



"Our Neighborhood. Our Choice."
BMHA Perry Choice Neighborhood

The Neighborhood-Based
Supportive Service Network
Working Plan Component

Prepared by

The UB Center for Urban Studies

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Table of Contents

| | |
|--|----|
| Executive Summary | 3 |
| Introduction | 4 |
| The Need | 6 |
| Performance Indicators..... | 8 |
| The BMHA-PCN Supportive Service Network..... | 11 |
| Operations and Management..... | 40 |
| Funding Strategy and Budget | 43 |

Executive Summary

Residents of the Perry Choice Neighborhood face a number of challenges in their lives which neighborhood service providers can assist with, but residents encounter obstacles to obtaining these services due to a lack of information about what is available to them and uncertainty about how to apply. Many excellent supportive service providers are located within the neighborhood, but could serve local residents better by working together on a place-based approach that ensures all needs are met proactively and holistically. The Supportive Service Network strategy will bring neighborhood providers together to establish a placed-based Collaborative, where planning, marketing, communications, outreach and evaluation will occur as a collective effort that expands the capacity of all providers to improve the quality of life and self-sufficiency of residents. The Network will provide high quality case management and service coordination for residents through a partnership with the UB School of Social Work and the Buffalo Municipal Housing Authority (BMHA) to ensure that the challenges facing residents wellbeing are met holistically and that residents receive the technical support they need to connect to appropriate services. To help overcome transportation obstacles and the need for a community gathering space, a new community center will be established to centrally locate some neighborhood services, provide community space, and expand existing recreation opportunities. Finally, the Network strategy will expand several successful evidence-based supportive service programs operated by regional partners into the neighborhood to bolster the existing supportive service system.

The PCN Supportive Service Plan is divided into five parts. The first part (Section 1.0) is the introduction which provides an overview of the plan and planning process. The second section (2.0) will outline the need for a supportive service strategy in the PCN. Because the plan is based on an in-depth needs assessment of the PCN, the needs assessment that is included in this plan will be abbreviated. Those desiring a more detailed analysis of the socioeconomic conditions found in the PCN should see *Technical Report #2: A Needs Assessment of the Perry Choice Neighborhood*. Section 3.0 includes a look at the desired outcomes of the supportive service strategy in the form of Performance Indicators that will be used to measure success. Section 4.0 includes an analysis and explanation of the Supportive Service Network and its four component parts: The Supportive Service Collaborative; The BMHA-UB Social Work Case Management Support Unit; the Lanigan Life Chances Center; and the PCN Healthy Living Initiative. In Section 5.0, the operations and management of the Network is discussed.

1.0 Introduction

The BMHA-Perry Choice Neighborhood initiative is designed to transform this distressed, underdeveloped community into a viable mixed income neighborhood, which serves a platform that enables residents to become economically secure and financially self-sufficient and that helps children graduate from high school on time and be ready for college or a career. To make this happen, there needs to be established a network of neighborhood supportive services that will generate positive outcomes related to the residents' health, education, employment, safety and overall socioeconomic well-being. To make this happen, a network of neighborhood-based supportive services must be built that help residents, especially children, grapple successfully with the challenges they face trying to improve the quality of their lives.

This report outlines a plan to build such a neighborhood-based supportive service network in the BMHA-PCN. This network would provide individuals, families and households with the support they want and need to meet the challenges they will face trying to improve their lives and standard of living. This plan is based on a resident needs assessment, done by the UB Center for Urban Studies. The data informing the Needs Assessment came from a variety of sources. The demographic data came mostly from the 2000 and 2010 census, with additional information coming from census data compiled by the Nielsen Company, and the American Community Survey. The census information on the BMHA Commodore Perry Homes and Extension (Perry development) was derived from a series of BMHA resident list compiled by the BMHA on September 14, 2011. To gain insight into the views of the residents, 86 household surveys (22% of all households) were conducted in the Perry development, along with another 67 surveys from household in the Old First Ward and in the northern section of the PCN. In addition to these surveys, five (5) focus groups were held with residents in Commodore Perry, the Old First Ward and the what we call the North Ellicott section of the PCN (the area north of Commodore Perry Homes and Extension). Additionally, interviews were held with representatives of most of the supportive service agencies operating in the PCN.

Lastly, this plan is the outgrowth of a yearlong planning process, which involved the BMHA, the UB Center for Urban Studies, the UB School of Social Work, the Community Action Organization of Erie County and more than 15 supportive service agencies in the BMHA-PCN and Greater Buffalo area. The drafts of the threshold supportive service plan were distributed and discussed by all members of the planning committee and their commentary was integrated into the planning document. The section of the planning document on the Case Management

Support Unit was developed by the UB School of Social Work with input from the UB Center for Urban Studies.

In developing this plan, the committee used a more restrictive definition of supportive services than the one used in 2012 Choice Implementation NOFA. That document defined supportive services as “all activities that will promote upward mobility, self-sufficiency, or improved quality of life, including such activities as literacy training, activities that promote early learning and the continuum of educational supports, remedial and continuing education, job training, financial literacy instruction, day care, youth services, aging-in-place, public transportation, physical and mental health services, economic development activities, and other programs for which the community demonstrates need.” While we agree with the essence of this definition, within this transformational plan, some of these activities, such as economic development, early learning and the continuum of educational supports, and some adult education programs are included elsewhere in the transformation plan. Thus, the supportive service plan has a more exclusive menu of supportive services.

This plan focuses on two (2) interactive target populations. One focus is on the residents of Commodore Perry, Frederick Douglass Towers, and the A.D. Price Extension, while the other focus is on residents who do not reside in public housing in the PCN. The reason for this distinction is that the realities of the BMHA residents, while similar, still differ in important ways from the realities of other residents in the Perry Choice Neighborhood. For this reason, a strategy customized to their circumstances is needed, while simultaneously developing a strategy that focuses on the realities of residents in the PCN proper. This is based on the premise that the activities of residents of the BMHA affect those living in the surrounding neighborhood, while the activities of those living in the surrounding neighborhood affect residents of the BMHA. In addition, this approach aligns with the requirements of HUD through the Choice Neighborhood program. Thus, our planning strategy must embrace the *entire community*, while accounting for the particularities found in the BMHA housing developments.

2.0 The Need

The Perry Choice Neighborhood is a mixed-income, racially diverse community that is characterized by a large number of people living on the economic margin. It has a jobless rate of 57%, a median household income of \$21,000, and about 40% of the residents living below the poverty line. Although the neighborhood has the highest proportion of public housing, assisted housing and Section 8 housing units in the city, affordability is still a big issue. For example, about 40% of PCN residents pay 50% or more of their income on housing, which poses a huge barrier to economic security and financial self-sufficiency.

Residents living so close to the economic edge are bound to run into problems. This is where the neighborhood-based supportive service system comes into play. Every underdeveloped neighborhood with high levels of socioeconomic distress should possess a strong network of supportive services. The reason is that such institutions ought to be more easily accessed by residents and should also have much greater insight into the problems residents living in those locales are most likely to face. Yet, the mere existence of supportive service institutions in a neighborhood does not automatically mean that they will obtain the desired outcomes; and this is what has happened in the PCN. Although a number of supportive services are located in this neighborhood, the data from surveys, interviews and focus groups demonstrate that their presence alone is not producing the desirable outcomes for neighborhood residents.

There appear to be four (4) major reasons why this is the case. The first is that PCN supportive service institutions operate in silos. Some collaborations and partnerships exist, but not among the institutions as a whole, which keeps them from optimizing their impact on service delivery in the neighborhood. The second and third factors are interrelated and interactive. PCN Supportive service institutions did not have strong neighborhood outreach programs. The result is that many residents do not know about the services they offer.

This “lack of knowledge” causes them to underutilize these neighborhood-based services. Indeed, it appears that residents tend to get most of their information about services from the community “grapevine.” A fourth barrier to accessing quality supportive services is that residents are increasingly withdrawing from participation in formal society. Because of negative views about institutions, these residents embed their lives in the “informal sector,” where they mostly interact with friends, family and acquaintances. So, what they know about the quality and accessibility of neighborhood support services comes from these informal encounters.

Moreover, these residents do not come out to meetings, rarely participate in formal events, and reach out for assistance only when they are in a crisis situation. Lastly, there is no case management system operative in the neighborhood, not even within the BMHA.¹ The goal of a case management system, operating within the context of support service coordination, is to make sure that residents are referred to the services they need or want and that the issues concerning them are resolved. Within this framework, case management is responsible for tracking clients, monitoring their movement through the system, and staying with them until issues are satisfactorily resolved. The case manager also functions as an advocate and protector of the client's rights. The service coordination and case management system, then, should be at the core of any strong supportive service system. The absence of such a system is yet another obstacle to individual and family's ability to achieve financial self-sufficiency and social stability.

¹ Case management refers to an individual or family-centered approach to assisting people of all ages with obtaining the services they need or want. It includes screening/assessment/risk management, individualized service planning based on resident needs and choices, provision of options and information, linkage/referral to formal and informal services and supports, service coordination of the client-level, crisis intervention, follow-up, advocacy, monitoring/evaluation of resident progress as well as timeliness and effectiveness of service delivery, and maintenance of records.

3.0 Performance Indicators and Metrics

There are a number of key indicators of performance that will be used to assess the effectiveness of the Supportive Service strategy at meeting the needs of the community. These indicators have been developed in conjunction of the People-based outcomes identified by HUD, and from what residents and service providers in the Perry Choice Neighborhood have identified as critical outcomes that the system should strive to achieve.

3.1 Supportive Service Provider Performance Indicators and Metrics

1. All supportive service providers in the (PCN) and Old First Ward (OFW) will partner to form a Collaborative designed to enhance the delivery of supportive services in the PCN.
 - a. 90% of all supportive service providers within the PCN will be members of the Collaborative
 - b. 90% attendance rate at all monthly meetings during Years 1 through 5
 - i. Number of resident meetings held as part of Transformation Plan / Choice Neighborhoods grant
 - ii. Number/percent of residents that have participated in a Choice Neighborhoods-related meeting
 - iii. Number of residents that participate in 50 percent or more of all Choice Neighborhoods -related meetings
 - iv. Number of residents occupying leadership positions on councils or committees formed as part of the Choice Neighborhood effort
 - c. 95% participation in all voting proceedings
2. A proactive support service system approach exists that emphasizes prevention and early intervention in health, human and social issues.
 - a. A supportive services system-wide plan will be in effect by the end of Year 1 that focuses on preventing crisis situations and actively engages residents in the service provision process
 - i. Number and percent of residents who have health insurance
 - ii. Number and percent of children who have health insurance
 - iii. Number of residents covered by Medicaid or Medicare
 - iv. % of families with dental insurance
 - v. # of families with a primary language other than English
 - b. An aggressive outreach strategy will be implemented by the end of year 1 that includes a Collaborative Website, information brochure and branding
3. A neighborhood service coordination system will connect residents to the appropriate supportive health, educational, human and social services when needed.
 - a. The Case Management Support Unit will have served 100 or more families by the end of year 1
 - b. # of children in out of home placements
4. The Collaborative will employ local, state, and/or federal best practices in developing its supportive service delivery model.
5. Case workers will follow-up to ensure that individuals and families received the services they need.

- a. A Case Management Unit is established in Commodore Perry
 - b. A Licensed Social Worker is hired to supervise case management activities
 - c. The number of University at Buffalo School Social Work graduate students interning as case workers.
6. A shared data management and tracking system will be developed for the Collaborative to ensure that residents are receiving the appropriate supportive services.

3.2 Neighborhood Resident Performance Indicators

7. Residents of the PCN have knowledge and information about the supportive services available in the PCN and across the region, and are able to access them.
- a. 100% of public housing units in the PCN will have received a door-to-door visit by community health workers by the end of Year 1
 - b. 100% of public housing units in Commodore Perry Homes and Extension will have received a door-to-door visit by the Case Management Support Unit by the end of Year 1.
 - i. Number of original assisted residents in Case Management
 - ii. Number of original assisted residents not in Case Management
 - iii. Number of new assisted residents in Case Management
 - iv. Number of new assisted residents not in Case Management
8. All residents will be able to obtain healthy and affordable food in the PCN.
- a. # children living in food deserts
9. Affordable day care options will be available to all working families of the PCN that will enable single-parent households to obtain the appropriate supportive health, educational, human and social services when needed.
- a. Number and percent of children, from birth to kindergarten entry, participating in center-based or formal home-based early learning settings or programs
10. 90% of working-age residents of the PCN have at least a high school diploma (or GED) and/or employable skills that allow them to obtain a full-time job that pays a living wage or to start a business in the Western New York (WNY) region.
- a. High School graduation/completion rate
 - b. Number/percent that are employed
 - c. Number/percent that are unemployed
 - d. Number enrolled in job training or other workforce development programs
 - e. Number completed job training or other workforce development programs
11. The number of households in the PCN below the poverty level will be reduced by 5%, which will enable individuals and families to afford the cost of housing, utilities, and all basic necessities required to maintain a self-sufficient, healthy lifestyle.
- a. Number of households at or below the poverty line
 - b. Average household income
 - c. Median household income
 - d. Number of households receiving TANF
 - e. Number of households enrolled in food stamps or WIC
 - f. Number enrolled in SSI

- g. Number of families experiencing homelessness
12. 10% of qualified families within the BMHA developments of the PCN will enroll in the Family Self-Sufficiency Program.
13. Residents in the PCN are financially literate.
- a. Number/percent enrolled in IDA or other savings program
 - b. Number/percent that have a bank account
14. 80% of residents in the PCN at all stages of the life cycle have a medical home (family physician) and have regular medical examinations.
- a. Number and percent of residents who have a place where they regularly go other than an emergency room when they are sick or need advice about their health
 - b. Number and percent of children, from birth to kindergarten entry, who have a place where they usually go, other than an emergency room, when they are sick or in need of advice about their health
15. Chronic disease rates for conditions such as heart attack, asthma, obesity, and diabetes are significantly lower throughout the PCN.
- a. Number and percent of residents, including children, with asthma
 - b. Number and percent of residents, including children, with Type II diabetes
 - c. Number and percent of children with lead poisoning
 - d. Number and percent of low birth weight babies born
 - e. Number and percentage of residents reporting stress or psychological distress
 - f. Number and percent of adults unable to work due to health restrictions
 - g. Number and percent of residents, including children with hypertension
 - h. Number and percent of residents, including children with high cholesterol
16. Residents of the PCN regularly engage in healthy lifestyle activities that promote good nutrition, exercise, physical health, emotional and psychological well-being.
- a. Number and percent of residents, including children, reporting good physical health

4.0 The BMHA-PCN Supportive Service Network

The shared vision of the Buffalo Municipal Housing Authority (BMHA) and the UB School of Social Work and supportive service agencies in the Perry Choice Neighborhood is to create a *place-conscious* supportive social system that will enable residents achieve financial self-sufficiency, improve their living standard and enhance the quality of their lives. *Place-consciousness* refers to the development of a neighborhood-based supportive service system that intentionally seeks to move individuals and families towards financial self-sufficiency and social stability. To achieve this outcome, the supportive service planning team designed a strategy with four interactive components: *the PCN Collaborative, BMHA-UB PCN Case Management Support Unit, Lanigan Life Chances Center, and the Healthy Living Initiative*. The vision is to meld these various components into a single whole, which operates under the leadership of the PCN supportive service management team.

4.1 PCN Collaborative

The PCN Collaborative will be composed of supportive services organizations in the Perry Choice Neighborhood, the BMHA, and other supportive service organizations in Buffalo and Erie County. To move individuals and families toward financial self-sufficiency, social stability and healthy living, the PCN-Collaborative will develop a strategy based on seven (7) primary activities.

4.1.1 Share knowledge and information among PCN Collaborative (PNC-C) Members –
The PCN-C will develop a four (4) point strategy to share knowledge, information and data with PCN-C members.

4.1.1.1 A PCN-C listserv will be established to facilitate ongoing communications among collaborative members.

4.1.1.2 An annual neighborhood conference will be held to share experiences, best practices and strategies for bolstering the delivery of services inside the neighborhood.

4.1.1.3 A quarterly e-newsletter will be established to keep service providers informed about what is happening in the neighborhood and to share with others with information about their institutions and the supportive services activities taking place in Buffalo and Erie County.

4.1.1.4 The PCN-C will establish a data warehouse to provide members with updates on demographics of the PCN and the City of Buffalo, as well with data on various health, environmental and neighborhood

indices, including crime. A data needs assessment will be completed to gain insight into the specific type of data that PCN service providers need and want. The needs assessment will also gather information on the best approaches to use in sharing the information.

- 4.1.2 **Optimize opportunities for joint fund raising** – Knowing the types of programs and activities offered by PCN-C will create opportunities for collaborations on grant proposals and other fund raising opportunities. Along these lines, the PCN-C will seek opportunities for collaborations and will also develop a set of outcome and metrics that will make it possible to determine the impact of our collective efforts on the realization of positive outcomes for PCN residents.
- 4.1.3 **Establish a Case Management Support Unit** – the BMHA and the University at Buffalo School of Social Work will establish the BMHA-UB Case Management Coordination Unit, which will operate under the auspices of the BMHA Resident Services Office. This unit will be run by the UB School of Social Work, and it will employ a licensed social worker who will supervise SSW graduate student interns who will function as case managers. During years 1-3, the unit will implement a case management program in the three (3) BMHA developments located in the PCN. In years 4-5 that program will be implemented throughout the PCN.
- 4.1.4 **Establish a PCN-C community outreach strategy** -- The Collaborative will work closely with the partners to develop a system-wide outreach strategy to inform Perry Choice Neighborhood residents about all of the supportive services available to them. This process will also involve “branding” the Collaborative, so that residents receiving services from any participating agency will recognize that they are members of the collaborative. This strategy will help to develop trust between PCN residents and members/components of the Network.
- 4.1.5 **Developing a System-wide development strategy** -- A key function of the collaborative will be to develop strategies for forging opportunities for joint projects.
- 4.1.6 **Creating Links to the Case Management Support Unit** – In year 4 of the Perry Choice Neighborhood, the BMHA-UB School of Social Work Case Management Support Unit will interface with the PCN Collaborative. A multi-stakeholder database will be established so that providers can track cases and share information about the clients they serve in order to more effectively manage service provision.
- 4.1.7 **Meeting regularly to plan and coordinate activities and strategies** – Leaders of agencies in the PCN-C will hold bi-monthly meeting to plan and coordinate activities, events, initiatives and to ensure that Collaborative-wide efforts are proceeding effectively.

4.2 BMHA-UB SSW PCN Case Management Support Unit (PCN-CMSU)

The purpose of the BMHA-UB Case Management Support Unit is to construct a university-based case management model of service delivery and to design a system that *complements* and *strengthens* the existing BMHA service delivery program and that constructs a case

management system that can be applied to other BMHA housing developments. The PCN Case Management Support Unit is the heart of the BMHA-PCN Supportive Service Network strategy, and the “hub” around which the entire PCN support system will operate. The PCN-CMSU will be housed in the Resident Services Division of the BMHA and it will be supervised by the University at Buffalo School of Social Work. The PCN-CMSU will utilize a “trauma informed human rights perspective” to deliver holistic support and case management services for residents in the PCN. A trauma informed system of client care takes into consideration the potential role that violence and victimization play in the lives and development of individuals and anchors treatment around mental health and other human services. The approach is based on an understanding of traumatic experiences that are typically part of living in distressed neighborhoods, as well as a conceptualization of residents as psycho-social, biological beings. Within this context, the PCN-CMSU will deliver holistic support and case management services to residents in collaboration with human services providers that are located inside and outside of the PCN.

The PCN-CMSU will deliver a neighborhood-based case management system based on referral, counseling and tracking. The unit will assess the problem(s) that individuals face and help them navigate the supportive service infrastructure inside and outside the PCN. Also, the PCN-CMSU will play a leading role in the developing the PCN supportive service system by engaging in the following activities:

- 4.2.1 The PCN-CMSU will be responsible for improving the coordination of partners within the collaboration** and for identifying gaps in the service delivery system.
- 4.2.2 Work with service providers located inside and outside the PCN to build on the strengths of existing providers**, thereby improving the entire service delivery system.
- 4.2.3 Develop an information strategy to connect the PCN-CMSU activities to residents of the BMHA PCN housing developments and across the PCN.**
- 4.2.4 The PCN-CMSU will be a “hub” that provide supportive services for PCN programs and activities.** To achieve this goal, the PCN-CMSU will interface with select groups.
- 4.2.5 Responsibilities of the PCN-CMSU and Interfacing with BMHA Housing Aides.** In conjunction with the UB School of Social Work, the following section outlines the responsibilities of the PCN-CMSU and how it will work with BMHA Housing Aides to deliver services to residents of the PCN:

Responsibilities

- The case management support unit will not provide direct clinical services to residents, but will provide educational and other support workshops to the community.

- Coordinate the referral of residents to multiple services agencies across the PCN and the metropolis.
- Identify critical gaps and duplications in the service delivery system and identify the unique needs of the residents.
- Provide follow up and monitoring of individual cases to ensure that needed services are being received and progress is being made to solve their problems.
- The licensed social worker will coordinate the activities of the unit and supervise the UB student interns/case workers. The licensed social worker will work with the UB student interns/case workers to ensure that each resident gets referred to the most appropriate service providers and that their particular issues are resolved.
- Assist residents with navigating the supportive service network by advocating on behalf of the service plan for needed client resources and services.
- Develop detailed database and plans for each resident and share this information with other members of the BMHA team as appropriate.

Interface with BMHA

- The PCN-CMSU will structure an interactive connection with the housing aide in Commodore Perry, A.D. Price, and Frederick Douglass, with the intent of developing an aggressive, proactive approach to case management and service coordination.
- The PCN-CMSU will work with the housing aides to establish a sophisticated case management system to ensure resident needs are met holistically.
- The PCN-CMSU program initially will be implemented over a three-year time span. In year one, the program will be implemented in Commodore Perry, where it will be refined and developed. In year two, it will be expanded to one of the other two BMHA developments in the PCN, A.D. Price or Frederick Douglass. In year three, it will expand to the third BMHA development.

4.2.5 The PCN-CMSU Management Structure -- A licensed social worker (LSW) will lead the PCN-CMSU and will oversee the activities of the case managers. The service plans for clients will be constructed on a case-by-case basis and tailored to the specific needs of each person entering the system. The LSW will also monitor the progress of each case that is opened and regularly meet with case managers to discuss any issues or difficulties that may occur with an individual in the system. In addition, the LSW will be the point person to the PCN Collaborative and will be the primary point of contact with all service providers located inside and outside of the PCN. Graduate interns from the UB School of Social Work will provide case management services for the PCN-CMSU. The case management team will consist of anywhere from 5-8 students throughout the calendar year, depending on need. The interns will be the direct point of contact for PCN residents and supportive agencies they need. The Case Managers will handle all screening, assessment, risk management, crisis intervention, referral, tracking/follow-up, advocacy, and ongoing monitoring of a resident's progress at solving the problem(s) they are

facing. In addition, this unit will also participate in other activities that are deemed appropriate by the UB School of Social Work.

4.2.6 Operations of the Case Management Support Unit -- The workflow of residents entering the Case Management Support Unit is described in Figure 1 below. All residents who are in need of the assistance and case management services provided by the Unit will enter through the Licensed Social Worker, who will in turn assign a case manager to the resident, or household, in need of assistance.

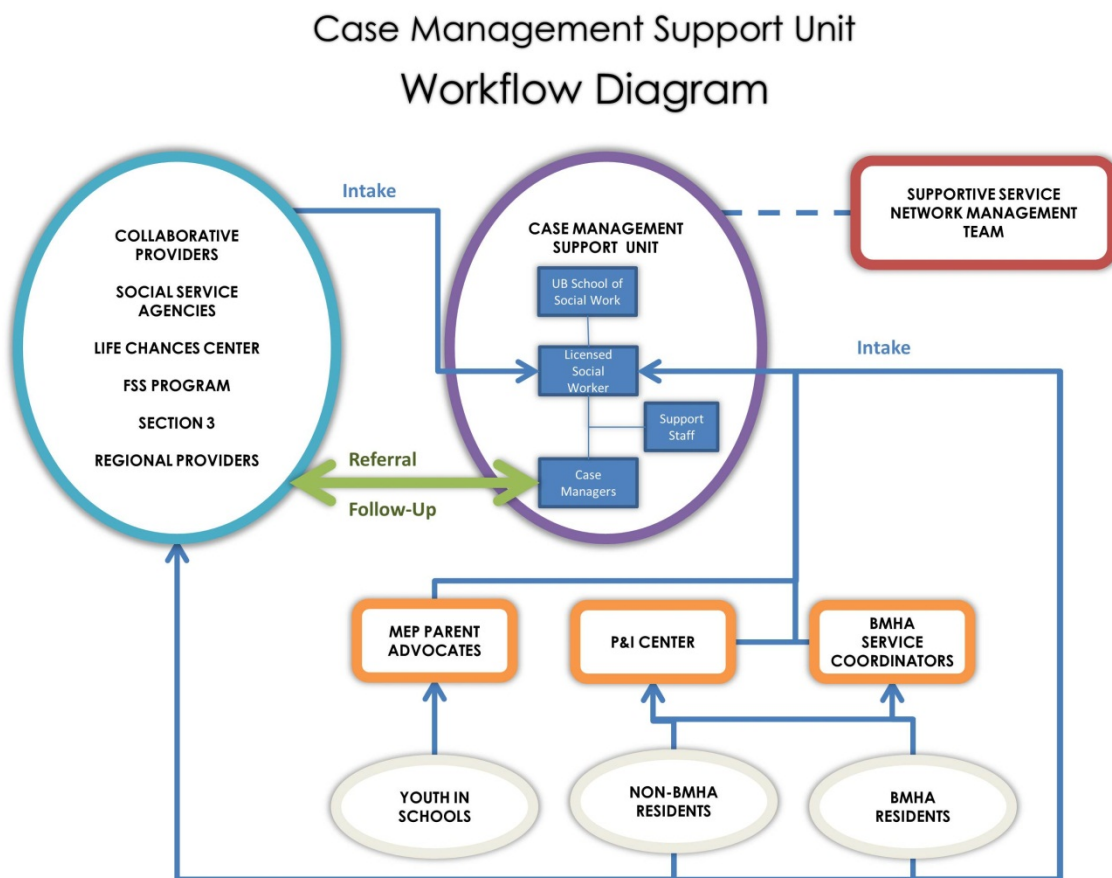


Figure 1. Case Management Support Unit Workflow Diagram

4.3 Lanigan Life Chances Center

The Lanigan Life Chances Center (LLCC) is a neighborhood-based multi-service center that will function as a community center and “hub” of neighborhood life. The LLCC is modeled after the Belle Center, which is located on the West Side of Buffalo. This will be an 80,000 square

foot facility that will also function as a regional destination. Not only will the LLCC provide a range of services, but it also functions as a community gathering place and site for entertainment, fitness and recreation. The Perry Choice Neighborhood will be recreated as a mixed-income neighborhood. In these types of residential settlements, there is a tendency of the different social groups to isolate themselves in their own silos, thereby thwarting the development of "community." A function of the LLCC will be to breakdown these silos and build a sense of "community" within the PCN.

The following is a list of programs and activity centers that will operate within the Life Chances Center and are directly managed by programming staff of the LLCC. The LLCC will be managed by the Police Athletic League (PAL) of Buffalo, who have a longstanding tradition of recreational and community center management within the neighborhood and throughout the city as a whole. These programs have been designed to meet identified neighborhood needs that other providers either do not provide, or were identified through the needs assessment.

4.3.1 Computer Lab and Classroom Facility -- The LCC will have a large multi-purpose computer lab that will be used to teach residents different computer-based skills, youth-based after school programs, and to provide residents with general access to the Internet and computer software. The lab will also be used to teach adult education classes. The computer lab will be partitioned into two separate classrooms as needed.

4.3.2 The Senior Center -- The Senior Center will be a multi-purpose social gathering space for seniors in the neighborhood. It will include a multi-purpose space for various games and activities of interest to the seniors in the community as well as a refrigerator and lounge furniture for day-to-day socializing.

4.3.3 The Great Room -- The Great Room will be a large multi-purpose room that can be rented for community events and activities. The purpose of this room will be to provide a large space where larger community functions and meetings can take place, as well as provide rental income to the LCC.

4.3.4 The PCN Case Management Support Unit (UB School of Social Work) -- In partnership with BMHA Residential Services, the UB School of Social Work will manage the PCN-CMSU which will provide residents with comprehensive case management to ensure that residents are successful at acquiring and utilizing all of the supportive services they need. The Unit will also provide thorough follow-up with residents to ensure their success while navigating through all services and programs they access.

4.3.5 The Supportive Service Network Management Team Offices -- The Supportive Service Network Management Team Offices will house the governing bodies of the supportive service collaborative, mini-education pipeline, and the Life Chances Center administration staff. These facilities will also include meeting space and other accommodations for the staff of the LCC.

4.3.6 Early Learning Center (ELC) - Community Action Organization (CAO) -- The ELC will be built based on CAO's expertise and help to prepare children in the neighborhood for entering school. This will include both a Head Start and an Early Head Start program. The ELC will also serve as an "academic" child day care for working families.

4.3.7 Neighborhood-Based After School Program (Computers for Children) -- The neighborhood-based after school program will cater to meeting the supportive and educational needs of school-age children in the PCN. The program will include classroom activities as well as tutoring and mentoring programs.

4.3.8 Buffalo Swim Racers Program (Buffalo Swim Racers) -- The Olympic-sized swimming pool in the Lanigan Recreation and Fitness Center will be used to develop a swimming based academic support program modeled after the USA Swim Team affiliated club being developed at City Honors High School. The Buffalo Swim Racers are targeted for the PCN and will be the neighborhood's swim-academic support program. The program will operate out of a partner's site in the PCN until the new Life Chances Center is built.

4.3.9 The Planning & Information Center -- The Planning & Information Center will consist of six (6) Buffalo AmeriCorps members, through a partnership with the Belle Center, who will be responsible for community organizing, community outreach, youth development, and the delivery of programs that are designed to increase the skill base and the capacity of PCN residents of all ages. The Planning & Information Center currently is located at the corner of Louisiana Street and South Park Avenue is the Commodore Perry Homes and Extension, but its operations will move into the LCC once it is built.

4.3.10 Fulton Street Food Pantry (Catholic Charities) -- For decades, Catholic Charities has operated a highly utilized food pantry service in the neighborhood in its office on Fulton Street in Commodore Perry Homes and Extension. According to Catholic Charities, about 90% of those currently served by the food pantry are from Commodore Perry Homes and Extension. This service is needed by residents and will continue to operate in its current space until it is re-located to the Life Chances Center.

4.3.11 Recreation and Fitness Center (City of Buffalo) -- The Lanigan Field House and Fitness Center will be a comprehensive recreation and fitness facility located within the Life Chances Center that will meet the needs of both youth and adult residents of Perry Choice Neighborhood. It will include a full-size gymnasium, a weight and fitness room, a multi-purpose room, a parlor/game room, and an Olympic-sized swimming pool facility.

4.4 The Healthy Living Initiative

The Health Challenge

The health status of a neighborhood is its single most important quality of life indicator. If people are unhealthy, depressed and have bodies ravaged with disease, they will not be able meet the challenges which they will face in everyday life. To obtain neighborhood level health data, the BHMA, in partnership with the New York State Health Department and the Statewide Planning and Research Cooperative System, compiled data on seven indicators to gain insight into the health status of residents of the Perry Choice Neighborhoods: birth weight, Myocardial Infarction (heart attack), asthma, diabetes, obesity, air quality and health insurance. This information was drawn from zip codes 14204, 14206, 14210, and 14212. These zip code boundaries are broader than the PCN, but because of the similarity of socioeconomic condition found in these adjacent neighborhoods, the data nevertheless provides reliable information on the health status of the Perry Choice community. In this section, we refer to this larger area, from when the data was drawn, as the greater PCN.

The findings suggest that many health issues confronting residents in the greater PCN are related to environmental issues, socioeconomic conditions, lifestyle, nutrition, and lack of access to preventive health care. For example, one big health concern is the low birth weight of babies in the greater PCN. Babies who are born weighing less than 2,500 grams (5.5 lbs.) are considered low-birth weight babies, and they are at-risk for having greater developmental and growth problems, as well as cardiovascular disease, Type 11 Diabetes, and sensory-neural impairments, and visual, auditory and intellectual impairment.

The issue of low-birth babies is a serious problem in the PCN. The percent of low-birth babies per 1000 live births is 49% greater in the PCN than in Erie County and 60.5% greater than New York State (Table 1). The large number of low-weight babies in the PCN means that children in this community should be carefully monitored and receive regular check-ups, so that any health issues can be identified and diagnosed before they become more serious.

Asthma is also a major problem in the greater PCN. The percent of asthma emergency room visits among children per 10,000 hospitalizations is 44% greater in the PCN than in Erie County and 64% greater than in New York State. This high rate of asthma may be related to environmental conditions found in greater PCN. For instance, the percentage of commercial properties per acreage (22.6%) is significantly higher in the greater PCN than in Buffalo [15.3%] (Table 1). The heavy concentration of industry, along with the location of the I-190 New York State Thruway adjacent to the community, continues to provide a high volume of trucks and automobiles traffic in the greater PCN.

Particularly disturbing are the high rates of Myocardial Infarctions (heart attacks), diabetes and obesity found in the greater PCN. There is a 129% difference in the number of myocardial infarctions (heart attacks) per 10,000 between the PCN and Erie County (Table One). This figure is particularly troublesome because the occurrence of heart attacks can be reduced through medication, diet and exercise. On this point, about 55% of the residents in the greater PCN are either overweight or obese (Table 1). In addition, the rates of diabetes in the PCN are also high. More specifically, the rates of diabetes-related hospitalizations are higher in the PCN than in Erie County (Table 1).

This brings us to the issue of health insurance. The good news is that most residents (99%) have some form of health insurance. The bad news is that the percentage of residents with publicly funded health care is about 75% greater in the PCN than in the Erie County. On the flip side, the percent of residents in Erie County holding private insurance is about 48% greater than in the PCN (Table 1). At the same time, the percent of residents with self—paid insurance is slightly higher in the PCN than in Erie County. So, while most residents have some form of insurance, the type of coverage they have differs greatly. The availability of health insurance does not mean that residents have access to regular medical care. Economic issues still matter. The ability to afford the co-pays that accompany visits to physicians and clinics might be an intervening factor. For example, most residents said they had some form of health insurance

and a regular source of medical care, but the surveys showed that they still used the emergency room as their primary source of regular medical care and information about health issues.

This finding is significant for two (2) interrelated reasons. First, it suggests that many residents do not have a medical home and/or co-pays keep them from visiting their doctors on a regular basis. Second, although there is no shortage of health care facilities in the PCN, most residents do not regularly use the facilities found there. In fact, a family care clinic located in the Commodore Perry Homes and Extension had to close because of underutilization.

The Needs Survey suggests that a low health literacy rate might be a contributing factor. The survey suggests that residents of the Commodore Perry Housing Development have some difficulty understanding the health information they received from various sources. Specifically, residents indicate having trouble understanding a doctor or nurses' oral instructions, understanding and filling out forms, and following instructions on labels of medicine. Also, most residents (85%) indicate they did not know how to access all of the health care services they and other members of their household needed, and they seem not to know about many health services found in their community. Also, while the residents appear to understand nutritional issues, they say cost, not nutritional value, is the prime determinant of the food stuffs they purchase.

Table 1. Health Indicators for the Greater PCN

| Indicator | | Zip Codes 14204, 14206, 14210, 14212 (Perry Choice Neighborhood) | Erie County | State - NYC |
|---|-------------------|--|-------------|-------------|
| Low birth weight (per 1,000 live births) | | 105.8 | 64.1 | 56.6 |
| Asthma ER visits among children (per 10,000 hospitalizations) | | 145.6 | 93.4 | 75.4 |
| Myocardial Infarction hospitalization (per 10,000 hospitalizations) | | 181.3 | 38.9 | 37.4 |
| % of adults with health benefits (using birth record data) | Public Insurance | 48.2% | 27.5% | 32.6% |
| | Private Insurance | 47.1% | 69.6% | 62.0% |
| | Self-paid | 3.75% | 2.0% | 2.3% |
| | Other/Unknown | 0.9% | 0.9% | 3.2% |
| | | | | |
| Using SPARCS: | | | | |

| | | | | |
|--|-------------|---------|-------------|-------|
| Diabetes (inpatient, any dx) per 10,000 hospitalizations | | 2,064.0 | 1803.8 | |
| Diabetes (outpatient, any dx) per 10,000 hospitalizations | | 682.1 | 584.1 | |
| Diabetes (inpatient, primary dx) per 10,000 hospitalizations | | 225.3 | 141.7 | |
| Diabetes (outpatient, primary dx) per 10,000 hospitalizations | | 47.6 | 37.7 | |
| Using birth record data: | | | | |
| Obesity | Underweight | 4.9% | Underweight | 3.6% |
| | Normal | 40.4% | Normal | 48.3% |
| | Overweight | 23.5% | Overweight | 24.7% |
| | Obese | 31.2% | Obese | 23.4% |
| Diabetes pre-pregnancy (per 10,000 pregnant woman) | | 62.9 | 72.7 | |
| Gestational Diabetes (per 10,000 pregnant women) | | 426.8 | 472.1 | |

*The data used is from the Statewide Planning and Research Cooperative System (SPARCS) 2007-2009, and Live Birth data from 2004-2008

*The data used is from the Statewide Planning and Research Cooperative System (SPARCS) 2004-2009, and live birth data from 2004-2008

Physical Environment

A neighborhood's physical attributes, including buildings, parks, streets, sidewalks, and businesses, have a direct impact on how residents behave in their environment and interact with each other. Based on the PCN Needs Assessment, many facilities serving residents are located within a one-mile radius; however residents find difficulty accessing them. Most residents

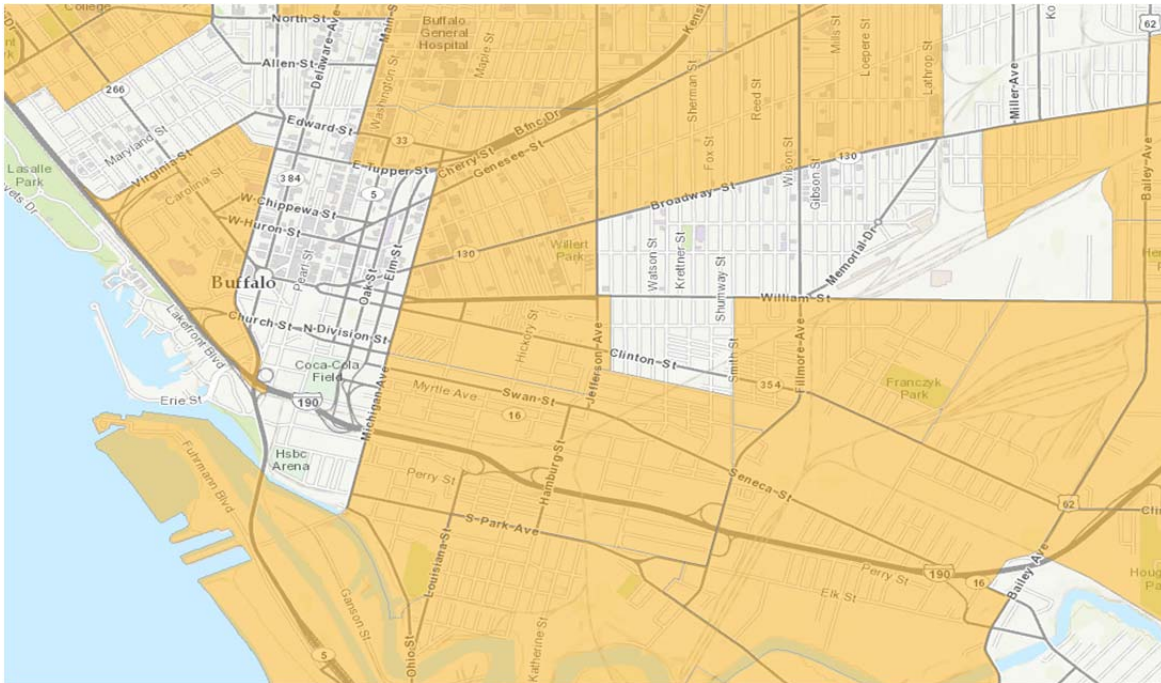
expressed dissatisfaction with the level of access to supportive services, as well as a general dependency on a limited public transportation system to meet their daily needs.

The Neighborhood component of the PCN Transformation Plan references a vision of creating a vibrant, walkable and sustainable neighborhood with complete streets, access to high quality services, entertainment, recreation, and a transportation hub that connects residents to the region. Although the neighborhood has many assets, there are many aspects of the physical environment that can contribute to poor health. A lack of local access to fresh healthy foods, and a neighborhood character that discourages residents from walking are two characteristics that are not currently serving to improve the health and quality of life for PCN residents.

Food Access

Most PCN residents need to travel considerable distances to shop for groceries. In fact, there is no traditional grocery store located in the PCN. Tops Markets, a local grocery chain, has a stores located at 1275 Jefferson Avenue (3.1 miles north of Commodore Perry) and at 1460 South Park Avenue (2.1 miles east of Commodore Perry). However, with transportation options limited due to access issues and income levels, both stores can be considered inaccessible for Perry residents. Therefore, most Perry residents are forced to shop at Basha's Market/Gas Station and the Dollar Store, both located adjacent to Commodore Perry, but where fresh food and produce is scarcely available. According to the USDA Economic Research Service, consumer choices about food spending and diet are likely to be influenced by the accessibility and affordability of food retailers--travel time to shopping, availability of healthy foods, and food prices. Some people and places, especially those with low-incomes, may face greater barriers in accessing healthy and affordable food retailers, which may negatively affect diet and food security.

Food access can also be measured by the people and places facing barriers to accessing healthy and affordable food, resulting in consequences of food access limitations on food spending, diet, and health. According to the USDA food access research atlas, the census tracts within the PCN area have low access and low income, in addition to a significant number of housing units that are far from supermarkets and do not have vehicles.



■ = Low income census tracts where a significant number or share of residents is more than ½ mile from the nearest supermarket

Multi-level impacts

In addition to the socio-economic impacts to the health of residents within the Buffalo Perry Choice Neighborhood, it is necessary to consider the relationship that exists between each individual and their environment. While individuals are responsible for instituting and maintaining his or her lifestyle changes to reduce personal risk and improve health, individual behavior is determined to a large extent by social environment, e.g. community norms and values, regulations, and policies. Barriers to healthy behaviors are shared among the community as a whole. As these barriers are lowered or removed, behavior change becomes more achievable and sustainable. The most effective approach leading to healthy behaviors is a combination of the efforts at all levels--individual, interpersonal, organizational, community, and public policy.

- At the **individual level**, personal history and biological factors influence how individuals within this neighborhood behave and increase their likelihood for good or poor health.
- Interpersonal **relationships** with family, friends, intimate partners and peers may influence health behavior.
- **Organizations** often provide intervention strategies that can encourage, support, or undermine health behavior or conditions. Several organizations are working to improve the health and quality of life in the Buffalo Perry Choice Neighborhood, but greater collaboration can lead to greater positive health outcomes for residents.

- **Community** contexts in which social relationships occur (schools, neighborhoods, workplaces) and environmental conditions encourage or discourage healthy living.
- **Societal** factors include economic and social policies that create access to, funding for, and health and conditions for health.

According to the National Prevention, Health Promotion and Public Health Council, preventing disease requires more than providing people with information to make healthy choices. While knowledge is critical, communities must reinforce and support health by making healthy choices easy and affordable. A healthy community environment is one where the air and water are clean and safe; where housing is safe and affordable; where transportation and community infrastructure provide people with the opportunity to be active and safe; where schools serve children healthy food and provide quality physical education; and where businesses provide healthy and safe working conditions and access to comprehensive wellness programs. When all sectors promote prevention-oriented environments and policies, they all contribute to health.

Within the context of the People Plan component of the Buffalo Perry Choice Neighborhood, the health initiatives identified or proposed will aim to address these impacts to health on all levels. Some programs are geared toward the individual, while other strategies focus on community context and attitudes toward personal health that are developed through relationships. These efforts will work toward improving the quality of life and health of this neighborhood, with an understanding that many plans and programs are also underway locally with the support of organizations and government institutions at a variety of scales.

Connections to Other Plans, Initiatives, and Transformation Plan Components

The Healthy Living Initiative of the PCN Transformation Plan was developed to be consistent with, and in support of, many other current health programs and assessments in the Western New York region including the City of Buffalo Wellness Program, The Erie County Department of Health Community Health Assessment, and the New York State Department of Health Prevention Agenda.

The City of Buffalo Wellness Program initiated the “Creating Healthy Communities” strategy and the “Wellness Institute of Greater Buffalo” to help create healthy communities in Buffalo through collaboration and the creation of social capital, environmental capital, economic capital, and human capital. The City of Buffalo Wellness program offers personal health resources, community health resources, workforce health promotion resources and information on wellness events. Much like the City of Buffalo Wellness Program, the Healthy

Neighborhood Initiative is centralized on a comprehensive approach to healthy communities that involves the collaboration of public and private sectors and the provision of resources to residents and communities to create and sustain health.

The PCN Healthy Living Initiative will connect to this effort through several ways:

- The P2 Niagara Falls Task Force will be recreated in PCN as the P2 PCN Task Force. The PCN collaborative will look to include Wellness Institute as a partner in this effort.
- The WNY-Mobile Safety Net Team will hold regular Resource Events at various PCN locations on a quarterly basis. The Wellness Institute of Greater Buffalo will be included at these events and be invited to participate at each resource event.
- The Wellness Institute will be invited to be a member and join the PCN Supportive Service Collaborative.

The Erie County Department of Health 2010-2013 Community Health Assessment evaluates the health status of Erie County residents and identifies current health problems in the community. Similar to the major health problems in the PCN, the major health problems for Erie County as a whole include lack of prenatal care, poor nutrition, asthma, diabetes, heart diseases, lack of access to care and utilization of primary care, and lack of health insurance. The Community Health Assessment also identifies currently available resources and the need for new resources to address those health problems. Many of the resources offered by the county to address current health issues are utilized in the Healthy Living Initiative to address health concerns in the PCN.

The PCN Healthy Living Initiative will connect to this effort by:

- Working with Erie County to get data specifically on the PCN, or at the PCN zip code level, to monitor and track health outcomes of residents of the PCN. This will be done in conjunction with the NYS Department of Health to have a continuous database of health indicators for the PCN that can be compared with county and state data in order to determine whether or not progress is being made on improving health outcomes.
 - Work with Erie County to connect the PCN Collaborative to new county resources that can be linked to PCN Major Health Issues.
- Invite the Erie County Department of Health to join the PCN Supportive Service Collaborative.
- Use the county information as a basis for inviting participating organizations to the WNY-MSNT resource events.

The New York State Department of Health (NYS-DOH) established the 2013-2017 Prevention Agenda as a call to action for local health departments, health care providers, and other stakeholders to collaborate at the community level to improve the health status of New Yorkers through an increased emphasis on prevention and addressing health disparities. A similar

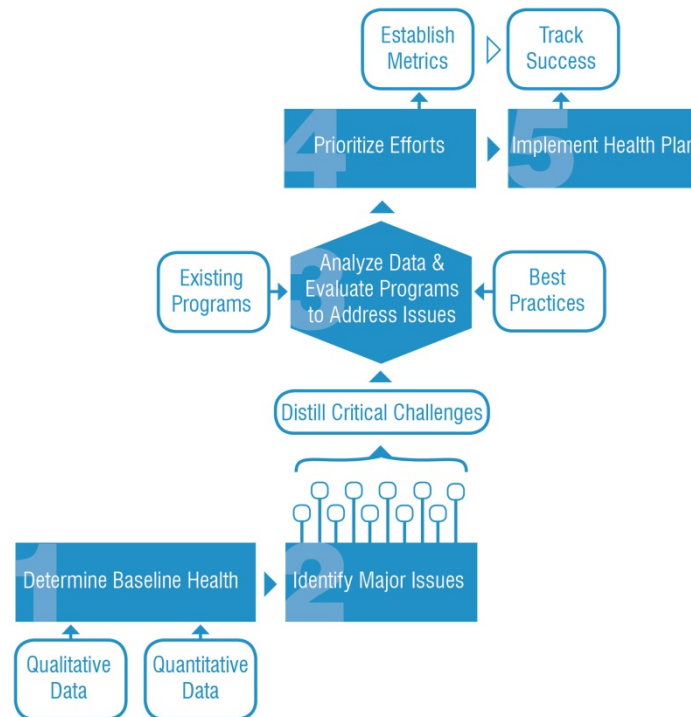
collaborative approach is utilized at the community level to improve the health of PCN residents through the Healthy Living Initiative. Many of the priorities of the Prevention Agenda overlap with priorities of the Healthy Living Initiative, including preventing chronic diseases (i.e., diabetes, obesity, asthma), promoting healthy and safe environments (i.e., improving air quality and safe housing), and promoting healthy women, infants and children (i.e., improving prenatal care to reduce babies born with low birth weight). Much like the Healthy Living Initiative in the PCN, the key to success in improving the health of communities with the Prevention Agenda is active engagement of local communities.

The PCN Healthy Living Initiative will connect to this effort by:

- Incorporating the five (5) NYS priorities into PCN Healthy Living Initiative.
- Use the PCN proposal to the NYS Department of Health - Community, Opportunity and Reinvestment Initiative (November 2012) as a connection to incorporate NYS programs on the PCN neighborhood level that address Prevention Agenda issues.
 - Connect PCN initiatives to funding opportunities through this program and grant write to bring in funding to add to existing programs at PCN providers, or establish new programs that aim to address these NYS priorities. .
 - Connect the programs of the P2 PCN Task Force to NYS-DOH Prevention Agenda.
- Ensure that the Prevention Agenda is connected to the PCN Safe Neighborhood Initiative and the Youth Development strategy.
- Mid-Erie Counseling is located in the PCN and is a member of the PCN collaborative. Mid-Erie provides holistic, innovative, evidence based mental health and chemical dependency treatment, education and support services to the community. Any mental health issues that PCN residents are struggling with will be referred to them through the PCN Case Management Unit.

The Healthy Living Initiative Strategy

A process based on accurate neighborhood-level data and specific to the PCN was used to develop a strategy to improve health within the community and set up a system to evaluate how effective implementation will be moving forward. As with other Transformation Plan components, the efforts focused on health are based on a community needs assessment that provides qualitative and quantitative data to both determine major issues, and establish a baseline from which to evaluate change in the future. The following diagram outlines the health planning process:



Based on data collected from the BMHA, in partnership with the New York State Health Department, and the Statewide Planning and Research Cooperative System, ten (10) major health issues have been identified for the PCN:

1. Low birth weight
2. Hypertension
3. Prostate cancer
4. Breast cancer
5. Asthma/poor air quality
6. Diabetes
7. Lack of a medical “home”/health insurance
8. Low health literacy
9. Myocardial infarction
10. Obesity

To best ensure that individuals in the PCN are able to face the challenges of everyday life, the poor health of the residents of PCN must be addressed.

The strategy for the Healthy Living Initiative involves simplifying the ten (10) major health issues into two (2) critical challenges that must be addressed in order to ensure that the current supportive service infrastructure meets the health and wellness needs of the residents of the PCN. First, the current system lacks some needed supports to ensure residents have fair access to a medical home that is both affordable and convenient to access. The closure of Sheehan

Hospital in the PCN has served to further reduce resident access to comprehensive healthcare. The relationship between health literacy and having a medical home is reciprocal. For individuals who have a regular medical home and make a trusted connection with a primary doctor, they are more likely to have higher health literacy. Conversely, having low health literacy can contribute to a lower utilization of the primary care physicians in the neighborhood because people have less knowledge about how to access all of the health care services available to them. By increasing the connection that people have to services (increasing access and thus decreasing barriers), health literacy may increase. Similarly, by increasing health literacy, the likelihood of having a medical home will also increase because people will have more knowledge about how (and when) to utilize health services. People who have regular access to and utilize a medical home are better able to manage chronic health conditions such as asthma, diabetes, and obesity. Additionally, expecting mothers who have a medical home are more likely to receive proper pre-natal care, thus reducing the likelihood that their child will have a low birth-weight. Therefore, establishing an infrastructure that ensures residents have access to a medical home is a primary objective of the Health Living Initiative.

Second, access to healthy foods in the neighborhood is also lacking. Availability of affordable, healthy foods is essential for the prevention of chronic illness and for insuring the general well-being of residents. Access to affordable and healthy food also increases the likelihood that individuals will eat nutritious foods, decreasing their risk for obesity, diabetes, myocardial infarction, hypertension, and having a child with low birth weight. Additionally, proper nutrition is associated with a lower risk for breast and prostate cancer. Without a supermarket operating in the entire Perry Choice Neighborhood, access to fresh, affordable, healthy foods is a challenge that residents have expressed during the needs assessment process. Therefore, there is a need for a new grocery store to be conveniently located within the PCN that would increase access to affordable and fresh produce throughout the year.

The Supportive Service System will address these needs through a series of new programs in the PCN that are connected to existing programs being delivered by partner institutions and models tailored to meet the neighborhood-based needs of PCN residents. The PCN-C will continuously look to add to this list by partnering with other organizations that operate programs or provide services that fit within the Healthy Living Initiative framework

By first establishing a supportive infrastructure to ensure a medical home for residents and increasing access to healthy foods in the neighborhood, all ten major health issues in the PCN will be addressed. The following programs will be established or expanded within the PCN to

work towards overcoming the two critical health challenges in the PCN and ultimately help the residents in the neighborhood to achieve a healthier and more positive quality of life.

The Program

The following existing and proposed programs are part of the PCN Healthy Living Initiative strategy.

Existing Programs

Massachusetts Avenue Project (MAP) Mobile Market -- Operated by Massachusetts Avenue Project (MAP), a local non-profit with a stellar track record for promoting healthy food access within the City of Buffalo. The Mobile Market is an existing evidence-based, nutrition equality program that uses a mobile food truck as a medium between local urban agriculture operations and low income neighborhoods that have limited access to fresh foods. The Mobile Market program increases access to healthy, affordable, locally-grown organic produce in communities underserved by supermarkets, while simultaneously employing and educating local youth in areas such as sustainable food production, urban agriculture, aquaponics, and healthy eating. MAP currently operates one mobile market site in the PCN at Harvest House on Jefferson Avenue, but will expand their reach in the PCN by serving an additional Mobile Market site in Commodore Perry Homes and Extension on an annual basis throughout the summer and early fall months, adjacent to Lanigan Field House and the Fulton Street Food Pantry. The Mobile Market will be able to serve all three (3) BMHA developments (Commodore Perry, AD Price, and Frederick Douglass) with these two locations.

MAP makes their produce affordable for low-income communities, by accepting Electronic Benefits Transfer (EBT) cards and by providing food at discount prices. The market will make one visit per week to Commodore Perry per week from June through October (or the end of the growing season).

The Mobile Safety-Net Team Supportive Service Resource Events -- The Mobile Safety-Net Team (MSNT) is a regional community outreach organization funded through the charitable John R. Oishei Foundation. The MSNT works with supportive service agencies to help them improve their effectiveness at bolstering the wellbeing the communities they serve. The MSNT has three (3) traveling teams to support and provide information in key areas of need, including:

- Financial & legal assistance, employment, health insurance, social services, crisis services, and food/nutrition

When it engages a local community, the MSNT spends about five (5) weeks creating a needs assessment for that community. In addition, they attempt to mitigate un-met needs by organizing local supportive services to better contribute to the community by organizing “Community Resource Events”. These events are a “one-stop shop” where residents can gather information; meet with case managers; and apply for services including food, housing issues, HEAP and utilities, health insurance, employment, senior services, veteran services, and more. Both local and regional providers attend the resource events.

The MSNT will work with all of the service providers in the PCN and with its regional partners to conduct regular bi-monthly supportive service resource events at multiple locations within the PCN, including the new Lanigan Life Chances Center. At these events, residents will be introduced to all of the services available to them in the neighborhood and will be able to directly apply for the services and assistance they need at these events. The PCN Case Management Support Unit (PCN-CMSU) will also be present at these events.

The Catholic Health/Mercy Health and Wellness Screenings -- Catholic Health’s Mercy Comprehensive Care Center is the only healthcare facility located within Commodore Perry Homes and Extension. Unfortunately, many residents are unaware of the numerous medical services offered by Mercy. This unawareness prevents them from accessing a quality health care facility right in their backyard. To better serve residents of the PCN, Mercy will use Catholic Health’s existing *Mission on the Move* model to provide screenings for heart-related conditions, diabetes, and general physiological wellness at all Mobile Safety-Net Team resource events. *Mission on the Move’s* mobile health van provides thousands of individuals with educational programs and free health care screenings in the following areas:

- Cholesterol, Glucose, Blood Pressure, Bone Density, Body Composition, Carbon Monoxide Testing, Peak Flow

Residents identified to be at risk for health conditions will be directed to Mercy or other appropriate providers for care and to the PCN-CMSU for assistance connecting with medical insurance providers and benefits.

The ECMC Mobile Mammography Unit -- In conjunction with the Mercy Health and Wellness Screenings, Erie County Medical Center will use its Mobile Mammography Unit to provide mammograms and transportation services for clients served at Supportive Service Resource Events, or at separately scheduled stops throughout the PCN. These scheduled

“Mammogram Days” will be held in Commodore Perry at least once per year, and in two (2) additional PCN locations annually as well.

Establishing a presence of the Mobile Mammography Unit in the PCN will help to address the major health issue of breast cancer in the neighborhood by increasing residents’ access to care and providing them with an opportunity to increase their health literacy. Regular mammography is important for any woman over the age of 40 to ensure that proper prevention measures for breast cancer are taken.

ECMC will coordinate this service directly with the PCN Collaborative, Planning and Information Center, and the PCN-CMSU to promote mammograms and the need to have them conducted annually as well as to coordinate outreach to the community so they are aware when the Mobile Mammogram Unit will be in the PCN.

All women in the PCN will be welcome to take advantage of this important service: insured Medicaid and Medicare, and the uninsured. In order to have a mammogram, a doctor’s script is necessary. However, those women without a physician will be able to obtain a script at the mobile unit. Appointments are required and will be coordinated in conjunction with the BMHA and the Planning and Information Center.

Proposed Programs

The Healthy Neighborhood Initiative consists of pre-existing programs throughout the Western New York area that were selected based on their ability to tackle major health issues in the PCN and demonstration of previous success in other regions. These current programs will be expanded from their current domains to service the PCN.

(Proposed new program) The Healthy Neighborhood Program – funded by the New York State Department of Health, this program works to place home inspectors in neighborhoods to offer home assessments and identify in-home asthma triggers, as well as education to help individual’s better control their asthma. According to the Erie County Community Health Assessment 2011-2013, asthma attacks can be triggered by irritants in old or poorly maintained homes such as cockroaches, mold and dust mites. Many of these triggers may be especially prevalent in the old, low-income houses of Commodore Perry. Therefore, the PCN Collaborative will work to connect with this program and expand these services into the PCN.

(Proposed new program) The Buffalo Prenatal-Perinatal Network – a service provided by Erie County, the programs offered by the Buffalo Prenatal-Perinatal network improve access to prenatal care through the provision of prenatal home visits, and other personalized care. By providing increased access to personalized prenatal care, the major health issue of low birth weight in the PCN can be addressed. Therefore, the PCN Collaborative will work with the Buffalo Prenatal-Perinatal Network to connect the resources offered by this program in to the neighborhood.

(Proposed new program) Healthy Heart Program – given the extremely high rates of myocardial infarction in the PCN, it is necessary to include a program related to heart health in the Healthy Living Initiative. The New York State Department of Health funds the Healthy Heart Program which provides funds for worksite wellness programs, community physical activity and nutrition coalitions as well as mini grants to local health units to make it easier for residents to choose healthy lifestyles and lower their risk for heart attack and hypertension. The PCN Collaborative will work with the NYS-DOH to expand the Healthy Heart Program in to the PCN. Additionally, with the application in to the NYS-DOH Community, Opportunity and Reinvestment Initiative, the PCN will be well positioned to connect the funding opportunities provided by the Healthy Heart Program to the PCN.

Successful models that address identified issues

Although the existing program expansions and new programs associated with the Healthy Living Initiative will move the neighborhood toward the goal of addressing the identified health challenges, there are also several successful models that the PCN can learn from moving forward. The following innovative programs have been implemented throughout the United States to address the same major issues facing the PCN.

Prostate Cancer

Prostate cancer is the most common cancer in men. In the United States in 2009, 206,640 men were diagnosed with prostate cancer, and 28,088 men died from it (USCS).

Successful Model: *The Barber Shop Initiative*

Major Issue: Prostate Cancer

The BarberShop Initiative is a program that was developed to address the lack of readily available, understandable and accurate cancer-related information in areas with significant minority populations. The initiative relies on partnerships between barbers and medical centers to directly deliver crucial information about prostate cancer prevention, treatment and supportive care in a sensitive and culturally acceptable manner.

According to the Prostate Net, educational and outreach efforts to Black communities for health screening or clinical trials have not been particularly successful, due to limited community and individual participation. Within minority communities, the barber and his shop have an important position as a place for social interaction and where free and open discourse occurs. Tapping into the barber's leadership to inform and influence his/her clients and neighbors has been an effective way to reduce and/or eliminate cultural barriers encountered when health care messages come from the traditional health care establishment.

Starting in 2004, the program targeted selected medical centers serving certain minority communities, then recruited and trained local barbers from the affected service area to function as lay health educators and patient navigators who motivate their constituencies to get screened and treated for prostate cancer. The medical centers found that this program enabled them to achieve a higher level of community and patient service - and to save lives.

Building on the Prostate Net's "Knowledge Net" program's technology, the BarberShop Initiative placed computer terminals in selected barbershops. These terminals are used exclusively to provide current information about prostate cancer detection and treatment through the Prostate Net site. Data reflecting the number of Knowledge Net users and the type of information accessed is also gathered and used by the initiative to better understand the needs of the populations served.

Asthma and Lung Health

A 2009 Report on the characteristics of successful asthma programs concludes that positive asthma outcomes were associated with specific program characteristics: being community centered, clinically connected, and continuously collaborative. Program developers and implementers who build these characteristics into their interventions will be more likely to realize desired asthma outcomes.

Successful Model: *The Community Asthma Prevention Program (CAPP)*

Major Issue: Asthma and Lung Health

The Children's Hospital of Philadelphia, as part of a cooperative agreement with the U.S. Department of Health and Human Services, Office of Minority Health, administers the Community Asthma Prevention Program (CAPP) in West Philadelphia. The program includes classes for families in familiar environments such as community centers, churches and schools. CAPP staff measure knowledge acquisition and retention among participants, as well as self-management behavior changes. Classes for parents and caregivers are group-facilitated by parent educators who have been trained by CAPP staff to conduct classes. The classes for children are led by teens and college students who are peer educators and who are trained to use the curriculum. A primary component of the CAPP program is the goal of using a "train the trainer" model is to leave neighborhoods and communities with lay asthma experts and in this way, sustain asthma prevention efforts.

Health Literacy

The National Library of Medicine defines health literacy as an individual's capacity "to obtain, process, and understand basic health information and services needed to make appropriate health decisions".

Successful Model: *North Carolina Program on Health Literacy*

Major Issue: Health Literacy

The Sheps Center for Health Services Research at the University of North Carolina – Chapel Hill established the Program on Health Literacy to promote collaboration and dissemination across the UNC-CH campus and beyond. The Program on Health Literacy represents a collaborative effort of the UNC Schools of Medicine, Nursing, Public Health, Dentistry, Pharmacy and Education as well as community organizations and neighboring universities. The group's overarching goal is to further health literacy collaborations among university disciplines to improve health outcomes.

The program offers a Health Literacy Universal Precautions Toolkit for medical care providers to assess their practice and make the changes necessary to connect with patients of all literacy levels. The toolkit was designed to be used by all levels of staff in a practice of providing primary care for adults and/or pediatric patients. Some examples of tools that are available include methods to improve spoken language, written communication, and encouraging patients to ask questions.

Obesity

Obesity continues to increase as a major health problem, with rates of childhood obesity tripling since the 1960's and more than 1/3rd of children now at risk for obesity (defined as having a body mass index between the 85th and 95th percentiles)

Successful Model: Let's Move

Major Issue: Obesity

Let's Move! Is a comprehensive initiative, launched by First Lady Michelle Obama, dedicated to solving the challenge of childhood obesity within a generation, so that children born today will grow up healthier and able to pursue their dreams. Combining comprehensive strategies with common sense, Let's Move! is about putting children on the path to a healthy future during their earliest months and years. The program focuses on giving parents helpful information and fostering environments that support healthy choices by providing healthier foods in our schools, ensuring that every family has access to healthy, affordable food, and helping kids become more physically active.

The Let's Move! Program understands that everyone has a role to play in reducing obesity, including parents, elected officials from all levels of government, schools, health care professionals, faith-based and community-based organizations, and private sector companies. The program's website offers step by step processes for a range of users to initiate a Let's Move effort locally. Elected officials can start by becoming a Let's Move! City or town, Schools can create a Health Advisory Council, and Health Care Providers can begin making BMI screening a standard part of care.

Performance Indicators and Metrics

a. Establish PCN Priorities

Based on the ten major health issues in the PCN we have established a strategy that simplifies the ten major health issues into two (2) critical challenges: (1) ensuring affordable and convenient access to a medical home to increase health literacy and opportunities for care and (2) ensuring access to affordable and healthy foods. Therefore, the first priorities in the PCN should focus on overcoming those two critical challenges, which will simultaneously address many of the other major health issues in the neighborhood. The existing programs that will be

expanded through the Healthy Living Initiative directly address the two (2) critical challenges and should therefore be prioritized. Since these programs are already well-established in the Western New York region, expanding the programs may require fewer resources than the establishment of new programs within the PCN. Additionally, since many of these programs have already been successful throughout the region.

Any existing program that does not address either of the two critical challenges, or any new program to be established, would take second priority to other existing programs.

Finally, moving forward, the PCN will look to add other local and regional providers who offer programs that address the major health issues identified for the PCN.

b. Target short term efforts and long term goals

Several short-term efforts will be established for the Healthy Living Initiative to best guide the planning resources and efforts towards successfully addressing the health needs of the PCN. First, efforts will be made to expand the existing Western New York programs into the PCN. This will involve establishing collaborative efforts with those agencies to facilitating the expansion. Through the expansion of the programs outlined in the Healthy Living Initiative, short-term effort will be applied to overcome the two critical health challenges in the neighborhood, which will set the stage for addressing the major health issues in the neighborhood by providing residents with increased opportunities to better their health. An additional short-term effort will be to continue to connect the PCN efforts to other existing organizations and programs throughout the greater WNY region that also work to address the major health issues and critical health challenges in the PCN.

The long-term goals for the Healthy Living Initiative are based on the performance indicators which were developed in conjunction with the People-based outcomes identified by HUD, and from what residents and service providers in the Perry Choice Neighborhood have identified as critical outcomes that should be achieved.

- Residents of the PCN have knowledge and information about the supportive services available in the PCN and across the region, and are able to access them.
- All residents will be able to obtain healthy and affordable food in the PCN.
- 80% of residents in the PCN at all stages of the life cycle have a medical home (family physician) and have regular medical examinations.
- Chronic disease rates for conditions such as heart attack, asthma, obesity and diabetes are significantly lower throughout the PCN.

- Residents of the PCN regularly engage in healthy lifestyle activities that promote good nutrition, exercise, physical health and emotional and psychological well-being.

c. Metrics

Several performance metrics have been established in order to measure each plan component's effectiveness in reaching the outcome of having children, youth and adults within the Perry Choice Neighborhood be physically and mentally healthy.

| Program/Strategy | Agency/Organization | Major Issue/Challenge | Performance Metrics |
|------------------------------|--|---|---|
| Health e3 | P2 Collaborative PCN Task Force | Low health literacy | #/% of residents with "Medical Home" |
| Navigate | P2 Collaborative PCN Task Force | Low health literacy | #/% with health insurance |
| Living Healthy | P2 Collaborative PCN Task Force | Diabetes, other chronic diseases | #/% reporting stress/psychological distress |
| Diabetes Prevention Program | P2 Collaborative PCN Task Force | Diabetes | #/% reporting good physical health |
| Health & Wellness Screenings | Catholic Mercy's Comprehensive Care Center | Heart-related conditions, diabetes, low health literacy | #/% reporting good physical health |
| Mobile Mammography Unit | Erie County Medical Center | Breast cancer | # of screenings |
| Mobile Markets | Massachusetts Avenue Project | Access to healthy foods | Healthy food sales totals |
| Bi-Monthly Health Fairs | Mobile Safety-Net Team | Low health literacy | #/% of residents with "Medical Home" |
| Fulton Street Food Pantry | Catholic Charity | Access to healthy foods | # of residents served |

4.5 P2 Collaborative PCN Task Force

The P2 Collaborative of WNY (P2), a proactive, regional multi-stakeholder organization with a focus on improving the health and wellbeing of WNY neighborhoods, will establish a community-based task force to improve health conditions in the Perry Choice Neighborhood using its highly successful model currently operating in the City of Niagara Falls, NY. Using an asset-based community development approach, P2 will work with service provider's members of the PCN Supportive Service Collaborative as well as other health and human service related agencies inside and outside of the target area to collect quality of life data in the PCN in order to evaluate needs and help build organizational and resident capacity to meet these needs.

P2 will focus empowering residents to take an active role in the improvement of their health by using community health workers to conduct door-to-door outreach and implement healthy living education programs. The PCN will continue to be engaged through utilizing the Community Conversation model P2 has adopted to allow the PCN to determine which social determinants of health from the residents' perspective will improve their conditions. The Task Force will focus on resident and youth leadership training, wellness, disease prevention and public safety.² Specific evidence-based programs that will be conducted through the initiative will include the following:³

4.5.1 Health e3: Explore. Engage. Educate. -- Health e3 is a program designed to empower residents to take an active role in improving and maintaining good health. Residents who participate will be introduced to the concept of a health care team (doctors, clinics, health plans, social services, etc.) and how to access these resources effectively. They will also be taught how to prepare for doctor visits to ensure that decision-making about health planning and treatment is shared between doctor and patient; and how to distinguish between high standards of care versus care that is insufficient to meet their needs. Finally, residents will learn how to develop a personal action plan to encourage healthy living.

4.5.2. Navigate Program -- Navigate is a program that will teach the employees at major employment centers in the neighborhood about how to understand and manage their health care plans in order to maximize positive health outcomes.

² JRO Foundation 2011 Annual Report

³ Information on specific programs obtained from P2 Collaborative document titled "Empowering Patients to Become Partners in their Health Care"

4.5.3. Living Healthy -- Living Healthy is an evidence-based program that seeks to help neighborhood residents manage chronic illness effectively. This program will not conflict with existing treatment management but will help residents who suffer from chronic illness to manage pain, stress, anger, and make improvements to their quality of life. There are four Living Healthy programs that cover general chronic disease, chronic pain, diabetes and HIV respectively.

4.5.4. Diabetes Prevention Program -- The Diabetes Prevention Program is an evidence-based program that seeks to help residents to reduce their risk for diabetes through structural lifestyle changes. A lifestyle coach will work with participants to lose weight through healthy eating, to engage in more physical activity, and to recognize and overcome barriers to living healthy.

5.0 Operations and Management

5.1 The PCN Management Team

A PCN Management Team (PCN-MT) will be established to manage, oversee and implement the programmatic activities of the of the Perry Choice Neighborhood Initiative as it relates to the Supportive Service Network, the Mini-Education Pipeline, the Youth Development Strategy, the Section 3/Business Development Strategy, and the Safe Neighborhood Initiative. The mission of this team will be to catalyze the programs necessary to improve the lives of people in the Perry Choice Neighborhood and to ensure that the outcomes of the People Strategy are met and exceeded for the duration of the grant and for decades to come. The PCN-MT will work directly with BMHA, schools, supportive service providers, foundations, government agencies and regional partners to achieve these ends.

5.1.1 The Executive Director -- The Executive Director of the PCN Management Team will oversee the organization and make sure that the mission and objectives of the Strategy are being met. The Director will work with the board of directors and staff to manage and enforce policies and work to help acquire and leverage resources for the long-term sustainability of the programs and initiatives outlined in the PCN Transformation Plan. The Director will also guide the development of new programming that achieves the mission of the organization.

5.1.2 The Finance and Development Officer -- The Finance and Development Officer will assist the Executive Director and the Board with fundraising activities for all of the programs and initiatives of the People Strategy. The Development Officer will also manage the day-to-day finances of the organization and keep track of expenditures and write financial reports.

5.1.3 Data Management Specialist -- The Data Management Specialist will help the partners in both the Mini-Education Pipeline and Supportive Service Network to maintain the various information sharing databases that will be required for efficient operation. The specialist will work closely with the Collaborative and the Case Management Support Unit to ensure that the multi-stakeholder case management database is fully operational at all times.

5.1.4 Administrative Assistant -- The administrative assistant will help the Executive Director and Team staff to manage files and records, schedule events and meetings, and assist

with communications and outreach activities. The Administrative Assistant will also help to delegate responsibilities to the Support Staff Interns.

5.1.5 Support Staff Interns -- Support staff interns will assist with various day-to-day operations and research tasks as required by the Supportive Service Network. Interns may assist the coordinating staff of any of the components and activities of the Supportive Service Strategy.

5.2 The Collaborative

The Collaborative will be an organization whose membership is composed of both neighborhood-based supportive service providers and regional agencies. The PCN-MT will provide the Collaborative with access to a program coordinator and support staff interns to carry out the programmatic and research objectives of the organization.

5.2.1 Program Coordinator -- The Program Coordinator will be hired and managed by the Team to oversee the operations and the programmatic activities of the Supportive Service Collaborative. The Coordinator will conduct meetings and assist the Collaborative with outreach, reporting, planning, and operational tasks. The Coordinator will also play a role in the oversight and development internal programming for the Life Chances Center under the guidance of the Collaborative.

5.3 The Case Management Support Unit (PCN-CMSU)

The PCN-CMSU will be managed by the UB School of Social Work and operate in conjunction with the Management Team and the Collaborative.

5.3.1 Licensed Social Worker (LSW) -- The licensed social worker will work closely with the UB School of Social Work to oversee and manage all operations of the Case Management Support Unit and will be responsible for guiding the Unit, coordinating outreach, evaluating progress at achieving the Unit's mission, and assigning case work to the Case Management Interns. The LSW will also provide support and consultation to the Interns throughout the process of managing casework in order to ensure that the Unit is equipped with knowledge about the supportive service system necessary to provide the proper guidance to individuals and families in the system. The LSW will also manage the Multi-Stakeholder Case Management database to keep track of all the clients served by the Unit and provide accurate follow-up.

5.3.2 Case Management Interns – Five (5) to eight (8) graduate students from the Master of Social Work (MSW) Program from the University at Buffalo will serve as the Case

Management Interns of the PCN-CMSU. Their responsibility will be to provide direct case management and service coordination for the residents of the Perry Choice Neighborhood. They will also be responsible for filing client data in the Multi-Stakeholder Case Management Database so that providers in the Collaborative can better serve clients of the Collaborative.

5.4 The Lanigan Life Chances Center (City of Buffalo/PAL/BMHA)

The Life Chances Center will be owned and operated by the City of Buffalo and BMHA in conjunction with the Buffalo Police Athletic League. A Facilities Manager or Director will be hired to manage the facility along with a more sophisticated support staff necessary to maintain a much larger footprint.

5.4.1 Operations Manager -- The Operations Manager will be responsible for managing the day-to-day operations of the Life Chances Center. The Manager will set policies for properly using the spaces within the Life Chances Center spaces and work closely with the external providers who operate in the space to make sure that they are appropriately accommodated.

5.4.2 PAL Support Staff -- Support staff may include employees hired by either BMHA or by the City of Buffalo that are responsible for maintaining various facilities within the Life Chances Center. These may include custodial staff, equipment technicians, and other staff needed to keep the facilities to a high standard of maintenance.

6.0 Funding Strategy and Budget

6.1 Overview

A sound financial plan is necessary for the Supportive Service Network in order to ensure that the initiatives established by the Network are both sustainable for the long-term and can operate effectively to meet the positive outcomes for residents outlined in the Performance Indicators and the People Outcomes sections of the Transformation Plan.

The Network strategy acknowledges that financial resources are finite, and seeks to establish sustainable financial structures to support the Network and ensure its long-term capacity to benefit the residents of the Perry Choice Neighborhood. A sustainable strategy will require that new programs and staffing positions essential to making the Network function cannot rely on temporary funding streams to perform core tasks (such as case management). In addition, new programs of the Network should enhance, rather than duplicate any of the services already sufficiently provided by supportive service agencies in the Collaborative. This means that the Network should not pursue sources of funding that would jeopardize the financial resources of partner agencies and/or members of the Collaborative.

The following principles describe the Network's approach at achieving financial sustainability:

- Leverage resources and investments within the neighborhood's existing supportive service infrastructure
- Pursue new commitments from partners for core aspects of all programming to ensure long-term sustainability
- Avoid tapping into the funding streams of established partners in the neighborhood except where additional resources can be gained through collaboration/partnerships
- Collaborate with providers to pursue new funding sources that will bolster existing programs or help create new ones where unmet needs exist
- Apply for funding to support increased numbers of clients at PCN supportive service agencies as a result of a proactive and aggressive case management system in the PCN.
- Pursue grant funding for program expansion and/or program enhancement

The Network attempts to build on the existing investments of providers to avoid duplicative new services that serve to weaken the neighborhood's existing supportive service system rather than strengthen it. Instead, the Network seeks to use existing infrastructure and investment to connect providers together to more effectively and comprehensively meet the needs of neighborhood residents through effective communication and outreach, system-wide planning and

evaluation, thorough regular needs assessments, and effective service coordination and case management.

6.2 Primary Funding Streams

In order to achieve this objective, the Supportive Service Network strategy (and staff positions to manage the process) will be added to the neighborhood's existing supportive service infrastructure in order to achieve maximum impact. The People Management System, a central staff division of the PCN Planning Initiative, will oversee the operations of the Collaborative, the Case Management Support Unit, and the Life Chances Center and ensure that all aspects of the system have the support necessary to achieve positive outcomes for residents. This non-profit organization and the necessary positions that must be added to the Network will be funded through a combination of sources, which include:

- Leverage existing investments.
- Seek additional investment commitments by partners.
- Pursuit of support through private foundations, grant opportunities, and through the HUD Choice Neighborhood Implementation Grant during the early development of the Network. Additional funding opportunities that will further ensure the long-term sustainability of these activities and staffing positions have also been identified and prioritized.
- On-going research into new grant opportunities on the local, state, and federal level.
- Partnering with New York State through its Department of Health – Community, Opportunity, and Reinvestment Initiative.

This report attempts to provide a preliminary analysis of funding needs and an initial funding plan for the Supportive Service Network, new staff and program activities necessary to make the neighborhood's supportive service infrastructure work more effectively for neighborhood residents.

6.3 Prioritizing Programs

6.3.1 Priority One: Needs Assessment Priorities and Greatest Impact

The most important priorities for early implementation will be programs and activities that directly respond to the critical needs and concerns identified by residents and stakeholders during the Needs Assessment process of the Transformation Plan. Residents expressed a lack of knowledge and awareness about the broad spectrum of supportive services available to them, how these services will result in positive outcomes for their quality of life and self-sufficiency, and about how to apply for these services. As such, improving "information literacy" is a critical first step to improving the effectiveness of the

supportive service system and the top priority for early implementation for the Supportive Service Network.

Secondly, Neighborhood supportive service providers also identified the lack of capacity and/or resources to provide effective case management and service coordination to residents. While providers have generally been effective at providing the services they offer to residents who approach them, they have not been able to effectively direct residents to other providers who may help them or follow up with residents to ensure that the services provided to them have effectively met the needs or solved the problems they are facing in their lives.

As such, the implementation of the Case Management Support Unit and the Neighborhood Outreach Strategy of the Collaborative will be the top two priorities for the first year of implementation. In order to reach the services residents need to improve their quality of life and self-sufficiency, they must first have knowledge of the services available to them and how to apply and access them. They must also have direct access to case managers who can help them guide through the entire network of services available to them, help them to apply for these services, and follow up with them to make sure provision was effective at meeting needs.

6.3.2 Priority Two: Established Resources/Partnerships and High Impact

The second priority for implementing programs of the Supportive Service Network will be those that are both high impact and have existing resources already committed to operate and sustain them. This will ensure the maximum short-term effectiveness of the Network at achieving quality of life objectives early on, and will help to ensure that providers are highly active early on in the implementation process. For instance, the Case Management Support Unit has resources committed by the School of Social Work and will have an extremely high impact on the effectiveness of the system as whole. Space has been designated for the Unit to operate within the neighborhood until the new Life Chances Center is constructed. BMHA Resident Services is also committed to assist the Unit through use of both P&I Center Staff and its Service Coordinators for outreach and referrals.

The Collaborative will also be established in a limited capacity early on in Year One because all partners will be identified and because a systems-wide outreach strategy for residents and an open dialogue between providers is essential for maximum effectiveness and impact of the system. While resources to fund the Collaborative

Program Coordinator need to be identified, the Collaborative can function as a low-cost but high-impact program of the Network in the interim. All of the core activities that compose the Healthy Living Initiative will begin in Year One because they will have immediate impacts on the lives of residents will complement existing priorities, and resources/management commitments from all core providers have already been obtained.

6.4 Prioritizing Funding Sources

A nation-wide funding search was conducted to determine appropriate grants and funding opportunities at the federal, state, local, and foundation levels that could help bolster and expand the programs and initiatives that will be incorporated into the Supportive Service Network. Both government and private foundation funding sources were examined during the search. The Network will implement all core programming operations without relying on additional grant resources for initial implementation, but will focus on using grants as potential funding sources to promote the long-term sustainability of programming and the expansion of programs to serve additional residents. Funding opportunities have been prioritized in the following manner:

- **High Priority:** High priority grant opportunities are those that most closely relate to the programs that we are implementing through the Transformation Plan and will provide significant financial resources to support such programs. These grants are those which our programs closely connect to what the grant opportunity will fund, ensuring that our programs have a highly competitive chance to be funded. In addition, funding opportunities identified as high priority typically will provide long-term support or will fund component of the Network that is a high priority for early implementation or expansion.
- **Medium Priority:** Medium priority funding opportunities are highly relevant to the programs and initiatives of the Network but may provide more limited resources than high priority opportunities. Medium priority opportunities may also predominantly fund secondary components of the Network Strategy which are not essential to early phases of implementation. Medium priority opportunities may also provide significant resources but provide limited detail about the specifics of what the grant opportunity will fund.
- **Low Priority:** Low priority funding opportunities typically provide limited financial resources and/or offer a vague description of what they will fund, which makes it difficult to determine whether the funding opportunity closely matches Network programs. While relevant to components and programs of the Network, the chances of obtaining these resources are limited and may have a smaller impact than medium or high priority opportunities. Low priority grants may also fund tertiary components of the Network that are to be implemented in later phases of the Perry Choice Neighborhood Initiative.

6.5 Grant Priorities

6.5.1 General Program Funding

There are a number of local foundations that have a broad spectrum of potential activities in which they fund. Each of these foundations should be a high priority to pursue in order to support various components of the Network.

| Name of Opportunity | Funding Source | Amount | Funding Cycle | Priority |
|---|---|----------------------|--------------------|----------|
| - | John R. Oishei Foundation | Open | Ongoing | High |
| Programming Grants for Quality of Life and Civic Initiatives in Multiple States | The M&T Charitable Foundation | Open | Ongoing | High |
| Community Foundation Competitive Grants | Community Foundation of Greater Buffalo | Open | Annual | High |
| 21st Century Fund | Community Foundation of Greater Buffalo | \$100,000 | Every Two Years | High |
| - | The Ford Foundation | Open | Ongoing | Medium |
| - | JP Morgan Chase Co. | Open | Ongoing | Medium |
| Grants to Nonprofits for Health, Culture, Education, and Social Services | The Hearst Foundations | \$30,000 - \$250,000 | Ongoing | Medium |
| Grants to U.S. Non-Profits/Gov't Entities for Individual and Community Health Initiatives | Kresge Foundation | Not Listed | Ongoing | Medium |
| | Walgreens Foundation | Not Listed | Ongoing | Medium |
| Planning Program and Local Technical Assistance Program | Economic Development Association | \$100,000 | August 3, 2012 - ? | Low |

6.5.2 Supportive Service Collaborative

The Supportive Service Collaborative has a number of components that would benefit from bolstering through additional financial resources. The Collaborative members have already committed to the Initiative and it is important to build momentum quickly to begin undertaking planning and Network-wide neighborhood outreach and marketing activities. The following tables identify funding opportunities that should be pursued, sorted by priority for each program or activity.

Communications and Outreach

| Name of Opportunity | Funding Source | Amount | Funding Cycle | Priority |
|---|-------------------------|--|---|----------|
| Grants for Non-Profit Publicity and Advertising | Google Foundation | Up to \$10,000 in advertising services | Open | Medium |
| Internet Publicity Services for Non-Profits in the U.S. | YouTube Foundation | In-Kind Services | Open | Medium |
| Understanding Health Literacy | National Inst of Health | Variable | Dependent upon discretionary budgeting. | Medium |

Events and Activities

| Name of Opportunity | Funding Source | Amount | Funding Cycle | Priority |
|---|---|--------------|---|----------|
| Behavioral and Social Science Research on Understanding and Reducing Health Disparities (R01) | National Inst of Health | Not Reported | Open | High |
| Basic Social and Behavioral Research on Culture, Health, and Well Being (R24) | National Inst of Health | \$1,425,000 | Annual | High |
| Research Conference Grant (R13) | National Inst of Health | Not Reported | Dependent upon discretionary budgeting. | Medium |
| Grants for U.S. Nonprofits for Projects and Programs that Provide Basic Human Needs | Bank of America Charitable Foundation | Open | Open | Medium |
| Grants to New York State For/Non-Profits and Others to Provide Broadband Service to Underserved Areas | NYS Empire State Development Broadband Program Office (NYS ESD BPO) | Open | Not Reported | Medium |

Back Office Support/Technical Assistance

| Name of Opportunity | Funding Source | Amount | Funding Cycle | Priority |
|-----------------------------------|--------------------|---------------------------|---------------|----------|
| Taproot Foundation Service Grants | Taproot Foundation | \$45,000 in-kind services | Not Reported | Medium |
| The WNY Foundation | The WNY Foundation | \$30,000 | Open | Medium |

6.5.3 The Case Management Support Unit

The Case Management Support Unit, scheduled for immediate implementation, would benefit from additional financial resources to expand initial capacity by 2014. As one of the most important components of the Supportive Service Network Strategy, the Unit is the top priority for

the pursuit of additional funding sources during Year One of implementation to ensure that expansion to serve more residents takes place according to schedule by Year 5. The addition of a BMHA-focused service coordinator and supports to help maintain as many as 8 case management interns and a highly efficient multi-stakeholder case management database could enable to system to serve as many as 450 households annually by Year 5.

Licensed Social Worker/BMHA Service Coordinator

| Name of Opportunity | Funding Source | Amount | Funding Cycle | Priority |
|--|-----------------------|---|----------------------|-----------------|
| Service Coordinators in Multifamily Housing | HUD | \$15 million available for new service coordinator programs | Annual | High |
| Multifamily Housing Service Coordinators Grant Program | HUD | Not Reported | Annual | High |

Operating Support, Child Specialist

| Name of Opportunity | Funding Source | Amount | Funding Cycle | Priority |
|--|--|--------------------------|---|-----------------|
| Partnerships to Demonstrate the Effectiveness of Supportive Housing for Families in the Child Welfare System | Administration for Children and Families | \$500,000 to \$1 million | Annual, July 30 th , for 5-Year Grant Period | High |

Data Sharing Software

| Name of Opportunity | Funding Source | Amount | Funding Cycle | Priority |
|---|-------------------------------|---------------|---------------------------|-----------------|
| Health Tools to Promote Effective Patient Provider Communication, Adherence to Treatment and Self-Management of Chronic Diseases In Underserved Populations | National Institutes of Health | Not Reported | Open until Sept. 17, 2014 | Medium |

Communications and Outreach*

*Communication and Outreach Grants identified in the Collaborative will be pursued in conjunction for the SSCU.

6.5.4 The Lanigan Life Chances Center

The Lanigan Life Chances Center is a major facility with a number of core programs that will require additional resources to support over the long term. The following tables identify funding opportunities that should be pursued, sorted by priority for each program or activity.

Senior Center

| Name of Opportunity | Funding Source | Amount | Funding Cycle | Priority |
|--|--|--|---------------|----------|
| Grants to U.S. Non-Profits, Public/Private Agencies, and Others to Promote Senior Volunteerism | Corporation for National and Community Service Senior Education Classes | \$16 million available, roughly \$60,000 per grant | Not Reported | High |
| Self-Development of People Grant | Presbyterian Mission Agency | Open | Not Reported | Low |

Fitness Center

| Name of Opportunity | Funding Source | Amount | Funding Cycle | Priority |
|---|-------------------------------|------------------|-------------------------|----------|
| Finish Line Youth Foundation Grants | Finish Line Youth Foundation | \$1000 to \$5000 | Annual | Medium |
| Improving Diet and Physical Activity Assessment | National Institutes of Health | \$200,000 | Open until Sept 7, 2015 | Medium |
| Healthy Habits: Timing for Developing Sustainable Behaviors in Children and Adolescents | National Institutes of Health | Not Reported | Not Reported | Medium |

Computer Lab

| Name of Opportunity | Funding Source | Amount | Funding Cycle | Priority |
|-----------------------------------|----------------|--|---------------|----------|
| RDK Foundation Community Grant | RDK Foundation | Up to \$25,000 | Not Reported | Medium |
| Technology Grants for Non-Profits | Mobilebeacon | Discount on Internet Services for \$120 per year per modem | Open | Low |

6.5.5 The Healthy Living Initiative

The Healthy Living Initiative largely takes advantage of existing resources and programs leveraged and operated by partners in the Network and expand these existing programs to cover residents in the Perry Choice Neighborhood.

MAP Buffalo Grown Mobile Market

| Name of Opportunity | Funding Source | Amount | Funding Cycle | Priority |
|---|---|----------------|----------------------|-----------------|
| National Grassroots Grant Program | Ben & Jerry's Foundation | Up to \$15,000 | Not Reported | Medium |
| Local Sustainability Matching Fund | Urban Sustainability Directors Network Foundation | UP to \$75,000 | Annual | Medium |
| Improving Diet and Physical Activity Assessment (R01) | National Institute of Health | Open | Annual | Low |

Health and Supportive Service Resource Events

| Name of Opportunity | Funding Source | Amount | Funding Cycle | Priority |
|---|---------------------------------------|----------------------|----------------------|-----------------|
| The National Giving Program: Health and Wellness | The Wal-Mart Foundation | \$250,000 or Greater | Not Reported | High |
| The Hearst Foundations Health Grants | The Hearst Foundations | \$250,000 | Ongoing | High |
| Grants to U.S. Non-Profits for Projects and Programs that Provide Basic Human Needs | Bank of America Charitable Foundation | Open | Not Reported | Medium |
| Educational Grants for the Healthcare Community | Ethicon Foundation | Open | Ongoing | Medium |

6.5.5 Family Self Sufficiency

By expanding the existing Family Self-Sufficiency program and aggressively marketing it to residents of public housing in the PCN, BMHA can help bolster the wealth of residents and build an effective model that can later be applied across all BMHA developments and housing choice voucher recipients.

Additional FSS Coordinator

| Name of Opportunity | Funding Source | Amount | Funding Cycle | Priority |
|--|-------------------------------|-----------------------------|----------------------|-----------------|
| Housing Choice Voucher Family Self-Sufficiency | Housing and Urban Development | Up to \$69,000 per position | Annual | High |