



# BROOKS-TLC HOSPITAL SYSTEM, INC.

Affiliated with Kaleida Health



**BROOKS**  
MEMORIAL HOSPITAL



**TLC HEALTH**  
NETWORK

## COMMUNITY SERVICE PLAN 2025-2027

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Dear Friends and Neighbors,

At Brooks-TLC Hospital System, we see our community not just as the place we serve—but as our home. Each day, our caregivers, staff, and volunteers work alongside you to make Chautauqua County a healthier, more hopeful place for all who live here. As we take part in the 2025 Chautauqua County Community Health Assessment, we're reminded that health isn't only found in our clinics or hospital—it's built in our schools, our churches and our workplaces.



The 2025 Brooks-TLC Hospital System, Inc. Community Health Assessment is proud to present the 2025-2027 Community Service Plan. This report gives us a deeper understanding of the strengths and challenges that define our region, and addresses the high-level needs of our communities we serve. We know that access to primary care is more than a matter of distance or appointment times—it's about trust, relationships, and understanding the social realities that shape a person's ability to get and stay healthy. Whether it's addressing barriers like transportation, housing stability, or food security, we're committed to ensuring that primary care meets people where they are, in every sense.

Nutrition remains one of the simplest yet most powerful tools for lasting wellness. Through partnerships with local food programs, providing access to local farm produce and educational initiatives, Brooks-TLC is helping families make informed, affordable choices that support their health. Our focus on chronic disease prevention—especially in areas like diabetes and heart health—is grounded in the idea that small, supported changes can yield big results over time.

We're also facing substance use and behavioral health concerns with compassion and collaboration. These are not individual struggles but community challenges, tied to economic pressures, trauma, and access to care. Brooks-TLC continues to work closely with local agencies, partnerships and recovery programs to foster a system of care that supports prevention, treatment, and long-term recovery—without stigma or isolation.

Equally important to our shared future is investing in the next generation of healthcare professionals right here in Chautauqua County. By partnering with local and regional schools, training programs, and universities, we're helping to educate and inspire the local workforce who will serve our neighbors for years to come. This commitment ensures that the care provided in our community is not only skilled but also grounded in the understanding of who we are and what we value.

Good health takes all of us—patients, providers, families, and community leaders—working together. The insights from this health assessment, coupled with feedback from our community members, will guide our path to help Brooks-TLC continue to deliver high-quality care while addressing the deeper roots of wellness in our county.

Thank you for allowing us to be part of your lives and your health journeys. Together, we can build a stronger, more connected, and healthier Chautauqua County.

With gratitude,

A handwritten signature in blue ink, appearing to read 'Ken Morris', written in a cursive style.

Ken Morris  
President and Chief Executive Officer  
Brooks-TLC Hospital System, Inc.

## Brooks TLC Hospital System, Inc.

### Mission, Vision, and Values

#### Our Mission

*To provide high-value care to advance health and wellness.*

#### Our Vision

*To be trusted for providing the best quality and compassionate care for a healthier community.*

#### Our Values

*All Brooks employees are I-CARE Ambassadors who strive to incorporate the I-CARE (Integrity, Compassion, Accountability, Respect, Empathy) values into the work of caring for our community. Considered role models, our I-CARE Ambassadors perform ordinary work extraordinarily well, and exemplify acts of extraordinary performance within the context of the I-CARE values.*

#### Integrity

Our actions are guided by our ethical commitments

#### Compassion

We provide excellence with personal kindness

#### Accountability

We take responsibility for personal & team actions

#### Respect

We advocate for the dignity of others

#### Excellence

Commitment to quality, innovation and continuous improvement

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## Brooks TLC Hospital System, Inc.

Community Health Assessment (CHA)  
Community Health Improvement Plan (CHIP)  
Community Service Plan (CSP)  
New York State 2025 - 2027

### COUNTY COVERED:

**Chautauqua County**

### PARTICIPATING LOCAL HEALTH DEPARTMENT:

**Chautauqua County  
Department of Health**

7 N Erie St, Mayville, NY 14757

<https://chautauquacountyny.gov/public-health/public-health>

### COALITION/ENTITY COMPLETING ASSESSMENT AND PLAN:

Brooks-TLC Hospital System, Inc. has developed this Community Service Plan (CSP) in close collaboration with the Chautauqua County Health Department (CCHD), which served as the lead agency for the county-wide Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). This individual plan for Brooks-TLC reflects the hospital's specific role, capabilities, and service area, while aligning with the shared priorities identified through the Chautauqua County Community Health Planning Team (CCCHPT).

The CCCHPT includes Allegheny Health Network–Westfield Memorial Hospital, UPMC Chautauqua Hospital, Chautauqua County Department of Mental Hygiene and Social Services, Chautauqua County Office for Aging Services, Chautauqua Health Network, Healthy Community Alliance, Heritage Ministries, Prevention Works, The Chautauqua Center, The Resource Center, and the Western New York Public Health Alliance. Together, these partners collaborated with CCHD to analyze data, engage community members, and identify county-level priorities. Brooks-TLC's CSP is presented on behalf of the hospital as its individual contribution to this broader collaborative effort and reflects shared priorities designed to strengthen local coordination, leverage collective resources, and improve health outcomes for residents of northern Chautauqua County.

## Brooks TLC Hospital System Inc:

### Brooks Memorial Hospital

529 Central Ave  
Dunkirk NY 14048  
7 days a week  
716-366-1111

### Gowanda Urgent Care and Medical Center

34 Commercial St.  
Gowanda, NY 14070  
7 days a week  
(716) 532-8100

### Cassadaga Outpatient Substance Use Disorder Clinic (Chemical Dependency)

33 N. Main St.  
Cassadaga, NY 14718  
Monday – Friday  
(716) 595-3355

### Derby Outpatient Substance Use Disorder Clinic (Chemical Dependency)

7020 Erie Road  
Derby, NY 14047  
Monday – Friday  
(716) 947-0316

### Lake Erie Medical Services

Primary Care  
General Surgery and GI  
Services  
Oncology and  
Hematology  
Orthopedics and Spine  
Pain Management  
716-672-2000

### Locations:

**Dunkirk**  
419 Central Ave.  
Dunkirk, NY 14048  
716-672-2000

529 Central Ave  
Dunkirk NY 14048  
716-672-2000

**Fredonia**  
268 W. Main St.,  
Suites 2&3  
Fredonia, NY 14063  
716-672-2000

**Jamestown**  
107 Institute Street  
Jamestown, NY 14701  
716-672-2000

**Derby**  
Derby Professional Park  
7060 Erie Road,  
Suite 500  
Derby, NY 14047  
716-672-2000

## B. Executive Summary

### Introduction

New York State Public Health Law, Section 40-2.40, requires Local Health Departments to work with community partners to conduct a Community Health Assessment (CHA) and develop a Community Health Improvement Plan (CHIP), while the New York State Department of Health requires hospitals to complete a Community Health Needs Assessment (CHNA) and Community Service Plan (CSP) every three years.<sup>26,27</sup> Brooks-TLC Hospital System Inc. (BTLC) participated with the Chautauqua County Health Department, Allegheny Health Network–Westfield Memorial Hospital, and UPMC Chautauqua to complete the 2025–2030 CHA/CHIP for Chautauqua County, which describes community conditions, social determinants of health (SDOH), health status, and community assets and resources.<sup>26,27</sup>

Brooks-TLC Hospital System, Inc. (BTLC) is a 65-bed community hospital in Dunkirk serving northern Chautauqua County and surrounding rural areas. This 2025–2027 CSP is an individual plan for BTLC, developed in close collaboration with the Chautauqua County Health Department (CCHD), which served as the lead agency for the 2025–2030 CHA and CHIP.<sup>26,27</sup> The Chautauqua County Community Health Planning Team (CCCHPT) included Allegheny Health Network–Westfield Memorial Hospital, UPMC Chautauqua Hospital, Chautauqua County Department of Mental Hygiene and Social Services, Chautauqua County Office for Aging Services, Chautauqua Health Network, Healthy Community Alliance, Heritage Ministries, Prevention Works, The Chautauqua Center, The Resource Center, and the Western New York Public Health Alliance.

CCHD and the CCCHPT led a county-wide process that combined quantitative data analysis with primary data collection through community and provider surveys, focus groups, and key-informant interviews to identify priority health needs and SDOH.<sup>8,27</sup> BTLC then used these county-level findings, together with its own internal data and a Health Equity Impact Assessment (HEIA) conducted for the relocation to a new replacement hospital in Fredonia, to select a focused set of New York State Prevention Agenda priorities that are feasible for a small, resource-constrained hospital and aligned with county goals.<sup>28,33</sup>

## Key Findings

Chautauqua County is a micropolitan, largely rural county in which approximately 44 percent of residents live in low-population-density areas.<sup>2,8,3</sup> County Health Rankings data show that Chautauqua County performs slightly worse than New York State overall on several key indicators: food insecurity is 15 percent, severe housing problems affect 15 percent of households, drug overdose deaths are 52 per 100,000, and median household income is about 56,000 dollars compared with 82,100 dollars statewide.<sup>8</sup> The CHA also highlights elevated adult obesity and frequent mental distress, as well as persistent child poverty and pockets of limited access to primary and behavioral health care.<sup>6,8</sup>

Primary data gathered through county surveys and engagement activities indicate that residents view mental health, substance use, access to affordable healthy food, safe and affordable housing, and economic stress as top concerns.<sup>8</sup> Internal BTLC SDOH screening data show that approximately 10 percent of hospitalized patients report housing instability and about 3 percent report food insecurity, confirming that basic-needs challenges are common within BTLC's inpatient population. The HEIA further documents that the Brooks-TLC service area is medically underserved, with high poverty, limited primary and specialty care access, transportation barriers, and a substantial Latino population in Dunkirk,<sup>3</sup> underscoring the need for equitable access, language support, and attention to rural and minority communities during and after relocation to Fredonia.

Taken together, these findings support BTLC's focus on:

- Economic stability (unemployment, poverty, nutrition security).
- Social and community context (substance misuse and overdose prevention, healthy eating).
- Health care access and quality (through integrated screening and referral, though no stand-alone objective is selected in this domain).
- Education access and quality (opportunities for continued education and workforce pathways)

## 2025-2027 Prevention Agenda Priorities

BTLC's CSP aligns with the New York State Prevention Agenda and the Chautauqua County CHA/CHIP by selecting the following objectives and related interventions:<sup>26,27</sup>

### DOMAIN 1: ECONOMIC STABILITY

#### Priority: Unemployment (Objective 2.0)

SMART Objective: Reduce unemployment among individuals aged 16 and older from 6.2% (2022) to 5.5% (2030).

BTLC supports New York State Objective 2.0 (reduce unemployment among individuals aged 16 years and older from 6.2 percent to 5.5 percent) by implementing a Student Employee Program that offers entry-level positions, job shadowing, and mentoring for high school students, recent graduates, and student attending local colleges. This strategy addresses local economic vulnerability—reflected in lower median income and child poverty—and builds pathways into stable health-care employment that can improve both economic and health outcomes.<sup>10,3</sup>

#### Priority: Nutrition Security (Objective 3.1)

SMARTIE Objective: Increase food security among households with annual income less than 25,000 dollars.

BTLC supports New York State Objectives 4.1 (increase the percentage of low-income adults able to pay housing and utility bills) and 3.1 (increase food security among low-income households) by integrating standardized SDOH screening and referral into patient workflows<sup>1, 4, 5, 27</sup>. Internal data indicating 10 percent housing instability and 3 percent food insecurity among hospitalized patients demonstrate the need for this approach, which aligns with county data and county priorities around housing stability and access to affordable, healthy food<sup>10, 8</sup>. Patients screening positive will be linked to housing support, utility-assistance programs, financial counseling, food pantries, and SNAP/WIC enrollment assistance through partnerships with community and governmental organizations reducing nutrition insecurity in communities experiencing high levels of food insecurity.

#### Priority: Poverty (Objective 4.1)

SMARTIE Objective: Increase the percentage of adults with an annual income of less than 25,000 dollars who were able to pay their mortgage, rent, or utility bills in the past 12 months.

BTLC supports New York State Objective 4.1 (increase the percentage of adults with an annual income of less than 25,000 dollars who were able to pay their mortgage, rent, or utility bills in the past 12

months) by integrating standardized SDOH screening into patient workflows to identify housing and utility instability, financial strain, and related needs <sup>1, 4, 5, 24, 27</sup>. Internal data showing that approximately 10 percent of hospitalized patients screen positive for housing instability demonstrate a clear and actionable need that aligns with county data on severe housing problems (15 percent of households) and priorities around housing stability and affordability <sup>8,7</sup>. Patients screening positive for housing or utility concerns will be linked to housing support, utility-assistance programs, financial counseling, and other community resources through coordinated referral pathways with local partners.

## DOMAIN 2: SOCIAL AND COMMUNITY CONTEXT

### **Priority: Primary Prevention, Substance Misuse, and Overdose Prevention (Objective 10.0)**

SMART Objective: Increase the number of unique individuals enrolled in OASAS treatment programs from 1,107.8 to 1,218.6.

BTLC supports New York State Objective 10.0—to increase the number of unique individuals enrolled in Office of Addiction Services and Support (OASAS) treatment programs—through implementation of Substance Use Disorder Screening and Referral using the SBIRT (Screening, Brief Intervention, and Referral to Treatment) model in hospital and clinic settings. SBIRT is an evidence-based, public health-oriented approach used to identify, reduce, and prevent problematic substance use, including alcohol, opioids, and other drugs <sup>25, 30</sup>. In the hospital environment, SBIRT promotes early detection of risk, enhances patient safety, and contributes to improved clinical and population-level outcomes. <sup>25, 30</sup>

Incorporating SBIRT into BTLC patient workflows allows for systematic screening of patients across the spectrum of risk, from low-risk use to probable substance use disorder. The primary aims are to identify unhealthy substance use early, prevent escalation to dependence or serious complications, and reduce avoidable readmissions, complications, and adverse events related to substance use. In addition, SBIRT supports and aligns with broader population-health and social-determinant screening efforts already underway at the county level.

Patients who screen at moderate or high risk will receive a brief, structured conversation focused on motivation, safety, and harm reduction, followed by referral when indicated to OASAS-certified treatment providers, county mental hygiene services, and peer recovery supports <sup>27, 30</sup>. By embedding SBIRT within routine care, BTLC advances the Social and Community Context domain and strengthens access to timely, evidence-based substance use services in a county with elevated overdose mortality and frequent mental distress. <sup>8, 27, 30</sup>

### **Priority: Healthy Eating (Objective 19.0)**

SMART Objective: Decrease the percentage of adults who consume no fruits or vegetables daily from 28.4 percent to 27.0 percent.

BTLC supports New York State Objective 19.0—to decrease the percentage of adults who consume no

fruits or vegetables daily from 28.4 percent to 27.0 percent—by promoting access to fresh and affordable produce through a hospital-based farmers market<sup>10, 11, 12, 13, 27</sup>. Each Friday from late spring through fall, BTLC sponsors a farmer’s market in the hospital parking lot, creating a consistent, neighborhood-level access point for fruits and vegetables. This setting is particularly important in northern Chautauqua County, where many residents face transportation challenges.

The hospital’s location along several established public bus routes operated by the Chautauqua Area Regional Transit System (CARTS) makes the farmers market more accessible to residents who rely on public transportation for essential needs. By bringing local farm-fresh produce directly to the BTLC campus, the market reduces travel and cost barriers and offers healthy foods at prices that are often lower than those found in traditional grocery stores.<sup>10, 12, 13</sup> This effort supports county priorities around healthy eating and chronic disease prevention and complements broader work to improve nutrition security and food access for residents of northern Chautauqua County.<sup>7, 8, 27</sup>

### **DOMAIN 3: NEIGHBORHOOD AND BUILT ENVIRONMENT**

For this CSP cycle, BTLC has not designated a stand-alone Prevention Agenda objective under Domain 3. However, initiatives described in Domains 1 and 2—particularly the hospital-based farmers market and housing-focused SDOH screening—have direct implications for neighborhood environments by improving access to healthy foods and supporting safer, more stable living conditions. BTLC will continue to monitor neighborhood-level indicators and may consider future Domain 3 objectives as resources and county priorities evolve.

### **DOMAIN 4: HEALTHCARE ACCESS AND QUALITY**

BTLC has not selected a stand-alone Prevention Agenda objective within Domain 4 for this CSP cycle. However, the hospital’s work under other domains—particularly SDOH screening, SBIRT implementation, and linkage to community resources—directly supports health care access and quality by identifying unmet needs, coordinating referrals, and improving connections to primary, behavioral, and social services. These efforts enhance overall care quality in northern Chautauqua County without requiring additional, resource-intensive clinical programs.

### **DOMAIN 5: EDUCATION ACCESS AND QUALITY**

#### **Priority: Opportunities for Continued Education (Objective 42.0)**

SMART Objective: Increase the percentage of high school seniors that attend a 2- or 4-year college from 70.2 percent to 77.0 percent.

BTLC supports Objective 42.0 by partnering with Northern Chautauqua school districts, SUNY Fredonia, and Jamestown Community College to host High School Career Days. These events introduce students to a range of health-care careers, explain post-secondary education options and financial aid, and highlight BTLC’s Student Employee Program as an accessible entry point into the local health-care workforce.

By connecting students to real-world examples of health-care roles and offering clear information on

educational pathways, BTLC supports Education Access and Quality and promotes long-term economic stability and health for youth and families in its service area. Over time, these efforts are expected to contribute to higher post-secondary enrollment among local students and to a stronger, more locally rooted health-care workforce.

### **Data Sources Used to Identify and Confirm Priorities**

BTLC's priorities are informed by a robust mix of secondary and primary data:

- New York State Prevention Agenda dashboards and related state data, providing county-level indicators for unemployment, food security, housing, chronic disease, mental health, and substance use.<sup>26, 27</sup>
- County Health Rankings & Roadmaps, which document key SDOH and outcome metrics, including food insecurity, severe housing problems, overdose deaths, income, and education for Chautauqua County.<sup>8</sup>
- U.S. Census and American Community Survey data, used to characterize demographic and economic conditions in the BTLC service area.<sup>2</sup>
- Chautauqua County CHA and CHIP documents (including prior 2022–2024 reports), which provide historical trend data and community-identified priorities.<sup>6,7</sup>
- The Health Equity Impact Assessment (HEIA) for the Kaleida Brooks Memorial Hospital relocation and new building, which describes the Brooks-TLC service area as medically underserved, highlights transportation and language barriers, and identifies rural residents, low-income families, older adults, immigrants, and people with behavioral health and substance use disorders as key groups at risk of inequitable access.<sup>3</sup>
- Internal BTLC data, including SDOH screening results (housing instability about 10 percent; food insecurity about 3 percent among hospitalized patients) and utilization data reflecting limited local primary care and behavioral health capacity.
- Community and provider input collected through the 2025 Chautauqua County Community Health Survey, provider surveys, focus groups, and HEIA listening sessions, which confirmed the importance of addressing mental health and substance use, housing, food access, transportation, and economic stress.<sup>7, 3</sup>

These sources were used together to confirm that BTLC's selected priorities reflect both county-wide needs and the specific experiences of patients and communities in northern Chautauqua County.

### **Partners and Roles:**

#### **COMMUNITY PARTNERS:**

Representatives from local Community Based Organizations (CBOs), various Chautauqua County representatives, and members of the Chautauqua County Community Health Planning Team (CCCHPT) met several times to share input and expertise related to their work during the CHIP priority selection and intervention planning process.

#### **COMMUNITY PARTICIPANTS:**

Chautauqua County residents provided input through participation in the community health equity assessment which community issues and health conditions were most important to them through

surveys, interviews and focus groups.

### **Interventions and Strategies:**

Interventions and strategies tied to BTLC's selected priorities were chosen based on community and provider input regarding gaps in existing efforts and infrastructure, as well as the hospital's capacity as a small, resource-constrained facility. All interventions included in this CSP correspond to New York State Prevention Agenda priorities and are designed so that they can be embedded into routine clinical workflows or implemented through practical, community-based partnerships. Several BTLC strategies are intentionally structured to address multiple priority issues—such as housing and nutrition security, or economic and education stability—rather than functioning as stand-alone programs.

County surveys, focus groups, and the Health Equity Impact Assessment (HEIA) highlighted that, although resources exist in Chautauqua County for mental health and substance use treatment, employment support, nutrition security, and housing stability, many residents are unaware of these services, face transportation or language barriers, or struggle to navigate fragmented systems<sup>7,3</sup>.

In response, BTLC's CSP emphasizes:

- Systematic identification of need through standardized SDOH and substance-use screening.<sup>1, 4, 5, 15, 15, 30</sup>
- Active linkage to existing community assets by building clear referral pathways from BTLC to housing and utility-assistance programs, food supports, behavioral-health providers, workforce and education partners, and community-based organizations.<sup>1, 4, 15, 15, 19, 18</sup>
- On-site, low-barrier access points—such as the hospital-based farmers market and Student Employee Program—that bring services directly to patients, staff, and nearby residents, reducing transportation and cost barriers.<sup>3,8,10,13</sup>

BTLC will partner closely with CCHD, CCCHPT organizations, and additional community-based organizations to put these strategies into practice, with each partner contributing complementary strengths (e.g., care delivery, behavioral-health expertise, navigation, transportation, language access, or outreach). To support mental health and substance-use resilience specifically, BTLC will continue to enhance SBIRT-based screening and referral and will collaborate with behavioral-health and harm-reduction partners to ensure timely access to appropriate levels of care. Recognizing the strong links between health, housing, food access, and economic opportunity, BTLC's interventions are designed to connect patients to stable employment, educational pathways, and community-based supports that help individuals and families maintain health and remain safely in their homes.

### **Progress and Evaluation:**

BTLC will use internal and external measures to monitor progress and guide continuous improvement:

#### **Internal measures:**

- Percentage of inpatient encounters with completed SDOH screening (housing/utility, financial strain, food security).

- Percentage of positive SDOH screens with documented referrals to housing, utility, food, or financial-assistance resources, and where possible, confirmed linkages.
  - Percentage of eligible encounters with completed SBIRT screening, and for those with positive screens, the percentage receiving a brief intervention and a referral to substance use disorder (SUD) or behavioral-health services.
  - Student Employee Program participation, completion, hiring, and 12-month retention.
  - Number of High School Career Day events, student participation, and the number of students subsequently entering BTLC employment or internships.
  - Number of farmers market events, and attendance estimates.
- Where feasible, BTLC will stratify key indicators by age, gender, ZIP code, and race/ethnicity to identify disparities and support equity-focused improvements, consistent with the HEIA’s emphasis on monitoring impacts on underserved populations. <sup>3</sup>

#### External measures:

- County Health Rankings indicators (e.g., food insecurity, severe housing problems, overdose deaths, unemployment, child poverty, education).<sup>8</sup>
- New York State Prevention Agenda metrics for the selected objectives (2.0, 3.1, 4.1, 10.0, 19.0, 42.0).<sup>27</sup>
- Periodic updates from CCHD’s CHA/CHIP reporting and any HEIA-related follow-up on access, transportation, language, and service utilization patterns. <sup>3,6,7</sup>

BTLC’s internal CHIP/CSP workgroup will review data at least annually and provide updates through CCHD-convened CHA/CHIP meetings and community-partner gatherings. As new data and community feedback emerge, BTLC and its partners may refine objectives, adjust interventions, and explore additional strategies—especially around transportation, language access, and behavioral health—to ensure that the CSP and the new hospital configuration continue to advance health equity for residents of northern Chautauqua County.

## C. Community Health Improvement Plan / Community Service Plan (CHIP/CSP)

### PARTNER & COMMUNITY ENGAGEMENT

#### **Partner Engagement:**

Brooks-TLC Hospital System, Inc. (BTLC) developed this individual Community Service Plan in close collaboration with the Chautauqua County Health Department (CCHD), which served as the lead agency for the 2025–2030 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP).<sup>26,27</sup> BTLC participates in the county’s CHA/CHIP implementation structure and maintains an internal Quality Committee to coordinate hospital-specific efforts.

The BTLC Quality Committee will meet at least quarterly throughout the 2025–2027 CSP period to review goals, objectives, and tasks associated with each BTLC priority. These meetings will be used to review process measures (e.g., screening and referral rates, program participation), identify barriers, and plan adjustments to improve implementation. They will also serve as preparation time for county-wide community partner meetings, ensuring that BTLC can share updates on its progress and align its activities with the broader county plan.

BTLC will continue to participate in the Chautauqua County Community Health Planning Team (CCCHPT) which post plan submission was renamed to the Chautauqua Health Action Team (CHAT) on a regular basis to monitor the CHA/CHIP. Community-partner meetings will be held approximately every four months to update partners on progress, share data, and support ongoing collaboration. As the county approaches its mid-cycle CHA/CHIP update, BTLC anticipates that CHAT will increase meeting frequency, and BTLC will adjust its internal cadence accordingly to support timely planning and reporting.

#### **Community Engagement:**

The priorities, objectives, interventions, and action plans in this CSP/CHIP section were developed to align with the New York State Prevention Agenda and to reflect community and provider input gathered throughout the Chautauqua County CHA/CHIP process.<sup>8, 26,27</sup> County surveys, focus groups, and interviews highlighted mental health and substance use, access to affordable healthy food, safe and affordable housing, and economic stress as top concerns.<sup>7</sup>

BTLC also incorporated internal social determinants of health (SDOH) screening data into its decision-making. Approximately 10 percent of hospitalized patients screen positive for housing instability and about 3 percent for food insecurity, confirming that basic-needs challenges are present within BTLC’s own inpatient population. These internal findings mirror county-level data on severe housing problems and food insecurity and reinforced the decision to focus on poverty, nutrition security, and healthy eating.

## **PROCESS AND CRITERIA TO IDENTIFY MAJOR COMMUNITY FACTORS AND HEALTH CONDITIONS PRIORITIZATION METHODS**

To select BTLC's CSP priorities, BTLC used a structured process that combined primary, secondary, and internal data sources. Secondary data included County Health Rankings & Roadmaps, New York State Prevention Agenda indicators, U.S. Census and American Community Survey data, and prior Chautauqua County CHA/CHIP reports.<sup>10, 26, 27, 2, 7</sup> Primary data included the 2025 Community Health Survey, provider surveys, and focus groups and key-informant interviews with residents, health care providers, and community-based organizations<sup>8</sup>. Internal BTLC data included SDOH screening results, utilization patterns, and key findings from the Health Equity Impact Assessment (HEIA) conducted for the Brooks-TLC hospital relocation.<sup>3</sup>

Each potential issue was evaluated using three core criteria:

- Scope – how widespread the issue is (for example, prevalence of food insecurity, severe housing problems, unemployment, overdose deaths, or low educational attainment).
- Severity – the seriousness of its impact on health outcomes, quality of life, and equity.
- Impact/feasibility – BTLC's realistic capacity, as a small, financially constrained hospital, to address the issue through clinical workflows, care coordination, and partnerships, considering existing programs and resources.

Using these criteria, the Chautauqua County Community Health Planning Team (CCCHPT) and BTLC reviewed community factors and health conditions identified through the CHA/CHIP. For BTLC, particular weight was given to county indicators showing elevated food insecurity, severe housing problems, overdose mortality, frequent mental distress, and economic vulnerability; internal SDOH data documenting housing instability and food insecurity among hospitalized patients; and HEIA findings that the Brooks-TLC service area is medically underserved, with transportation and language barriers and a substantial rural and Latino population.

From the broader CHA/CHIP priority list, BTLC then selected New York State Prevention Agenda objectives that:

- Directly reflect community-identified needs in northern Chautauqua County.
- Can be addressed through efficient, high-leverage changes in screening, referral, and partnership rather than stand-alone, resource-intensive programs.
- Are supported by evidence-based or evidence-informed interventions that fit BTLC's staffing, financial, and operational context.

## **PROGRESS AND EVALUATION**

Progress toward BTLC's CSP goals will be reviewed and measured using both internal and external data sources.

- Internal monitoring – BTLC will use electronic health records and simple tracking tools to monitor:

- SDOH screening rates (housing/utility/financial strain, food insecurity) in ED and inpatient care.
- SUD screening, brief intervention, and referral rates under the SBIRT model.
- Numbers and proportions of patients referred to housing, food, financial, and behavioral-health resources, and, where feasible, confirmation of linkage.
- Participation and outcomes for the Student Employee Program (enrollment, completion, hiring, retention) and High School Career Days (attendance and subsequent engagement with BTLC).
- Farmers market activity (number of events, attendance estimates, use of any vouchers or incentives).

Where possible, BTLC will stratify key indicators by basic demographic characteristics (e.g., age, gender, ZIP code, race/ethnicity) to identify disparities and support health-equity improvements, consistent with findings and expectations outlined in the HEIA.

External monitoring – BTLC will use County Health Rankings, Prevention Agenda dashboards, and Chautauqua Health Action Team (CHAT) updates to track county-level trends in food insecurity, housing, overdose deaths, unemployment, child poverty, and educational outcomes. While BTLC alone cannot change population-level indicators, these data will be used to ensure continued alignment with county priorities and to inform collective action within the CHAT.

BTLC’s internal Quality Committee will review progress at least annually, share findings with CCHD and CHAT partners, and recommend adjustments as needed. As data and community feedback emerge, BTLC will refine objectives, enhance or streamline interventions, and consider additional collaborations to ensure that its CSP continues to advance health, equity, and access for residents of northern Chautauqua County.

## JUSTIFICATION FOR UNADDRESSED HEALTH NEEDS

The Community Health Assessment process identified a wide range of health issues affecting Chautauqua County residents. Each issue was evaluated using quantitative data, community and provider input, and stakeholder feedback.

While each issue presents unique challenges and deserves attention, limited resources and the need for prioritization require both health systems to focus on a limited number of high-impact health priorities. The following considerations guided decisions to exclude some issues from focused CSP/CHIP interventions at this time:

**Limited Ability to Have a Measurable Impact:** Some health issues would require large-scale systemic, policy, or financial changes beyond the scope of local public health and current partnerships. These issues were deprioritized to ensure that selected priorities can be addressed effectively within existing or realistically attainable capacity.

**Existing Efforts and Infrastructure:** Some issues are already being addressed by specialized agencies, hospitals, and community-based organizations. In these cases, duplicating efforts would not be an efficient use of public health resources. The CHA/CSP/CHIP partners will instead continue to collaborate and support these existing efforts where appropriate.

**Community Input and Stakeholder Consensus:** Priority-setting was strongly informed by community surveys, provider surveys, focus groups, and stakeholder meetings. Issues that consistently received lower rankings or were not identified as urgent concerns were not selected for focused action, though they remain important.

**Alignment with State and Local Frameworks:** Priorities were selected to align with the New York State Prevention Agenda, and other established health improvement goals. Issues that fell outside these frameworks are less likely to receive broad partner support or sustained resources. Resource Limitations: Available time, staffing, and financial resources to support the CHA/CSP/CHIP cycle are finite. The Workgroup chose a limited number of high-impact priority areas to allow for concentrated, measurable efforts rather than spreading resources too thinly across many issues.

While certain health issues were not selected as top priorities for this cycle of the Community Health Improvement Plan, they remain important and will continue to be monitored. Opportunities to address these needs through partnerships, policy development, or future CHA and CSP/CHIP cycles will be considered as resources allow.

## **DEVELOPMENT OF OBJECTIVES, INTERVENTIONS, & ACTION PLANS**

Planning for BTLC's 2025–2027 CSP occurred in parallel with CCHD's 2025–2030 CHA/CHIP process.<sup>26,27</sup> CCHD and the CCCHPT led county-wide data collection, analysis, and priority setting. BTLC then selected a subset of New York State Prevention Agenda objectives within that framework, based on hospital-specific capacity and alignment with its service area.

BTLC's CSP maintains the exact New York State language for each selected Prevention Agenda objective and defines hospital-level interventions and measures that are appropriate for a small, 65-bed hospital.<sup>28</sup> The objectives are organized by domain, with each domain including one or more BTLC priorities.

For each objective, BTLC identified:

- A concise, feasible intervention that can be integrated into existing workflows (e.g., screening at intake, referral processes, campus-based farmers market, student employment and career events).
- A limited family of measures that can be tracked using electronic health records, simple spreadsheets, and existing administrative data (e.g., screening and referral rates, program participation and completion, event attendance).
- Key community partners (e.g., housing and food agencies, behavioral-health providers, schools, CARTS, employers) who will help implement and sustain interventions.

## **DISTRIBUTION PLAN: SHARING FINDINGS WITH COMMUNITY**

Once finalized, BTLC's CSP will be made available to internal and external audiences and integrated into the larger Chautauqua County CHA/CHIP communication plan.

- Public availability – BTLC will post its CSP on the hospital's website and make printed copies available upon request.
- Partner communication – BTLC will share CSP highlights and progress updates at CHAT and CHA/CHIP partner meetings, reinforcing how hospital-level interventions support county-wide goals. BTLC will also provide summary information to community partners directly involved in implementation (e.g., housing agencies, food pantries, CARTS, schools, and behavioral-health providers).
- Internal communication – BTLC leadership will present the CSP, including objectives, interventions, and key measures, to internal governance bodies and staff, ensuring that clinical teams and departments understand their roles in implementation. Updates will be provided through staff meetings, internal newsletters, and dashboards as data become available.

## D. 2025-2027 Prevention Agenda Priorities (Objectives and Interventions)

### Domain 1: Economic Stability

#### PRIORITY: UNEMPLOYMENT

Objectives: (NYS 2.0) Reduce unemployment among individuals aged 16 and older from 6.2% (2022) to 5.5% (2030).					
DESIRED OUTCOME	INDICATOR	DATA SOURCE	POPULATION	BASELINE	TARGET
Reduce the percentage of people unemployed	Percentage unemployed	ACS / NYS Prevention Agenda dashboard	Everyone aged 16 or older in Chautauqua County	County value corresponding to 6.2% NYS baseline	5.5% (2030) or better

#### Disparities Being Addressed

Individuals with limited earning potential, especially those with high school or equivalent education, or less; individuals with coexisting socioeconomic barriers such as unreliable transportation, poor access to childcare, or difficult interpersonal relationships.

#### Interventions

##### Intervention 1.2.0.1

BTLC will develop and maintain a Student Employee Program that offers paid entry-level employment, job shadowing, and mentoring in hospital roles for high school students, recent graduates, and under-employed adults in northern Chautauqua County. This approach reflects evidence that workforce development, linked to local labor-market demand and supportive supervision, improves economic stability and long-term employment outcomes and is endorsed in the New York State Prevention Agenda as an evidence-informed strategy.<sup>3, 8, 20, 21, 27,</sup>

#### Evidence Based Intervention Reference

- County Health Rankings “Sector-based workforce initiatives” and related workforce strategies (career pathways, adult vocational training, youth apprenticeship, summer youth employment), which show that coordinated training and work-experience programs improve employment and earnings.
- Healthy People 2030 – Social Determinants of Health (Economic Stability) framing unemployment as a key determinant of health, supporting employment programs as public-health interventions.
- New York State Prevention Agenda 2025–2030, which emphasizes economic stability and employment as cross-cutting levers for health equity.

- American Community Survey and County Health Rankings county-level data, which can be used to target and evaluate the Student Employee Program by describing local unemployment trends and labor-force participation.

### Family of Measures

- 1.2.0.1.1 Number of Student Employee Program participants per year.
- 1.2.0.1.2 Percentage of participants who complete at least 6–12 months of employment.
- 1.2.0.1.3 Percentage of participants offered ongoing employment at BTLC.
- 1.2.0.1.4 Twelve-month retention rate among BTLC-hired participants.
- 1.2.0.1.5 Participant demographics (age, ZIP code) to monitor reach and equity.

### Timeframe

January 1, 2026 – December 31, 2027

### Implementation Partner

Hospital

### Partner Roles and Resources

BTLC provides employment, mentoring, and supervision; schools and colleges support recruitment, coordination of schedules, and academic counseling; community partners help address transportation and social barriers (e.g., referrals to CARTS, child-care supports).

**PRIORITY: POVERTY**

Objective (NYS 4.1): Increase the percentage of adults with an annual income of less than \$25,000 who were able to pay their mortgage, rent, or utility bills in the past 12 months from 85.1% to 89.4%					
DESIRED OUTCOME	INDICATOR	DATA SOURCE	POPULATION	BASELINE	TARGET
Improve financial stability and housing/utility security among low-income residents	Percentage of adults < \$25,000 income able to pay mortgage/rent/utility bills in past 12 months	NYS Prevention Agenda dashboard	Adults with annual income < \$25,000	85.1% (NYS baseline)	89.4% (2030)

**Disparities Being Addressed**

Low-income adults in northern Chautauqua County with high housing-cost burden, risk of utility shut-offs, and difficulty meeting basic monthly expenses

**Interventions**

**Intervention 1.4.1.1 – SDOH Screening and Referral for Housing/Utility/Financial Strain**

B TLC will implement standardized SDOH patient screening in inpatient settings focused on housing stability, utility shut-off risk, and general financial strain, to be followed by referrals to housing and utility-assistance programs and financial counseling. Evidence shows that SDOH screening and referral models identify unmet needs, improve connection to social services, and can reduce downstream health risks when combined with care coordination. <sup>1, 4, 15, 24</sup>

**Evidence Based Intervention Reference**

- AHRQ PSNet “System approaches to social determinants of health screening and intervention,” describing a large-scale SDOH screening program with referrals to community resources for food, housing, transportation, and financial strain.
- CDC “Screening and referral care delivery services and unmet health needs,” showing that SDOH screening plus referral can reduce unmet social needs and improve chronic-disease care.
- Forehand et al., 2025 (integration of SDOH screening and referral tools), which demonstrates the feasibility and impact of embedding standardized SDOH tools and referral workflows into health systems.

- CDC and Healthy People 2030 SDOH resources, which explicitly highlight economic stability, housing, and financial hardship as modifiable determinants that can be addressed via screening and connection to services.
- Medicare Payment Advisory Commission report on SDOH interventions, summarizing evidence on health-system strategies to identify and address financial strain, housing, and other needs.

### Family of Measures

- 1.4.1.1.1 Percentage inpatient encounters with completed SDOH screening (housing/utility/financial).
- 1.4.1.1.2 Percentage of screened patients who screen positive for housing or utility instability or financial strain.
- 1.4.1.1.3 Percentage of positive screens with documented referral to housing/utility/financial-assistance resources.
- 1.4.1.1.4 When available, stratification of screening and referral metrics by ZIP code and race/ethnicity to monitor equity.

### Timeframe

January 1, 2026 – December 31, 2027

### Implementation Partner

Community Based Organizations. Housing and utility-assistance agencies, Chautauqua County Department of Social Services, Southwestern Independent Living, and other CBOs.

### Partner Roles and Resources

Partners accept referrals, provide case management, assist with applications for rent/utility assistance, and share de-identified feedback on linkage and capacity to inform BTLC workflow refinement.

**PRIORITY: NUTRITION SECURITY**

Objective (NYS 3.1): Increase food security in households with an annual income of less than \$25,000 from 42.0% to 51.1% (NYS)					
DESIRED OUTCOME	INDICATOR	DATA SOURCE	POPULATION	BASELINE	TARGET
Improve food security and reduce food hardship among low-income households	Percentage of adults reporting food security in past 12 months	NYS Prevention Agenda dashboard	Improve food security and reduce food hardship among low-income households	Percentage of adults reporting food security in past 12 months	NYS Prevention Agenda dashboard

**Disparities Being Addressed**

Low-income residents, rural households, and those living in areas with limited grocery access and higher food-insecurity rates than the state average

**Interventions**

**Intervention 1.3.1.1 – SDOH Screening and Referral for Food Insecurity**

BTLC will use standardized SDOH screening to identify food-insecure patients in ED and inpatient settings and will connect them to food pantries, SNAP/WIC enrollment, congregate meals, and nutrition-incentive or food-as-medicine programs where available. Health-care-based food-insecurity screening combined with referral and food interventions is recognized as a promising approach for improving nutrition security and supporting chronic disease management. <sup>1, 9, 13, 16, 23, 34</sup>

**Evidence Based Intervention Reference**

- AHRQ PSNet SDOH screening innovation and related system-level approaches, which include food insecurity among core screening domains and use community health workers to link patients to nutrition resources.
- USPSTF food-insecurity screening recommendation (2025), which recognizes accurate screening tools and describes evidence and research gaps, informing how a health-system screening and referral program should be structured and evaluated.
- Gus Schumacher Nutrition Incentive Program (GusNIP Nutrition) Incentive Program Year-4 impact findings, documenting that produce-incentive and produce-prescription programs improve food security and fruit/vegetable intake, supporting referrals from screening to incentive-based programs.
- Houghtaling et al., 2024 (GusNIP produce prescriptions), showing that eligibility for produce prescriptions is associated with higher fruit and vegetable intake and better food security.

- County Health Rankings What Works for Health strategies related to food access (mobile produce markets, CSA, farmers' markets, fruit & vegetable incentive programs), which present evidence for community-level food-security interventions that patients can be referred to.

### **Family of Measures**

- 1.3.1.1.1 Percentage of inpatient encounters with completed food-insecurity screening.
- 1.3.1.1.2 Percentage of screened patients who screen positive for food insecurity.
- 1.3.1.1.3 Percentage of positive screens with documented referral to food resources (pantries, SNAP/WIC, meals on wheels).

### **Timeframe**

January 1, 2026 – December 31, 2027

### **Implementation Partner**

Local food pantries, Chautauqua County Department of Social Services, Meals on Wheels, faith-based and civic organizations providing food assistance.

### **Partner Roles and Resources**

Partners accept referrals, provide food and navigation support, assist with benefit applications, and share aggregate data on service use when available to inform program planning.

**Domain 2: Social and Community Context**

**PRIORITY: PRIMARY PREVENTION, SUBSTANCE MISUSE, AND OVERDOSE PREVENTION**

Objective (NYS 10.0): Increase the number of unique individuals enrolled in OASAS treatment programs from 1,107.8 to 1,218.6 (per 100,000 or state-specified denominator)					
DESIRED OUTCOME	INDICATOR	DATA SOURCE	POPULATION	BASELINE	TARGET
Increase timely identification and treatment of SUD	Number of unique individuals enrolled in OASAS programs	NYS OASAS / NYS Prevention Agenda dashboard	Residents with substance use disorders	1,107.8 (baseline)	1,218.6 (2030)

**Disparities Being Addressed**

Residents in northern Chautauqua County experiencing high rates of overdose deaths and frequent mental distress, with limited local access to SUD and behavioral-health services, especially in rural communities and among low-income and minority populations

**Interventions**

**Intervention 2.10.0.1 – SBIRT-Based SUD Screening and Referral**

BTLC will implement SBIRT workflows in the ED, inpatient units, and primary care. SBIRT is an evidence-based approach shown to reduce risky substance use and improve linkage to treatment when integrated into routine care. <sup>25, 30, 27</sup>

**Evidence Based Intervention Reference**

- Substance Abuse and Mental Health Services Administration (SAMHSA) Evidence-Based Practices Resource Center, which curates’ interventions such as SBIRT, motivational interviewing, and medication-assisted treatment that increase identification of SUD and linkage to care.
- National Institutes of Health / Office of Disease Prevention evidence-based programs repository, which includes SUD prevention and treatment interventions suitable for integration into screening and referral workflows.
- The Community Guide, which summarizes evidence for alcohol and other drug use prevention and treatment strategies, including screening and brief interventions in clinical and community settings.
- Healthy People 2030 objectives for substance use and access to treatment, framing increased

treatment enrollment as a national public-health goal consistent with your OASAS objective.

- New York State Prevention Agenda 2025–2030, which prioritizes behavioral-health and substance-use outcomes and supports community-clinical linkages to treatment.

### **Family of Measures**

- 2.10.0.1.1 Percentage of eligible inpatient encounters with completed SUD screening.
- 
- 2.10.0.1.2 Percentage of patients with positive screens who receive a documented brief intervention.
- 
- 2.10.0.1.3 Percentage of positive screens with a documented referral to SUD/behavioral-health services.

### **Timeframe**

January 1, 2026 – December 31, 2027

### **Implementation Partner**

TLC Substance use disorder clinics, Chautauqua County Department of Mental Hygiene and Social Services, OASAS-certified treatment providers, Prevention Works, The Chautauqua Center, The Resource Center, peer recovery organizations

### **Partner Roles and Resources**

Partners accept warm hand-offs and referrals, provide outpatient and residential SUD care, harm-reduction services, and peer supports, and collaborate on cross-training and naloxone distribution. based organizations regarding screening

**PRIORITY: HEALTHY EATING**

Objective (NYS 19.0): Decrease the percentage of adults who consume no fruits or vegetables daily from 28.4% to 27.0%					
DESIRED OUTCOME	INDICATOR	DATA SOURCE	POPULATION	BASELINE	TARGET
Increase daily fruit and vegetable consumption	Percentage of adults consuming no fruits or vegetables daily	NYS Prevention Agenda dashboard	Adults 18+ in Chautauqua County	28.4% (NYS baseline)	27.0% (2030)

**Disparities Being Addressed**

Adults in rural and low-income areas with limited access to affordable, healthy foods, higher obesity and diabetes prevalence, and transportation barriers to grocery stores

**Interventions**

**2.19.0.1 – BTLC Hospital-Based Farmers Market**

BTLC will sponsor a weekly farmers market in the hospital parking lot from late spring through fall, featuring local farm-fresh produce at affordable prices and prioritizing acceptance of SNAP and WIC. Where feasible, BTLC will work with partners to implement nutrition-incentive models (“double up” produce vouchers or prescriptions). Evidence from GusNIP and similar programs shows that farmers markets and produce prescriptions can increase fruit and vegetable intake and reduce food insecurity among low-income populations. <sup>10, 11, 13, 16, 23</sup>

**Evidence Based Intervention Reference**

- County Health Rankings “Farmers markets” strategy, which finds evidence that farmers markets increase access to fresh produce and are associated with higher fruit and vegetable consumption.
- County Health Rankings strategies for WIC & Senior Farmers’ Market Nutrition Programs, EBT at farmers markets, mobile produce markets, CSA, and fruit & vegetable incentive programs, all of which demonstrate positive effects on produce intake and food security and can be integrated with or co-located at your market.
- GusNIP Nutrition Incentive Program Year-4 impact findings, documenting that produce-incentive and produce-prescription programs increase fruit and vegetable purchases and intake and improve food and nutrition security; these incentives are frequently implemented at farmers markets.

- County Health Rankings narrative materials (e.g., “Celebrating Farmers’ Markets”) highlighting how markets address access barriers to fruits and vegetables and contribute to healthier community food environments.

### **Family of Measures**

- 2.19.0.1.1 Number of farmers market events held per season.
- 2.19.0.1.2 Estimated attendance per event (e.g., counts or vendor estimates).

### **Timeframe**

Seasonal (late spring–fall) annually, 2026–2027

### **Implementation Partner**

Local farmers, SNAP-Ed providers, CARTS, community organizations serving low-income and rural residents.

### **Partner Roles and Resources**

Partners supply local produce, assist with outreach and SNAP/WIC enrollment, help structure incentive programs, and support transportation awareness (e.g., CARTS route promotion).

**Domain 1: Education Access and Quality**

**PRIORITY: OPPORTUNITIES FOR CONTINUED EDUCATION**

Objectives: (NYS 42.0) Increase the percentage of high school seniors that attend a 2- or 4-year college from 70.2% to 77.0%					
DESIRED OUTCOME	INDICATOR	DATA SOURCE	POPULATION	BASELINE	TARGET
Increase post-secondary enrollment among local high school graduates	Percentage of seniors enrolling in 2- or 4-year colleges	NYSED / NYS Prevention Agenda dashboard	High school seniors in Chautauqua County	70.2% (NYS baseline)	77.0% (2030)

**Disparities Being Addressed**

Students from low-income families, rural communities, and first-generation college-going households who face financial, informational, and social barriers to college and health-care careers

**Interventions**

**INTERVENTION 5.42.0.1 – High School Health-Care Career Days and BTLC Pathways**

BTLC will partner with northern Chautauqua school districts, SUNY Fredonia, and Jamestown Community College to host High School Career Days focused on health-care careers and educational pathways. Events will include panels, demonstrations, and information on 2- and 4-year programs, financial aid, and BTLC’s Student Employee Program as an entry into the health-care workforce. Evidence suggests that early exposure to health careers, mentorship, and clear pathway information increase interest in health professions and support successful transitions to post-secondary education. <sup>9,20, 21, 27,</sup>

**Evidence Based Intervention Reference**

- Healthy People 2030 – Education Access & Quality objectives, including increasing the proportion of high school graduates enrolled in college immediately after graduation, which aligns with Objective 42.0.
- Healthy People 2030 – Social Determinants of Health priority area, recognizing education as a key driver of health and equity.
- New York State Prevention Agenda 2025–2030 and community health planning resources, which embed education and economic stability as upstream levers for population health improvement in NYS.

- County Health Rankings “What Works for Health” strategies such as career & technical education, health career recruitment for minority students, and youth apprenticeship/summer youth employment programs, which document evidence that structured career-focused experiences improve educational and employment outcomes for youth.

### Family of Measures

- 5.42.0.1.1 Number of Career Day events held annually and number of student participants.
- 5.42.0.1.2 Pre/post survey results on student awareness of health-care careers and knowledge of 2- and 4-year pathways and financial aid.
- 5.42.0.1.3 Number of students who express interest in or enroll in the BTLC Student Employee Program, internships, or other hospital-based opportunities.

### Timeframe

Academic years 2026–2027

### Implementation Partner

Local school districts, SUNY Fredonia, Jamestown Community College, Chautauqua Health Network, and other education and workforce-development organizations

### Partner Roles and Resources

Schools and colleges assist with recruiting students, coordinating events, and sharing educational information; BTLC provides staff and content expertise; regional partners help align opportunities with broader workforce needs.

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