2022-2024
Monroe County Joint Community Health Improvement Plan

A collaborative report from
The Community Health Improvement Workgroup which is managed by the Center for Community Health & Prevention and includes several community partners. This report serves the following hospitals and health department:

Strong Memorial Hospital

Highland Hospital

Rochester General Hospital

Unity Hospital

Monroe County Department of Public Health

Prepared for: Monroe County
Prepared Jointly with: Common Ground Health

2022-2024
Monroe County Joint
Community Health Improvement Plan

Entity Completing Plan for Monroe County, NY

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Introduction

Local hospitals (University of Rochester Medical Center's Strong Memorial Hospital and Highland Hospital, Rochester Regional Health's Rochester General Hospital and Unity Hospital) and the Monroe County Department of Public Health are committed to working collaboratively with the residents and institutions of Monroe County, to improve the health of our community. Every three years, through a process mandated by the Affordable Care Act, and the New York State Department of Health, non-profit hospitals and the health department conduct a Community Health Needs Assessment (CHNA) to determine areas of community health concern. In Monroe County, the Community Health Improvement Workgroup (CHIW) brings together leaders from the hospitals, health departments, and community agencies to prioritize community health needs and develop and implement a Community Health Improvement Plan (CHIP) for addressing the needs of our county. Contained in this report is a summary of the results of the CHNA process, the identified health priorities for Monroe County, extensive improvement strategies with a detailed work plan, and a distribution plan for these efforts.

Identified Health Priorities

After examining local Monroe County data and the NYS Prevention Agenda Dashboards, we identified areas where Monroe County health indicators were worse than the state and failed to meet the Prevention Agenda goals for 2024. Importantly, extensive community engagement and input were gathered and incorporated before deciding on the following two areas as the main health challenges of focus for the 2022-2024 CHNA/CHIP:

Monroe County health priorities and goals for the 2022-2024 CHNA and CHIP are as follows:

Goal 1: Promote Healthy Women, Infants, and Children

Objective 1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child populations.

- **Intervention:** Enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families across the life course.

Goal 2: Promote Well-Being to Prevent Mental and Substance Use Disorders

Objective 2.1: Strengthen opportunities to build well-being and resilience across the lifespan

- **Intervention:** Integrate social and emotional approaches across the lifespan. Support programs that establish caring and trusted relationships with older people.
- **Intervention:** Enable resilience for people living with chronic illness: Strengthen protective factors including independence, social support, positive explanatory styles, self-care, self-esteem, and reduced anxiety.

Objective 2.2: Facilitate Supportive Environments to promote respect/dignity for all ages

- **Intervention:** Mental Health First Aid (MHFA) is an evidence-based public education program that teaches people how to respond to individuals who are experiencing one or more acute mental health crises or are in the early stages of one or more chronic mental health problems.
- **Intervention:** Policy and program interventions that promote inclusion, integration, and competence
- **Intervention:** Use thoughtful messaging on mental illness and substance use: Expert opinion in messaging about Mental, Emotional, and Behavioral Health humanize the experiences and struggles of person living with disorders; highlight structural barriers; avoid blaming people for the disorder or associate disorders with violence.

Although both of these areas will address disparities, the "Promote Healthy Woman, Infants and Children" focus area specifically calls out inequities based on race and socioeconomic status.

Process for Priority Identification

The Community Health Improvement Workgroup (CHIW) representing each hospital, the health department, and several community partners, meets monthly to discuss successes and challenges in addressing the goals of the Community Health Improvement Plan. In the summer of 2021, the CHIW began the 2022 CHNA process by having hospital representatives to the CHIW meet personally with their hospital's leadership to discuss needs and/or disparities that the healthcare systems identified as community health priorities. The priority areas from these meetings were then discussed in relation to the NYS Prevention Agenda focus areas as well as needs identified by the Monroe County Department of Public Health and the community.

In fall 2021, the CHIW members discussed the characteristics that would define how to prioritize the many needs in Monroe County. Important criteria include upstream interventions, importance of the problem to the community, especially in light of the pandemic, solutions that address the full age spectrum, and feasibility.

Next, several sources of data were examined to determine the top community health needs for Monroe County. The MCDPH and the Common Ground Health were instrumental in updating, analyzing, and sharing data for the CHIW to examine. Several areas of concern were identified and analyzed for consistency with hospital needs as well as the prioritization criteria with special attention to areas of need among vulnerable populations. The CHIW examined Monroe County metrics against the New York State's Prevention Agenda Dashboard and 2024 Prevention Agenda Goals. The CHIW identified areas where Monroe County:

- ❑ Fell short of the state goal for the Prevention Agenda 2024
- ❑ Faces significant disparity in race, ethnicity, geography, or socioeconomic status
- ❑ Contains a downward trend of "worse" or "significantly worse"

Additionally, after examining all the data available and after multiple discussions among the CHIW members, there was a strong inclination to not change the priority areas from the 2019-2021 Community Health Improvement Plan. It was agreed that Monroe County has made significant progress on establishing the infrastructure to support initiatives in the areas of mental health and disparities in maternal and child health. This inclination was supported also by the COVID pandemic slowing down

implementation work on the CHIP in the past few years. An important next step in establishing the priority health issues was to gather significant community input.

Community Engagement

The priority areas and interventions selected for the 2022-2024 Monroe County Joint Community Health Needs Assessment and Community Health Improvement Plan were selected with community input at each step in the process. Throughout the needs assessment process, representatives from the CHIW met with several community groups for feedback on the selected focus areas as well as goals and recommended interventions. The meeting dates for some of the most significant groups input sessions are shown below, and the comments, recommendations, and full summaries of these discussions are available in the "Community Engagement" section of the CHNA.

Table 1: Significant Group Input Sessions for Monroe County 2022-2024 CHIP Development

Group	Date
Community Advisory Council	September 21, 2021
Monroe County Board of Health	November 10, 2021
Maternal Child Health Advisory Group	November 17, 2021
African American and Latino Health Coalitions	December 16, 2021
Maternal Child Health Advisory Group	February 17, 2022
Community Advisory Council	March 22, 2022

The CHNA and CHIP were reviewed and adapted based on group feedback at each meeting, and discussed at the monthly CHIW meetings, until consensus was reached on the identified focus areas and types of intervention.

Community Health Improvement Plan

The objectives and interventions for each area of need were selected from the New York State Prevention Agenda's list of recommended, evidence-based interventions and programs.

Maternal child health is an area of concern for Monroe County, and the current disparities are unacceptable. The health systems with the community intend to continue enhancing collaboration with other programs by maintaining and expanding the Maternal Child Health Advisory Group (MCH-AG)—a collective of community partners, clinicians, researchers, and hospital administration.

Promoting mental health and well-being is a priority area of particular importance to our community members. Interventions focus on the upstream approach of addressing social determinants of health including poverty and employment to impact the long-term health of the community and address disparities in wealth.

Tables 3, 4, and 5 outline the goals, objectives, interventions, planned activities, future action steps, process measures addressed by the action steps, and the targeted timing of these action steps.

Significant Needs Not Addressed

The 2022 CHNA identified several main health challenges that are organized in the table below, according to the state Prevention Agenda Priority Areas. Highlighted areas are of particular concern for Monroe County based on all the data examined, and community input.

Table 2: Identified Main Health Challenges in Monroe County in 2022

Priority Area	Focus Area
Prevent Chronic Diseases	Healthy Eating and Food Security
	Physical Activity
	Tobacco Prevention
	Chronic Disease Preventive Care and Management
Promote a Healthy and Safe Environment	Injuries, Violence and Occupational Health
	Outdoor Air Quality
	Built and Indoor Environments
	Water Quality
	Food and Consumer Products
Promote Healthy Women, Infants and Children	Maternal and Women's Health
	Perinatal and Infant Health
	Child and Adolescent Health
	Cross Cutting Healthy Women, Infants, and Children
Promote Well-Being and Prevent Mental and Substance Use Disorders	Well-Being
	Mental and Substance Use Disorders Prevention
Prevent Communicable Diseases	Vaccine Preventable Diseases
	Human Immunodeficiency Virus (HIV)
	Sexually Transmitted Infections (STIs)
	Hepatitis C Virus (HCV)
	Antibiotic Resistance and Healthcare-Associated Infections

Based on the top prioritization criteria chosen by the CHIW (listed in the CHNA Summary), *Promote Well-Being* and *Cross-Cutting Healthy Women, Infants, and Children* were selected. However, these other indicated areas are still significant needs that must be addressed to improve the health of Monroe County. However, there are not enough resources to address all the areas of need simultaneously and therefore some areas cannot be prioritized. By focusing on social determinants and upstream interventions, the CHIW hopes to expand its impact to other areas of need, not selected as focus areas.

Work Plan for Implementation of New Initiatives

The Monroe County Community Health Improvement Workgroup has agreed to work collaboratively to implement the activities outlined in the work plan to move towards the desired impact. Each hospital and the health department have identified specific activities that they will continue to commit resources towards in the years to come. The following work plan details these specific commitments to support progress towards the goals of the 2022-2024 Community Health Improvement Plan (Tables 3 and 4). All four hospitals and the health department as well as community partners will work collaboratively on the same work plan towards the same goals. The interventions will be implemented in a collaborative manner, and the hospitals will delegate resources including representatives, meeting spaces, content experts and organizational connections. Our community partners are involved in the planning and implementation of all intervention strategies, from their selection to their completion.

Table 3: Monroe County Joint Community Health Improvement Plan 2022-2024 — Work Plan, Maternal and Child Health

Goal 1: Promote Healthy Women, Infants, and Children

Objective 1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child populations.		
Impact Measure	2022 Baseline	Goal by July 2025
Maternal mortality, rate per 100,000 live births	29.7 (Vital Records 2017-19) Significantly worse than the NYS Prevention Agenda goal of 16.0	Move from "Worsening" to "Improving"
	Disparity Maternal Morbidity Black non-Hispanic = 141 per 10K White non-Hispanic = 66 per 10K • REF: NYSDOH SPARCS Inpatient Dataset CGH (2016-2018)	Decrease disparity in Maternal Morbidity by race
Infant mortality, rate per 1,000 live births	7.1 (Vital Records, 2019) Significantly worse than the NYS Prevention Agenda goal of 4.0	Move from "No significant change" to "Improving"
	Disparity Infant Mortality Black = 16.9 per 1000 live births White = 3.9 per 1000 live births • REF: NYS DOH County Health Indicators by Race 2017-19	Decrease disparity in Infant Mortality by race
Percentage of preterm births (Delivery <37 weeks)	10.4% (Vital Records, 2019) Significantly worse than the NYS Prevention Agenda goal of 8.3%	Move from "No significant change" to "Improving"
	Disparity Preterm Births All county = 9% High risk zip codes = 11.9% • REF: Monroe County Perinatal Network Fast Facts 2021	Decrease disparity in preterm births based on zip codes
Suicide mortality - youth, rate per 100,000, 15-19 years	10.6 (Vital Records, 2017-19) Significantly worse than the NYS Prevention Agenda goal of 4.7	Move from "Worsening" to "Improving"
	Disparity Attempted Suicide All county youth reporting attempted suicide = 8% Rochester youth reporting attempting suicide = 10% • REF: 2019 Youth Behavior Risk Factor Survey, Monroe County and Rochester City School District	Decrease disparity in suicide attempts Rochester vs. Monroe County schools

Over-arching Intervention: Enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families across the life course.

Proposed Actions	Short term Outputs/Outcomes	Intermediate Metrics
A. Networking Build the connected network of perinatal health-related professionals with community agencies that address social determinants of health • Fully support the MCH-Advisory Group with meetings and resource sharing • Continue advisory support for ROC Family Teleconnects Screening program (RRH, URMC)	• # of MCH-AG meetings • # of speakers addressing social determinants of health, especially housing and racism *Target: 4 meetings/year with 1 speaker/meeting each year*	• # Collaborations, reach and/or programs resulting from MCH-AG network • # Advocacy towards addressing social determinants of health especially housing and racism *Target: Increase in depth of relationships, increase density of network analysis by 2024*
Reducing Maternal Morbidity and Mortality particularly for Black People giving Birth		
B. Doula Care Support doula services including full integration of doula care into healthcare systems • Support the Black Doula Collaborative to increase Doula's to serve BIPOC community (FLPPS, HBN, Finger Lakes Health, and HealthConnect One, RRH) • Educate the existing network of social workers and care managers at both health systems	• # Opportunities for hospital staff to learn with doulas and/or about doula care • # Advocacy efforts for Doula Support *Target: 4 educational opportunities in year 1*	• # Healthcare systems integrated with doula care (policies & procedures in place for Doulas) • # Patients who wanted Doula care & received it. *Target: 4/4 hospitals with Doula policies, procedures, 100% patients served by 2024*
C. Build Well-Being Strengthen opportunities to build well-being, mental health, and resilience for pregnant people and new families	• Use of community-based resources • # programs linking pregnant and young families to housing and food resources • Integration of mental health and resilience resources to new families *Target: Identification and sharing of resources, 2 new programs in year 1*	• Consider a survey of community members – esp. pregnant/new families assessing barriers to support • Food insecurity and housing insecurity rates among pregnant and new families *Target: Pre and post survey implemented, decrease in social need among new families for 2024*
Planned Activities: • Share and support resources such as the Gender Wellness Center (URMC), Parenting Village, Beautiful Birth Choices • Continue the Whole Child Initiative (RRH) • Connect with the Beauty Shops and Barber Shop Get it Done! (GID) program • Research ways to connect pregnant people and new families to housing and food resources • Healthy Baby Network integration with programs addressing social determinants including Foodlink program with Excellus • Infant mental health initiative led by Common Ground Health		
Reducing Infant Mortality and Preterm Birth particularly for Women in High-Risk Communities		
D. Social Supports Support local maternal/infant home visitor model programs; care manager, community health worker evidence-informed programs that provide social resources to pregnant people/new families • Coordinate efforts to link pregnant people to available resources • Support screening efforts to identify those in need of social support	• Number of residents served by social support programming • Decrease in barriers to accessing support services • # of agencies with Integration of Prototype standard intake process for social support *Target: Establish baseline metrics, 2 agencies with prototype integration year 1*	• Home visitor model programs (NFP, Healthy Moms, Baby Love) operational metrics maximized • # of clients receiving social support through ROC Family Teleconnects Screening • Increase the % of Births with "Adequate" Prenatal Care; 55% for high-risk zips (2020) *Target: Increasing trends, programs at operational capacity by 2024*

Social Supports Planned Activities:

- Fully support the Baby Love Program (URMC), Healthy Moms Program (RRH) and Nurse Family Partnerships (MCDPH)
- Build the Systems Integration Prototype for standardized intake and create systematic workflows in clinics and/or 2-1-1
- Continue ROC Family Teleconnects Screening program (RRH, URMC) with advisory support from MCH-AG
- Support Gender Wellness Ob/Gyn, including perinatal care managers and smoking cessation
- Support Health Homes programs, Healthy Steps program
- Share more about community-based programming: Mt. Hope Building Healthy Children program and Children's Institute expanding comprehensive screening program

E. Planned Pregnancies Support efforts for planned healthy-spaced pregnancies • Support the LARC Initiative @ Hoekelman including partnership with RRH • Facilitate IPP LARC for those patients who want it, evaluate results	• # Advocacy or education efforts to increase LARC availability for those wanting it *Target: At least 2 advocacy or education efforts for LARC in year 1*	• Decrease the percent of unintended pregnancies among live births; MC = 22.7%, High-Risk Zip = 35.5% • Decrease the number of births with pregnancy interval <18 months; MC = 28.2% (2021) *Target: By 2024, decrease the % of unplanned pregnancy among live births in high-risk zip codes by 5%*
Reduce Suicide Attempts among Youth, particularly in the City of Rochester		
F. Rochester City School District Connections Connect RCSD students to reproductive health education and services and assure mental health services, especially to teens	• # new interventions to support mental health at RCSD • # of new interventions to support reproductive health education at RCSD • # of advocacy, education, and funding efforts for MCTP and Center for Youth, as needed *Target: At least 2 new interventions at RCSD in year 1*	• Decrease the percent of adolescents in grades 9-12 who felt sad or hopeless for two or more weeks in a row in the past year; MC 32% (2019) • Decrease teen (15-19 yrs. old) birth in Rochester; 27/1000 in 2019 (223 births) *Target: Analyze results of 2022 YBRFS and plan interventions accordingly; continue positive trend in teen birth rates*

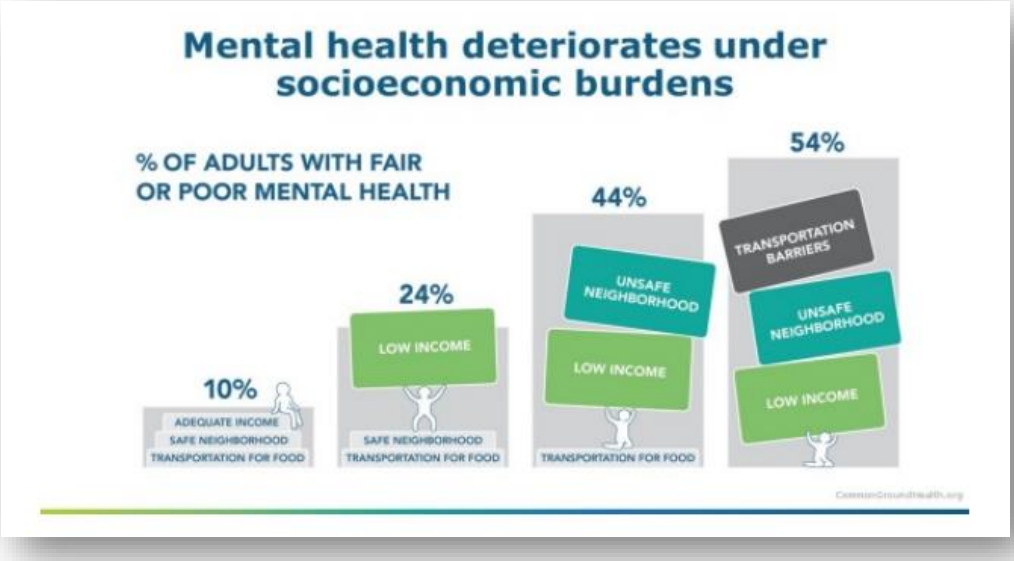
Planned Activities

- Consider opportunities with School Based Health Clinics in RCSD schools run though both RRH and URMC
- Support community programming like Metro Council for Teen Potential and Center for Youth through funding, partnership
- MCDPH for STD testing clinics, and connection to IMPACT
- Support for RRH Community Youth Behavioral Health Services

Table 4: Monroe County Joint Community Health Improvement Plan 2022-2024 — Work Plan, Mental Health and Well-Being

Goal 2: Promote Well-Being and Prevent Mental and Substance Use Disorders

Objective 1: Strengthen opportunities to build well-being and resilience across the lifespan. **Objective 2**: Facilitate supportive environments that promote respect and dignity for people of all ages.		
Impact Measure	2022 Baseline	Goal by July 2025
Frequent mental distress during the past month among adults, age-adjusted percentage	11.0 Age-Adjusted Percentage (NYS BRFSS, 2018) Worse than the NYS Prevention Agenda goal of 10.7	Move from "No significant change" to "Improving"
Emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate per 100,000 population	126.9 Age-adjusted Rate (SPARCS, 2019) Significantly worse than the NYS Prevention Agenda goal of 53.3	Move from "No significant change" to "Improving"
Suicide mortality, age-adjusted rate per 100,000 population	10.5 Age-Adjusted Rate (Vital Records 2017-2019) Significantly worse than the NYS Prevention Agenda goal of 7.0	Move from "Worsening" to "Improving"
Residents of the Finger Lakes Region reporting that they have personally dealt with mental or emotional health issues	55% (My Health Story, 2019)	Improvement, although difficult to anticipate impact of the pandemic.



Results of the My Health Story Survey for the 9 counties in the Finger Lakes Region (Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, and Yates County).

Intervention 1.1 Integrate social and emotional approaches across the lifespan. Support programs that establish caring and trusted relationships with older people. (Examples include the Village Model, Intergenerational Community, Integrating social emotional learning, Community Schools, parenting education.)

Proposed Actions	Short term Outputs/Outcomes	Intermediate Metrics
A. Social and Emotional Learning Aid in integration of social emotional learning (SEL) tools in hospitals and schools	• # SEL tools available in hospitals and schools • # Behavioral health school-based therapists • # Staff trainings to identify and de-escalate distressed patients	• # of disciplinary events in schools • # of youth and adults with training in self-management skills
Planned Activities • Behavioral Health School Based Therapists (RRH) • Integrated Substance Use Disorder and Mental Health Disorder Treatment in School-Based Health Center Sites (RRH) • Pediatric Telehealth Program at RCSD (URMC) • Ongoing training of staff to identify and de-escalate patients manifesting distress with challenging behaviors (UR, HH) • Chat BOT program for Social and Emotional Learning (URMC) • SEL supports in City Recreation Centers (RRH)		
B. Supporting Older People Support care and resource access in nursing homes (e.g., transitional care, workforce, intergenerational programs) • Consider connecting faith-based organizations to senior communities • Consider programs linking school-aged children to senior communities	• # of intergenerational programs initiated with elder care facilities • # Nurses' aides trained • # Programs offered by third-party organizations in independent and assisted living as well as nursing homes	• Nursing homes functioning at capacity • Mental health metrics among older people in Monroe County
Planned/Continuing Activities • ElderOne/PACE programming (RRH) • Transitions of Care (RRH, URMC) • Telemedicine, on-site subspecialty consults (UR HH) • Comprehensive Care Management team consisting of Social Workers, Health Home Care Managers and RN Care managers who work with individuals and families linking with community resources and/or advocacy organizations (UR HH) • Training site for nurse's aides (needed in multiple senior care settings) (MCDPH) • 5 Skilled Nursing Facilities, 3 of which are in Monroe County (RRH)		

Intervention 1.2 Enable resilience for people living with chronic illness: Strengthen protective factors including independence, social support, positive explanatory styles, self-care, self-esteem, and reduced anxiety.

C. Resilience Integrate and expand resilience training programs (e.g., for hospital employees, people with ACEs, food insecure) • Support Trauma Informed Care expansion in hospitals and public health settings • Continue Crisis Debriefing Teams (RRH) and Language of Caring (RRH)	• # Resilience training programs • # People attending resilience training programs • # of agencies or departments incorporating Trauma Informed Care	• Rates of depression; estimated prevalence 18 years and older = 20.6% (BRFSS, 2019)
D. Strengthen Economic Supports Strengthen household financial security particularly by advocating for programs and policies that stabilize housing and increase food security • Support an assessment of Rochester Housing – Review City of Rochester Housing Task Force report and address relevant recommendations (May 2022) • Advocacy for resident homeownership	• # Advocacy and/or education efforts for stable housing and increasing food security • # Education and career coaching sessions available for new parents • # Emergency food pantries	• Food insecurity rates for Monroe County = 11% (County Health Rankings 2022) • % of low-income populations that have low food access in Monroe County = 22.9% (US Dept of Ag 2019, ROCHealth) • Homelessness rates

Continued/Planned Activities:

- Residential Housing Program - Skyview Park (RRH)
- Foodlink Partnerships with hospitals (RRH, URMC) including Emergency Food Pantry
- Hospital representation on Rochester Monroe Anti-Poverty Initiative (RMAPI), work to raise the minimum wage ($15/hour)
- Health Home Care Management program – CMs assisting w short term needs and connecting individuals w sustainable solutions for housing and food security (URMC, RRH)
- Current WIC program with potential expansion (MCDPH)
- Lead Safe Housing program (MCDPH)
- Financial Support program for first time home buyers (URMC)
- Rochester General College of Health Careers (RGCOHC)

Intervention 2.1 Mental Health First Aid (MHFA) is an evidence-based public education program that teaches people how to respond to individuals who are experiencing one or more acute mental health crises or are in the early stages of one or more chronic mental health problems.

E. Mental Health First Aid (MHFA) Coordinate and support mental health first aid (MHFA) training efforts • Focusing on older adult, adult MHFA • Utilize trainings from MC Office of Mental Health and community-based orgs.	• # MHFA trainings • # MHFA trainees • # MHFA trainers	• # Poor mental health days • % of adults with poor or fair mental health

Intervention 2.2 Policy and program interventions that promote inclusion, integration, and competence

F. Diversity, Equity and Inclusion Aid in integration of policies and programs addressing equity and anti-racism efforts • Implement equitable hiring, interviewing, and promotion policies • Explore changing work requirements to be more inclusive of those with lived experiences +/- credentials	• # Additional Policies and programs addressing equity and anti-racism efforts • % People with lived experience engaged in development and decision-making roles in policies and programs • % People with lived experience engaged in implementation	• Improved measurement and evaluation of health outcome disparities based on race • Decrease in health outcome disparities in Monroe County • Increase in # of BIPOC leaders in the hospital systems and health department

Planned/continued Activities

- DEI Committee – Community Health Disparities Task Force (RRH)
- Implementation of the Equity and Anti-Racism Action Plan (URMC)
- Diversity Action Plan (MCDPH)
- Affirming Gender Care project
- Medical Legal Partnership program (RRH and URMC)
- Rochester RASE policy recommendations
- Intensive Immersion Learning Series: Culturally Competent and Anti–Racist Care and Treatment for Black Families (RRH)
- LGBTQ+ Designation through OASAS (RRH)

Intervention 2.3 Use thoughtful messaging on mental illness and substance use: Expert opinion in messaging about Mental, Emotional, and Behavioral Health humanize the experiences and struggles of person living with disorders; highlight structural barriers; avoid blaming people for the disorder or associate disorders with violence.

G. Destigmatizing Language Work to remove existing stigmatizing language and advocate for policies to support using thoughtful messaging and stigma-reducing language, particularly on mental illness and substance use	• # Stigma reduction documentation reviews • # Changes made on websites, presentations, and/or documents	• % Patients presenting with mental illness and substance use symptoms reporting positive interactions with providers

Planned/Continued Activities:

- Stigmatizing Language Project to minimize the use of stigmatizing language in the EMR (URMC)
- Implementation of the AMA-AAMC Equity Guide
- NYS MATTERS opportunities
- IMPACT outreach to family members of patients with SUD and training for Narcan and reduce MH stigma (MCDPH)
- Continued 2019-21 ED Language work

Table 5: Planned Activities by Organization (URMC, RRH, MCDPH)

Goal 1: Promote Healthy Woman Infants and Children			
Objective 1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote equity for maternal and child health populations. (NYS PA Cross Cutting goal)			
Proposed Actions	**Planned Activities**		
	URMC – Strong and Highland	**RRH – General and Unity**	**MCDPH**
A. Networking Build the connected network of perinatal health-related professionals with community agencies that address social determinants of health	- Send representation to MCH-Advisory Group quarterly meetings and actively participate - Continue ROC Family Teleconnects Screening program	- Send representation to MCH-AG and actively participate (quarterly) - Continue ROC Family Teleconnects Screening program - Continue the Whole Child Initiative	- Send representation to MCH-Advisory Group quarterly meetings and actively participate
B. Doula Care Support doula services including full integration of doula care into healthcare systems	- Support the existing network of social workers and care managers at both health systems - Advocate for doula integration - Support the Black Doula Collaborative	- Support the existing network of social workers and care managers at both health systems - Advocate for doula integration - Support the Black Doula Collaborative	- Support the Black Doula Collaborative
C. Build Well-Being Strengthen opportunities to build well-being, mental health, and resilience for pregnant people and new families	- Continue Gender Wellness Ob/Gyn connection to the MCH-AG and the CHIP activities - Encourage behavioral health programs for pregnant people - Support advocacy for food/housing when appropriate	- Fully support behavioral health programs at Healthy Moms Program - Support advocacy for food/housing when appropriate	- Support advocacy for food/housing when appropriate
D. Social Supports Support local maternal/infant home visitor model programs; care manager, community health worker evidence-informed programs that provide social resources to pregnant people/new families	- Fully support Baby Love Program - Support Gender Wellness Ob/Gyn, including perinatal care managers and smoking cessation - Support Health Homes programs, Healthy Steps program - Share Mt. Hope Building Healthy Children program and Children's Institute comprehensive screening program - Continue ROC Family Teleconnects - Collaborate around standard intake and process	- Fully support the Healthy Moms Program - Support Health Homes programs, Healthy Steps program - Continue ROC Family Teleconnects Screening program - Collaborate around standard intake and process	- Fully support Nurse Family Partnerships program - Collaborate around standard intake and process
E. Planned Pregnancies Support efforts for planned healthy-spaced pregnancies	- Support LARC Initiative at Hoekelman - Discuss birth spacing and LARC at visits when appropriate especially with Baby Love	- Discuss birth spacing and LARC at visits when appropriate especially with Healthy Mom program	- Discuss birth spacing and LARC on visits as appropriate, especially with Nurse Family Partnerships Program clients
F. Rochester City School District Connections Connect RCSD students to reproductive health education and services and assure mental health services, especially to teens	- Consider potential opportunities with School Based Health Clinics in RCSD	- Consider potential opportunities with School Based Health Clinics in RCSD - Support Community Youth Behavioral Health Services	- Continue STD testing clinics, and connection to IMPACT

Goal 2: Promote Well-Being and Prevent Mental and Substance Use Disorders			
Objective 1: Strengthen opportunities to build well-being and resilience across the lifespan.			
Proposed Actions	**Planned Activities**		
	URMC – Strong and Highland	**RRH – General and Unity**	**MCDPH**
A. Social and Emotional Learning Aid in integration of social emotional learning (SEL) tools in hospitals and schools	- Support Pediatric Telehealth Program at RCSD - Ongoing training of staff to identify and de-escalate patients manifesting distress - Continue Chat BOT program	- Continue Behavioral Health School Based Therapists - Support Integrated Substance Use Disorder and Mental Health Disorder Treatment in School-Based Health Center Sites - Continue SEL supports in R-Centers	
B. Supporting Older People Support care and resource access in nursing homes (e.g., transitional care, workforce, intergenerational programs)	- Support Transitions of Care - Continue telemedicine, on-site subspecialty consults - Support Comprehensive Care Management team linking with community resources and/or advocacy organizations	- Continue ElderOne/PACE - Support Transitions of Care - Expand Crisis Stabilization Services to avoid mental hygiene transports and Emergency Room visits for Mental Health and SUDs	- Continue as a training site for nurses' aides
C. Resilience Integrate and expand resilience training programs (e.g., for hospital employees, people with ACEs, food insecure)	- Consider opportunities for Trauma Informed Care assessment/improvement	- Continue behavioral health Best Practice series - Support Crisis Debriefing Team - Continue Language of Caring program - Consider opportunities for Trauma Informed Care improvement	- Continue trauma informed care initiative taking place in the Special Children's Services division of MCDPH
D. Strengthen Economic Supports Strengthen household financial security particularly by advocating for programs and policies that stabilize housing and increase food security	- Support Foodlink Partnerships - Continue representation on RMAPI - Support Health Home Care Management program - Continue Emergency Food Pantry - Continue first time home buyers' program - Raising min wage to $15/hour	- Continue Residential Housing Program - Skyview Park - Continue ElderOne/PACE - Support Foodlink Partnerships - Continue representation on RMAPI - Support Health Home Care Management program - Raising min wage to $15/hour	- Support current WIC program with potential expansion - Continue Lead Safe Housing program - Raising min wage to $15/hour
Objective 2: Facilitate supportive environments that promote respect and dignity for people of all ages.			
Proposed Actions	**Planned Activities**		
	URMC – Strong and Highland	**RRH – General and Unity**	**MCDPH**
E. Mental Health First Aid Coordinate and support mental health first aid (MHFA) training efforts	- Continue Golisano supporting programming for pediatrics - Support MHFA through the CHIW and consider opportunities for implementation	- Support MHFA efforts through the CHIW and consider opportunities for implementation	- Support MC Office of Mental Health and community-based organizations in offering trainings
F. Diversity, Equity, Inclusion Aid in integration of policies and programs addressing equity and anti-racism efforts	- Implementing the Equity and Anti-Racism Action Plan - Support Medical Legal Partnership program	- Continue DEI Community Health Disparities Task Force - Support Medical Legal Partnership - Continue Intensive Immersion Learning Series: Culturally Competent and Anti-Racist Care and Treatment for Black Families - LGBTQ+ Designation through OASAS	- Support Diversity Action Plan
G. Destigmatizing Language Work to remove existing stigmatizing language and advocate for policies for thoughtful messaging and stigma-reducing language, particularly on mental illness and substance use	- Support Health Literacy Team - Continue Stigmatizing Language Project to minimize the use of stigmatizing language in the EMR	- Continue behavioral health peer programs	- Continue IMPACT outreach to family members of patients with SUD and community training for Narcan and reduce mental health stigma

Community Engagement & Evaluation for 2022-2024 Implementation

The CHIW will continue to meet monthly throughout the implementation period of the 2022-2024 CHIP. Representatives from all hospitals, the local health department, the local office of mental health, and our community partners will continue to provide updates and feedback as the interventions are implemented. Progress updates will be given to the state of New York annually via the reporting structure provided, and community updates to local stakeholders and interested parties will be provided as requested. Community-wide meetings through the Maternal Child Health Advisory Group (MCH-AG) and the newly forming Mental Health Advisory Group (MH-AG) will ensure community participation and collaboration throughout the implementation period. Mid-course adjustments will be made if a change in approach or implementation is recommended by community partners. In addition, activities of the CHIW and progress measures will be posted on a newly forming website for community health improvement. The meeting schedule has been developed through 2022 and is in development for 2023 through 2024.

Table 6: Community Health Improvement Workgroup (CHIW) and Maternal Child Health Advisory Group (MCH-AG) Meeting 2022 Schedule

Date	Group
July 18, 2022	CHIW
August 15, 2022	CHIW
August 16, 2022	MCH-AG
September 19, 2022	CHIW
October 17, 2022	CHIW
November 16, 2022	MCH-AG
November 21, 2022	CHIW
December 19, 2022	CHIW

The Community Health Improvement Workgroup is comprised of representatives from each of the four hospitals, and the local public health department. Several other community-based organizations have joined the CHIW over the years and all are welcome to attend the meetings. Current membership includes:

University of Rochester Strong Memorial Hospital	Rochester Regional Health Rochester General Hospital
University of Rochester Highland Hospital	Rochester Regional Health Unity Hospital
Monroe County Department of Public Health	Common Ground Health
Center for Community Health & Prevention	Monroe County Office of Mental Health
211/Life Line	Rochester Regional Health Information Organization
Finger Lakes Performing Provider System	City of Rochester
United Way of Greater Rochester and the Finger Lakes	Monroe County Medical Society
Cornell Cooperative Extension	Systems Integration Project
African American Health Coalition	Latino Health Coalition

Dissemination

The executive summary and full text documents of the Monroe County Combined Community Health Needs Assessment and Improvement Plan for 2022-2024 will be made available on the websites of:

URMC: Strong Memorial Hospital and Highland Hospital

- ❑ https://www.urmc.rochester.edu/community.aspx

Rochester Regional Health: Unity Hospital and Rochester General Hospital

- ❑ https://www.rochesterregional.org/about/community-investment

Monroe County Department of Public Health

- ❑ https://www.monroecounty.gov/health-health-data

Physical copies of the Monroe County 2022-2024 CHNA/CHIP executive summary will be made available at the Center for Community Health & Prevention, Common Ground Health, and other community partner locations as requested. Printouts and digital copies of any CHIP related documents are always available upon request to interested parties.