectives are included in the Prevent Chronic Disease Priority Plan and four objectives have been developed for the Promote Well-Being and Prevent Mental Health and Substance Use Disorders Priority Plan. For each of these objectives, an output measure has been expressed, annual outputs have been quantified, project partners have been identified and a series of interventions have been constructed over a consecutive three-year period (2020 – 2022).

**Prevent Chronic Disease Plan:** The Prevent Chronic Disease Priority Plan seeks to achieve the following objectives:

- ✓ Reduce overall cancer mortality rates in Niagara County by improving the public’s access to cancer care and treatment;
- ✓ Decrease the number of lung and bronchial cancer deaths in Niagara County by expanding the number of prevention, detection and outpatient treatment visits recorded at the NFMMC Thoracic Center;
- ✓ Decrease smoking rates by organizing multi-session smoking cessation classes whose participants will include mental health clients and minorities;
- ✓ Assure that people with Intellectual and Developmental Disabilities (IDD) have unimpeded access to the cancer care that will be provided at the Medical Oncology Center that is being constructed on NFMMC’s campus and connect people with IDD to cancer prevention screening.

NFMMC is making a significant investment to ensure that the highest quality cancer services are more accessible to Niagara County residents. A $2.0 million Medical Oncology Center is under construction at the fourth floor of NFMMC. The Thoracic Center is already in operation and has the capacity to serve additional patients. The smoking cessation classes will be provided by an existing Behavioral Health Therapist. Further, outreach to the IDD community...patients, caregivers and providers...will be provided by an existing Community Health Worker.

The interventions set forth in the Chronic Disease Priority Plan will be supported by the Roswell Park Comprehensive Cancer Center, community-based organizations and by IDD service agencies.

**Prevent Mental Health and Substance Use Disorders Plan:** The NFMMC Community Services Plan also sets forth interventions with respect to the Promote Well-Being and Prevent Mental Health and Substance Use Disorders Priority Plan. The objectives of this priority plan include the following:

- ✓ Increase the percentage of primary care and OB-GYN outpatients who receive an annual SBIRT screen to detect depression;
- ✓ Assure that the overwhelming majority of patients complete SBIRT screens using an electronic device;
✓ Increase the number of patients who participate in behavioral health therapy for the treatment of depression at NFMMC’s integrated behavioral health/primary care/OB-GYN sites
✓ Engage patients with Major Depressive Disorder in evidence-based/web-based treatment that is available through a phone app.

Expanding and improving the effectiveness of NFMMC’s program to screen patients for depression using the SBIRT screening tool can be achieved at little or no added cost given that the program is already operational. Moreover, there are free or low-cost apps available for web-based treatment of Major Depressive Disorder.

**Summary of Plans:** The tables which follow set forth the specific Community Service Plans that will be pursued by NFMMC and its community partners during the years 2020-2022. These tables replicate the Excel-based Community Service project plans that have been submitted to the New York State Department of Health.
<table>
<thead>
<tr>
<th>Objective # 1</th>
<th>Access to Cancer Care</th>
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<tr>
<td>Objectives:</td>
<td>Reduce by 5% the average annual number of deaths from cancer in Niagara County from 510.2 during the period 2012-2016 to 485 during the period 2017-2022 by giving all Niagara County residents diagnosed with cancer equitable access to high quality cancer care (Treatment is a priority area for action pursuant to the NYS Comprehensive Cancer Control Plan 2018-2023).</td>
</tr>
<tr>
<td>Disparities:</td>
<td>For all cancer sites combined, residents of poorer counties (those with greater than or equal to 20% of the population below the poverty line) have 13% higher death rates from cancer in men and 3% higher rates in women compared with more affluent counties (less than 10% below the poverty line). Differences in cancer survival account for part of this disparity. Among both men and women, five-year survival for all cancers combined is 10 percentage points lower among persons who live in poorer than in more affluent census tracts. Even when census tract poverty rate is accounted for, however, African American, American Indian/Alaskan Native, and Asian/Pacific Islander men and African American and American Indian/Alaskan Native women have lower five-year survival than non-Hispanic Whites. More detailed analyses of selected cancers show large variations in cancer survival by race and ethnicity. Opportunities to reduce cancer disparities exist in prevention (reductions in tobacco use, physical inactivity, and obesity), early detection (mammography, colorectal screening, Pap tests), treatment, and palliative care.</td>
</tr>
<tr>
<td>Interventions:</td>
<td>Effective June 1, 2020, establish a Medical Oncology Center, in affiliation with Roswell Park Comprehensive Care Center, at Niagara Falls Memorial Medical Center as a means for improving access to cancer care and treatment for Niagara County residents, serving as a catalyst for promoting cancer screening and for lowering Niagara County’s extraordinarily high cancer mortality rate (Niagara’s cancer death rate is higher than 76% of the state’s counties and is nearly 36% higher than the New York State average rate).</td>
</tr>
<tr>
<td>Output Measure:</td>
<td>Output Measure: Reduce cancer mortality rate.</td>
</tr>
</tbody>
</table>
### Projected Year 1 Interventions:
One, during the first five months of 2020, construct the $2.0 million Medical Oncology Center on the 4th floor of Niagara Falls Memorial Medical Center. Two, following the open of the center on June 1, 2020, wage intensive outreach efforts to educate the public about the accessibility of cancer services in Niagara County. Three, during the period June 1, 2020 – December 31, 2020, provide 1,429 patient visits/infusion treatment sessions. Four, extend accreditation to the new Medical Oncology Center pursuant to the Quality Oncology Practice Initiative of the Association of Clinical Oncology.

### Projected Year 2 Interventions:
One, a total of 2,850 patient visits/infusion therapy treatment sessions are projected to be conducted at the Medical Oncology Center in 2021. Two, promote availability of New York State’s Medicaid Cancer Treatment Program and establish access to Designated Qualified Entities, who are responsible for enrolling clients in the program. Three) implement referral systems to ensure that people who need health insurance coverage for treatment are appropriately referred to an and enrolled in public health insurance program.

### Projected Year 3 Interventions:
One, a total of 3,257 patient visits/infusion therapy treatment session are estimated for the Medical Oncology Center in 2022. Two, establish working relationship with patient navigation programs to help patients and families navigate the cancer care system and support care coordination efforts. Three, create and operationalize pathways to refer patients to emotional and psychosocial support services. Four, use a patient satisfaction survey that will help the Medical Oncology Center team improve their patients’ experiences, such as tools created by the Agency for Healthcare Research and Quality.

### Implementation Partner:
Hospital

### Partner Role(s) and Resources:
Roswell Park Comprehensive Cancer Center is NFMMC’s partner in operating the Medical Oncology Center. NFMMC will lease physicians and support personnel from Roswell Park to staff the center. Roswell Park will implement its quality of care standards and clinical pathways to serve Niagara County residents receiving medical oncology care at the center. Area residents will no longer have to make the 40-mile round trip to Roswell’s Buffalo campus to receive cancer treatment. Bringing the best cancer care to Niagara County will result in improved compliance with treatment protocols and lead to a decrease in cancer mortality.

### Objective # 2
Lung Cancer Deaths
<table>
<thead>
<tr>
<th>Objectives:</th>
<th>Reduce the number of lung and bronchial cancer deaths in Niagara County from a baseline of 159 (2012-2016 NYS DOH data) to 143 mortalities in 2022 by expanding the number of prevention, detection and outpatient treatment patient visits recorded at the NFMMC Thoracic Center (increase Thoracic Center visits from a baseline of 350 in 2019 to 385 in 2020; 404 in 2021 to 424 in 2022).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disparities:</td>
<td>African-American men have the highest incidence and mortality rate of lung cancer. Moreover, African-American patients, both male and female, are less likely than white patients to receive stage-appropriate cancer care, including surgery, radiation, and systemic therapy. Reasons for these disparities are multifactorial, with contributions from patients, providers, disease-related factors, as well as the effects of residential segregation. Socioeconomic status is closely tied to poorer outcomes in lung cancer. This creates a situation in which low income increases the risk of lung cancer and increases the risk of dying from lung cancer, presumably from lack of appropriate treatment.</td>
</tr>
<tr>
<td>Interventions:</td>
<td>Recognizing that screening with low-dose CT is an evidence-based practice associated with a significant reduction in the number of lung cancer deaths in the screened population, the number of patients receiving prevention, detection and outpatient treatment of lung cancer at the Thoracic Clinic operated by Niagara Falls Memorial Medical Center, in affiliation with Roswell Park Comprehensive Cancer Center, will increase over a three-year period. (Frank C. Detterbeck et al, Chest. 2013 May; 143 (5 Suppl))</td>
</tr>
<tr>
<td>Output Measure:</td>
<td>Output Measure: Number of patients served by NFMMC Thoracic Center.</td>
</tr>
<tr>
<td>Projected Year 1 Interventions:</td>
<td>Implement the use of a Lung Cancer Assessment tool at all six NFMMC primary care practices that can assist patients in calculating the risk of developing lung cancer, inform primary care physicians of a patient’s risk of lung cancer and result in patient referrals to the Thoracic Center. Targeted Thoracic Center Visits: 385</td>
</tr>
<tr>
<td>Projected Year 2 Interventions:</td>
<td>Wage a broad-based outreach campaign that incorporates messaging from community-based organizations and reaches out and provides education to disparate groups experiencing higher rates of lung cancer. Targeted Thoracic Center Visits: 44</td>
</tr>
</tbody>
</table>
### Projected Year 3 Interventions:
Wage a broad-based outreach campaign that incorporates messaging from community-based organizations and reaches out and provides education to disparate groups experiencing higher rates of lung cancer. Targeted Thoracic Center Visits: 424

### Implementation Partner:
Community-based organizations

### Partner Role(s) and Resources:
Community-based organizations, particularly those serving Niagara County's minority communities, will assist NFMMC in developing the right messaging to effectively communicate with patients in NFMMC's service area. These organizations will host educational sessions on lung cancer screening for community residents and assist NFMMC in marketing these events. (This a recommended strategy in the NYS Comprehensive Cancer Control Program 2018-2023).

### Objective #3
**Smoking Cessation**

### Objectives:
Provide at least one multi-session smoking cessation course in 2020, two in 2021 and three courses in 2022.

### Disparities:
Although cigarette smoking has declined significantly since 1964, disparities in tobacco use remain across groups defined by race, ethnicity, educational level, and socioeconomic status. These populations include individuals in lower education groups; LGBTQ community and people with mental illness.

### Interventions:
Train a Behavioral Health Therapist to become a Roswell Park certified smoking cessation instruction and hold smoking cessation classes.

### Output Measure:
Output Measure: Number of classes held.

### Projected Year 1 Interventions:
Complete training for Behavioral Health Therapist and hold a minimum of one smoking cessation class that meets over multiple sessions. Targeted # of Classes: One

### Projected Year 2 Interventions:
Hold a minimum of 2 smoking cessation classes for which class participation is targeted to mental health clients, people with high ED and hospital utilization and Health Home clients. Targeted # of Classes: Two

### Projected Year 3 Interventions:
Continue to organize and hold smoking cessation classes: Targeted # of Classes: Three

### Implementation Partner:
Hospital
<p>| <strong>Partner Role(s) and Resources:</strong> | Various NFMMC departments and personnel from specialized programs waged by the medical center (ED and Inpatient Hotspotter programs, behavioral health related innovation projects, Health Home, etc.) will refer clients to the smoking cessation program. |
| <strong>Objective # 4</strong> | <strong>Access to Cancer Prevention and Care by IDD Population</strong> |
| <strong>Objectives:</strong> | The project has three important objectives: one, construct and equip a Medical Oncology Center at NFMMC that is barrier free and provides a physical plant that is conducive to serving people with Intellectual and Developmental Disabilities; two) during 2021 and 2022 connect 60 people with IDD to cancer screening; and three) work with at least 3 agencies serving those with disabilities on the project. |
| <strong>Disparities:</strong> | According to the Centers for Disease Control and Prevention, people with IDD have lower cancer screening rates than people without disabilities, making it more likely that cancer will be found later, when it is hard to treat. Disparities in cancer screening for people with IDD result in lower rates of screening, particularly for cervical cancer, breast cancer and colorectal cancer. |
| <strong>Interventions:</strong> | Construct a Medical Oncology Center at NFMMC that provides a physical plant that is conducive to serving people with Intellectual and Developmental Disabilities (IDD) and develop a comprehensive plan to advance Prevention, Awareness and Treatment for people with IDD. |
| <strong>Output Measure:</strong> | Output Measures: Number of people with IDD who are linked to cancer screening. |
| <strong>Projected Year 1 Interventions:</strong> | First, the Medical Oncology Center construction project, which is slated for completion on June 1, 2020, will feature: enlarged doorways, hallways, treatment bays and exam rooms that can accommodate wheelchairs and other adaptive equipment; lighting that is natural and non-fluorescent to accommodate IDD patients with sensory integration issues; and equipment that enhances the delivery on oncological care to IDD patients, including high-low exam tables, wheelchair and grab bar scales and appropriate seating in the patient waiting area. Second, upon the opening of the Oncology Center, staff and providers will be educated on the special needs of people with IDD. Third, in concert with local IDD services agencies, a plan will be developed to advance Prevention, Awareness and Treatment for people with IDD that incorporates evidence based principles developed by the Lurie Institute for Disability Policy at Brandies University. Targeted IDD Screens: 30 |</p>
<table>
<thead>
<tr>
<th>Projected Year 2 Interventions</th>
<th>Adopt outreach strategies in concert with IDD service agencies for educating IDD patients and their caregivers about the need for cancer screening and facilitate linkages to cervical, colorectal, breast and other types of cancer screening. Targeted IDD Cancer Screens: 30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected Year 3 Interventions</td>
<td>Continue to collaborate with IDD service agencies on NFMMC’s Prevention, Awareness and Treatment initiative for people with IDD and refer an additional 30 people with IDD to cancer screening. Targeted IDD Cancer Screens: 30</td>
</tr>
<tr>
<td>Implementation Partner:</td>
<td>Community-based organizations</td>
</tr>
<tr>
<td>Partner Role(s) and Resources:</td>
<td>IDD service providers will assist in meeting targeted objectives by participating in learning sessions on the barrier free Medical Oncology Center and on evidence-based strategies to improve cancer screening rates for people with IDD; encouraging these community-based organizations to develop unique plans to connect IDD clients to cancer screening, and working with IDD clients, their families and physicians on referrals to screening services.</td>
</tr>
</tbody>
</table>

**Promote Well-Being & Prevent Mental & Substance Use Disorders**

<table>
<thead>
<tr>
<th>Objective # 1</th>
<th>Reduce Prevalence of Major Depressive Disorders (MDD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives:</td>
<td>Increase the percentage of primary care patients and OB-GYN outpatients who receive an annual SBIRT assessment screen to identify depression.</td>
</tr>
<tr>
<td>Disparities:</td>
<td>Disparities in access and outcomes for medical illnesses are also present for depression. Research conducted by M. Alegria et al found differences in access to and quality of depression treatments between ethnic/racial minority patients and non-Latino whites (Psychiatry Services 2008 Nov 59;(11): 1264-1272)</td>
</tr>
<tr>
<td>Interventions:</td>
<td>Expand the use of SBIRT screening pursuant to the provisions of the Collaborative Care model to increase the percentage of annual SBIRT screens completed for unique primary care patients and OB outpatients from 35% in 2019 to 45% in 2020; 55% in 2021 and to 65% in 2022.</td>
</tr>
<tr>
<td>----------------</td>
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</tr>
<tr>
<td>Output Measure:</td>
<td>Percentage of primary care patients who complete a SBIRT screen annually</td>
</tr>
<tr>
<td>Projected Year 1 Interventions:</td>
<td>Commission AIMS Center experts to provide educational webinars to clinical staff and providers on the provisions of the Collaborative Care model, on the importance of providing SBIRT screenings to identify patients with depression, and on evidenced-based methods for connecting patients to integrated behavioral health therapy. Targeted Percentage of Patients Completing SBIRT Screens from 2019 Baseline: 45%.</td>
</tr>
<tr>
<td>Projected Year 2 Interventions:</td>
<td>Administer a read and sign learning tool to all primary care staff and providers to review the SBIRT screening process and the fundamental steps of the Collaborative Care model. Targeted Percentage of Patients Completing SBIRT Screens from 2019 Baseline: 55%.</td>
</tr>
<tr>
<td>Projected Year 3 Interventions</td>
<td>Review the SBIRT screening tool at a monthly Primary Care forum involving staff and providers. Targeted Percentage of Patients Completing SBIRT Screens from 2019 Baseline: 65%.</td>
</tr>
<tr>
<td>Implementation Partner</td>
<td>Advocates</td>
</tr>
<tr>
<td>Partner Role(s) and Resources</td>
<td>Experts from the AIMS Center of Washington University in Seattle, Washington will provide education and training to the NFMMC primary care team, introducing new techniques to expand use of SBIRT screening.</td>
</tr>
<tr>
<td><strong>Objective # 2</strong></td>
<td>Utilize Electronic Device to Complete SBIRT Screens</td>
</tr>
<tr>
<td>Objectives:</td>
<td>Implement program to have patients utilize an electronic device for the completion of annual SBIRT assessment so as to achieve the following targets: 70% of SBIRTS are completed electronically in 2021 and 80% are completed electronically in 2022.</td>
</tr>
<tr>
<td>Disparities:</td>
<td>Factors such as lower income or education have been found to be associated with lower levels of health literacy. This suggests that individuals likely to fall victim to social disparities, which in turn leads to worse health outcomes, are also more likely to have lower levels of health literacy. Use of electronic devices may help bridge the literacy gap.</td>
</tr>
<tr>
<td>Interventions:</td>
<td>Replace having patients fill out SBIRT forms by hand and then having staff enter responses into patients' electronic medical records, with the use of computer tablets that will allow patients' SBIRT responses to be entered into the EMR without manual intervention by staff.</td>
</tr>
<tr>
<td>---------------------</td>
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</tr>
<tr>
<td>Output Measure:</td>
<td>Output Measure: Percentage of SBIRT screens completed by patients with computer tablets or other electronic devices.</td>
</tr>
<tr>
<td>Projected Year 1 Interventions:</td>
<td>Prepare an action plan for electronically transferring SBIRT responses to patient electronic medical records in order to free up primary care and OB-GYN staff time and assure the accuracy of medical records. Start implementation in Year 2.</td>
</tr>
<tr>
<td>Projected Year 2 Interventions:</td>
<td>Implement program to use electronic devices (e.g. computer laptops, handheld devices, etc.) to complete SBIRT screens and have data transferred to the appropriate patient’s electronic medical record. Targeted % of Electronic SBIRTS Completed: 70%</td>
</tr>
<tr>
<td>Projected Year 3 Interventions:</td>
<td>Track and report on the percentage of patients completing SBIRT screens with electronic devices. Targeted % of Electronic SBIRTS Completed: 80%</td>
</tr>
<tr>
<td>Implementation Partner:</td>
<td>Consumer</td>
</tr>
<tr>
<td>Partner Role(s) and Resources:</td>
<td>Consumer, i.e. patient, will play an important role in this innovation by completing training on how to use the electronic device and potentially volunteering to assist other patients in using electronic equipment.</td>
</tr>
<tr>
<td>Objective # 3</td>
<td>Increase Patient Participation in Integrated Care</td>
</tr>
<tr>
<td>Objectives:</td>
<td>Increase the number of primary care patients, particularly minority patients, who receive behavioral health therapy at NFMMC's two integrated primary care/behavioral health sites and at the integrated behavioral health/OB-GYN site from 470 in 2019 to 503 in 2020; 553 in 2021; and to 609 in 2022.</td>
</tr>
<tr>
<td>Disparities:</td>
<td>Minorities are more likely than whites to delay or fail to seek mental health treatment. (R.C. Kessler et al, <em>British Journal of Psychiatry Supplement</em> 30 (1996)).</td>
</tr>
<tr>
<td>Interventions:</td>
<td>Assure that more SBIRT positive patients participate in the Collaborative Care (integrated behavioral health services) provided at two primary care sites and at the OB-GYN clinic.</td>
</tr>
<tr>
<td>Output Measure:</td>
<td>Number of patients testing positive for depression on SBIRT screens who enroll in the integrated behavioral health therapy programs that are offered at two primary care sites and at the OB-GYN clinic.</td>
</tr>
<tr>
<td>Projected Year 1 Interventions:</td>
<td>One, begin weekly tracking and reporting of the number of patients enrolled in Collaborative Care either at a primary care or OB-GYN clinical site. Two, conduct a survey of providers and staff to identify any barriers standing in the way of making warm handoffs from clinical staff to behavioral health providers. Three, remove any barriers standing in the way of enrolling patients in Collaborative Care services. Targeted Integrated Behavioral Health Enrollment: 503.</td>
</tr>
<tr>
<td>Projected Year 2 Interventions:</td>
<td>One, respond to survey suggestions for removing barriers to Collaborative Care enrollment and addressing workflow, logistical and warm handoff issues. Two, prepare and distribute a brochure at Collaborative Care sites on mental health issues impacting minorities. Three, reach out to local addiction treatment agencies to provide information on the Collaborative Care program and to urge them to refer clients seeking primary care and behavioral health treatment to NFMMC’s integrated behavioral health/primary care/OB-GYN services. Targeted Integrated Behavioral Health Enrollment: 553.</td>
</tr>
<tr>
<td>Projected Year 3 Interventions:</td>
<td>Issue a report on the total number of patients served by the Collaborative Care program and calculate the increase in minority participation from the first to the third year of the Community Services plan. Targeted Integrated Behavioral Health Enrollment: 609.</td>
</tr>
<tr>
<td>Implementation Partner:</td>
<td>Community-based organizations</td>
</tr>
<tr>
<td>Partner Role(s) and Resources:</td>
<td>NFMMC will reach out to community-based organizations to educate them on the availability of integrated behavioral health services at two NFMMC primary care centers and at the NFMMC OB-GYN clinic and to inform them on how they can refer their own clients to this program.</td>
</tr>
<tr>
<td>Objective #4</td>
<td>Utilization of Web-Based App to Reduce Percentage of Patients with Major Depressive Disorder (MDD)</td>
</tr>
<tr>
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<tr>
<td>Objectives:</td>
<td>With the aid of an evidence-based tool involving application of web-based guided self-help intervention, reduce the percentage of total patients at NFMMC integrated behavioral health sites and at the NFMMC Adult Outpatient Mental Health Clinic who have Major Depressive Disorder from 36% (424) in 2019; 35% (410) in 2020; 34% (398) in 2021 and to 33% (386) in 2022.</td>
</tr>
<tr>
<td>Disparities:</td>
<td>Serious mental illness such as Major Depressive Disorder is frequently untreated or undertreated. Many people with MDD receive no treatment. The American Psychological Association highlights the fact that there are disparities in the quality of care (i.e. access to comparable care or disparities in the treatment received at the same facility) have found to be related to racial, ethnic, geographic and socioeconomic differences.</td>
</tr>
<tr>
<td>Interventions:</td>
<td>In accordance with evidence-based research, new ways for a person to manage their mental health and avoid a major depressive episode are available on the internet. Specifically, there is an increasing number of self-help apps available that are based on tenets of cognitive behavioral therapy (CBT). By accessing one of these apps, a patient is given access to informational articles, diary-like mood tracking and built in motivational features. A CBT app helps modify thought patterns for a better mood and provides a depression severity test to permit a patient to evaluate progress.</td>
</tr>
<tr>
<td>Output Measure:</td>
<td>Output Measure: Reduce percentage of patients diagnosed with Major Depressive Disorder (MDD).</td>
</tr>
<tr>
<td>Projected Year 1 Interventions:</td>
<td>One, select the specific app that will used for this initiative. Two, train behavioral health therapists on the use of the app, on the evidence-based principles of CBT therapy, on the best methods for encouraging patients to install the app on their cell phone and for utilizing the app on a daily basis. Targeted % Reduction in Number of Patients with MDD from 2019 Baseline: 1%</td>
</tr>
<tr>
<td>Projected Year 2 Interventions</td>
<td>Continue to enroll patients with MDD in the CBT app project. Targeted % Reduction in Number of Patients with MDD from 2019 Baseline: 2%</td>
</tr>
<tr>
<td>Projected Year 3 Interventions:</td>
<td>Maintain effort to enroll patients with MDD in the CBT project. Targeted Reduction in Number of Patient with MCC from 2019 Baseline: 3%</td>
</tr>
<tr>
<td>Implementation Partner:</td>
<td>Consumer</td>
</tr>
<tr>
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</tr>
<tr>
<td>Partner Role(s) and Resources:</td>
<td>Consumers in this project are patient with MDD. Targeted results will be met if consumers dedicate themselves to utilizing the app.</td>
</tr>
</tbody>
</table>

**Maintenance of Partner Engagement:** Each priority action plan objective will require the development of a work plan specifying required activities, individuals responsible for each action step, quantifiable objectives and action timelines. As appropriate, these work plans will be shared with project partners. Additionally, the objectives of the two priority action plans will be incorporated into NFMMC’s annual strategic plan which requires outcome reports to the NFMMC board of directors on a quarterly basis.

**VI. Distribution of Report**

NFMMC will post its Community Service Plan and subsequent annual updates on its website: [www.NFMMC.org](http://www.NFMMC.org).

Additionally, the report will be distributed at quarterly meetings of the Connect 4 U coalition whose members include representatives of housing agencies, social services organizations, food pantries, consumer advocates, behavioral health agencies, IDD service agencies and other groups. The coalition will provide a forum for encouraging participation in this Community Services Plan.

**VII. Adoption of Community Services Plan**

The Community Services Plan was reviewed by the Board of Directors of Niagara Falls Memorial Medical Center on December 1, 2019. The Board enacted a resolution to demonstrate its approval of the plan. A certified copy of the resolution has been forwarded to the New York State Department of Health.
Appendix A

2018 Niagara County Community Health Survey
2018 Niagara County Community
Health Survey
We need YOUR help!

You can make a difference in the health and well-being of communities you care about in Niagara County! Help us figure out the best ways to meet the health care needs of communities across our county. Please take a few minutes of your time to fill out our completely confidential survey. Personally, identifying information is not required; responses cannot be tied back to any individual. This information will be used by the Niagara County Department of Health and local hospitals to find out what health issues are important to Niagara County residents and how to make the community a healthier place to live.

1) Are you a Niagara County resident or a college student resident?
   o Yes
   o Yes (college student)
   o No

2) What is your ZIP code? ________________

3) Do you have any kind of health care coverage or health insurance?
   o Yes
   o No
   o Used to, but don’t have any now
   o Don't know

4) How do you pay for your Health Care? (Check all that apply)
   o I have health insurance through my employer
   o I have Medicare
   o I use Medicaid
   o I am covered by the VA
   o I purchased health insurance through NYS of Health
   o I use Tribal health services/insurance
   o I pay cash

5) Where do you get most of your health information? Please select all that apply.

34
Doctor or Medical Provider
Library
Newspaper or Magazine
School Nurse/School Health Educator/Teacher
Computer or Internet
Social Media (Facebook, Twitter, etc.)
Television (TV) or Radio
Friends and Family
Health Insurance Company
Social Services
Head Start
WIC (Nutrition program for children and pregnant/nursing women)
Work Place
Other (please specify) ________________________________

6) How often do you see your primary care provider (doctor)?
   Several times a year
   For a yearly check-up
   Only when I’m sick
   I don’t go see my primary care provider
   I don’t have a primary care provider

7) When you seek medical care, where do you usually go?
   Doctor’s office
   Emergency room
   Urgent or Immediate care
   Health clinic
   Other (please specify) ________________________________

8) Roughly how long ago did you last visit a hospital emergency department for yourself?
   Within the past year
   1-3 years ago
   More than 3 years ago
   Never

9) In the past year, was there any time that you needed medical care but could not - or did not - get it? If no, skip to question 11.
   Yes
   No

10) What were the main reasons you did not get the medical care you needed? [Please choose all that apply]
    Cost - Without insurance, it was too expensive
    Cost - Even with insurance, it was too expensive
    Transportation -- It was too hard to get there
- Hours - They weren’t open when I could get there
- I couldn’t get time off from work
- I had no one to watch my children
- I couldn’t get an appointment for a long time
- The medical staff didn’t speak my language
- I couldn’t get a referral to see a specialist
- I didn’t know where to get the care I needed
- I decided not to go because I don’t like going to doctors
- Some other reason (please explain) _____________________________

11) If you go to the hospital, from which hospital do you or your family members get most of your care?
- Buffalo General Medical Center
- DeGraff Memorial Hospital
- Eastern Niagara Hospital, Lockport
- Erie County Medical Center (ECMC)
- Kenmore Mercy Hospital
- Medina Memorial Hospital
- Mercy Hospital
- Millard Fillmore Suburban
- Mount St. Mary’s Hospital
- Niagara Falls Memorial Medical Center
- Rochester General Hospital
- Roswell Park Memorial Institute
- Sisters of Charity Hospital
- Sisters of Charity Hospital – St. Joseph Campus
- Strong Memorial Hospital
- Veterans Administration WNY System
- Oishei Children’s Hospital
- Other (please specify) _____________________________

12) Have you ever been told by a doctor or a nurse, that you had any of the following? Please select all that apply.
- Blood sugar problems, or diabetes?
- High blood pressure, or hypertension?
- High cholesterol?
- Asthma, COPD, or other breathing issues?
- Extreme overweight or obesity?
- None of the above
- Other (please specify) _____________________________

13) When you think about your own health or the health of your community, which of the following issues are you most concerned about? Please select three (3).
- Access to affordable health care
- Access to healthy food
- Alcohol and/or substance use or addiction
- Asthma/COPD
- Child abuse/neglect
- Cancer
- Dental health
- Diabetes
- Domestic violence
- Family planning (pregnancy prevention)
- Firearm-related injuries
- Food/water safety and quality
- Heart-related issues (high blood pressure, heart disease, or stroke)
- HIV/AIDS
- Homicide
- Immunization and/or prevention of infectious disease (such as flu)
- Injury prevention (falls, motor vehicle safety, etc.)
- Infectious diseases (hepatitis, TB.)
- Infant death
- Maternal health (care for moms during and after pregnancy)
- Mental health/depression/anxiety
- Nutrition/eating a healthy diet
- Overweight/obesity; weight management
- Physical activity; fitness and exercise
- Safety of neighborhood
- Sexually transmitted infections
- Stress management
- Suicide Prevention
- Teenage pregnancy
- Tobacco/nicotine, quitting smoking
- Other (please specify) __________________

14) Would you say that your physical health is now excellent, very good, good, fair or poor?
- Excellent
- Very good
- Good
- Fair
- Poor

15) And your mental or emotional health - is it excellent, very good, good, fair or poor?
- Excellent
- Very Good
- Good
- Fair
- Poor
16) Do you use any of the following nicotine products? Please select all that apply:

- Cigarettes (e.g., Marlboro, Camel, Newport, Pall Mall, Winston, etc.)
- Electronic cigarettes
- Vape
- Smokeless tobacco (e.g., chewing tobacco, snuff, snus, etc.)
- Bidis/Kreteks
- Cigars, Cigarillos, Little Cigars, or Blunts
- Pipes or Hookah/Water Pipe
- Other (please specify) ____________________________
- I do not smoke

17) And how often, if ever, do you now smoke or use any nicotine product?
   - Never
   - Only occasionally
   - Some days
   - Most days
   - All days

18) Do you use e-cigarette now to quit smoking?
   - Yes
   - No

19) During the past 30 days, what drugs have you used recreationally (not prescribed by a doctor). Please choose all that apply as your anonymity is GUARANTEED.
   - I do not use any drugs recreationally
   - Anxiety medication (Xanax, Activan, etc.)
   - Codeine
   - Demerol
   - Dilaudid
   - Fentanyl
   - Heroin/Opium
   - Hydrocodone
   - Lortab
   - Marijuana
   - Methadone
   - Morphine
   - Norco
   - Oxycodeine
   - Percocet
   - Suboxone/Buprenorphine/Subsolve
   - Vicodin
   - Other (please specify) ____________________________
20) Have you administered Naloxone (Narcan) in the last year?
   o Yes
   o No
   o If yes, how many ______________________

21) During the past 7 days, on how many days were you physically active for a total of at least 30 minutes?
   o 1 day
   o 2 days
   o 3 days
   o 4 days
   o 5 days
   o 6 days
   o 7 days

22) Compared to your own level of physical activity 1 year ago, would you say you are now more active, less active, or about the same as you were then?
   o More Active
   o Less Active
   o The Same

23) In the future, what might help you make healthy changes in your life? Please select three (3).
   o Access to free workshops/classes in your community on exercise, diet, stress reduction, chronic disease management, and/or quitting smoking
   o Being part of a support group that supports and encourages healthy habits (example: a local church, the YMCA)
   o Getting more information from social media, internet, newspapers and TV
   o Getting reminders when you are due for certain tests (such as annual doctor visits)
   o Having more trust or comfort with the medical system
   o Having safe areas to exercise within your community
   o Having more affordable fresh fruits and vegetables or more healthy food choices at local convenience stores
   o Having the desire for me and my family to be healthier
   o Local hospitals and businesses offering free health screenings (blood pressure, etc.)
   o More recreational/sports opportunities that are appropriate to your age and skill level
   o Taking more time to talk with healthcare professionals (doctors, nurses, counselors, etc.)
   o Transportation
   o Other (please specify) _________________________________

24) What keeps you from eating more fruits and vegetables every day? Select all that apply.
   o Time it takes to prepare
   o Cost
   o The stores near me don’t sell fresh fruits and vegetables
   o I don’t like to eat healthy food
o My family does not like to eat healthy
o I am not sure how to cook/prepare fresh fruits and vegetables.
o I DO eat fresh fruits and vegetables
o Other: __________________________
25) What is your drink of choice on most days? Check all that apply.
   - Water
   - Milk
   - Pop or Soda
   - Diet Pop or Soda
   - Coffee (hot or Iced)
   - Tea (Hot or Iced)
   - 100% Juice
   - Juice Drinks
   - Energy Drinks (Monster, Amp, Red Bull)
   - Sports Drinks (Gatorade, Powerade)
   - Kool-Aid, Crystal Light, Other drink mixes
   - Beer, Wine, Liquor
   - Other: ____________________________

26) If you have alcoholic drinks, how often do you have 4 or more drinks in a row?
   - Never
   - Daily
   - Weekly
   - Monthly
   - Holidays/special occasions
   - Other (please specify) ____________________________

27) We are interested in what you are proud of in your community. What are some existing services or characteristics in the community that support the health and well-being of your family?

   ____________________________________________________

   ____________________________________________________

   ____________________________________________________

28) We are also interested in what you believe we are lacking in our community. What are some existing services or characteristics in the community that we do not have that would support the health and well-being of your family?

   ____________________________________________________

   ____________________________________________________

   ____________________________________________________

The following questions will tell us a little more about who is completing this survey. All responses are voluntary and completely confidential.

29) What is your age?
○ Under 18
○ 18 – 29
○ 30 – 39
○ 40 – 49
○ 50 – 59
○ 60 – 69
○ 70 and over

30) What is your current gender identity? (Check all that apply)
○ Male
○ Female
○ Male to female transgender
○ Female to male transgender
○ Other (please specify) ____________________________

31) Which one or more of the following would you say is your race? Select all that apply.
○ American Indian
○ Hispanic/Latino
○ Black/ African American
○ White/Caucasian
○ Asian/Pacific Islander
○ Prefer not to answer
○ Other (please specify) ____________________________

32) What is the highest grade or year of school you completed?
○ Never attended school or only attended kindergarten
○ Grades 1 through 8 (Elementary)
○ Grades 9 through 11 (Some high school)
○ Grade 12 or GED (High school graduate)
○ Some college or technical school
○ Associates Degree
○ Bachelors Degree
○ Masters Degree
○ More than a Masters Degree

33) Are you currently...?
○ Employed for wages
○ Self-employed
○ Out of work for 1 year or more
○ Out of work for less than 1 year
○ A Homemaker
○ A Student
○ Retired
○ Unable to work
○ Other (please specify) ________________________________

34) Is your annual household income from all sources —
○ $10,000 - $15,000
○ $15,000 - $20,000
○ $20,000 - $25,000
○ $25,000 - $35,000
○ $35,000 - $50,000
○ $50,000 - $75,000
○ $75,000+

35) How many people live in your home, including yourself? Please enter number for each age group

Number of children (17 and under) __________________________

Number of adults (18 to 64) ________________________________

Number of seniors (65 and over) ____________________________

The survey was released to the public in October of 2018 with a closing date of March 31, 2020. Paper surveys were collected and manually entered into the Survey Monkey. There were a total of 1,492 respondents. The following are the results of the survey as reported by