
Rochester Regional

Introduction

Rochester, NY and its surrounding communities in the Western Rochester Region have a long history of collaboration to improve the health of the Monroe County residents. Hospital systems in Monroe County include:

University of Rochester Medical Center

- Strong Memorial Hospital

State Department of Health for the past f ifteen years,

November

Community Health Improvement Workgroup

Since the submission of the Monroe County Joint Community Service Plan for 2014- 2016, the Community Health Improvement Workgroup (CHIW) has been meeting regularly to implement the plan. The four hospital systems provide financial and in-kind resources for CHIW, and have supported a chair to convene the group. The team meets monthly or bi-monthly and has been doing so, in this format, since May 2012. Each hospital system has one representative spot on the team in addition to public health experts from the Monroe County Department of Public Heath (MCDPH), and community member expertise from the Finger Lakes Health System Agency (FLHSA). The University of Rochester Center for Community Health serves as a facilitating agency for this process.

Roster of Team Members (March 2015)

NAME	T

Community Health Improvement Plan/Joint Community Service Plan

Based on the Prevention Agenda, Monroe County will implement several strategies to PREVENT CHRONIC DISEASE through the following:

Priority Area 1: Reduce obesity in children and adults

Overarching Goal 1

Progress on Priority 1

		3/15) [redacted]e planned	Goal (12/16): < 28.5% (reduced by 5%)
1.1. By December 31, 2016, expand the worksite wellness package at each hospital system by 3 effective interventions, as measured by increase in each hospital system's score on the community Worksite Wellness Index.			
Measures of success: Overall average score of HOSPITALS on the Monroe County Worksite Wellness Index (all 4 hospitals completed the index by 1/2014)	Baseline: H1: 92/115 rank #2 H2: 90/115 rank #3 H3: 70/115 rank #19 H4: 55/115 rank #30		

Green Machine criteria. In March, Well-U will hold a Variety4Life tasting event during which employees will sample healthy vending options and provide feedback as to their vending choices. Well-U is working with Crickler Vending to increase signage, awareness, and information about the Variety4Life and Green Machine options and to provide incentives for purchasing these items.

- Well-U and Food and Nutrition are offering weekly ($5 gift cards to Café 601), monthly (2 week gym memberships), and quarterly (FitBit) raffle prizes for employees who purchase Be in Balance items in Café 601

Physical Activity: Well-U plans to increase fitness class offerings from a baseline of approximately 8 classes per week to 17 classes per week, targeted at employees at various off-site locations in addition to those currently held at the medical center and River Campus (1.4.1 x). Well-U added yoga classes at the new College Town offices, as well as Chair Yoga classes to off-site locations with less space. Well-U will pilot a Couch to 5K program this spring in collaboration with the YMCA, culminating in the Chase Corporate Challenge.

Local Healthy Food: The University of Rochester Farmers Market connects the UR community to sustainable foods from local farmers. Each week, more than 20 vendors offer seasonal produce, baked goods, artisan crafts, spices, meats and more. Market customers can meet the vendors, sample goods, and receive nutrition education and cooking tips. The vision for the market is that by increasing access to fresh, local and affordable food, the farmers market is in alignment with Well-U's mission to support employee health.

The market is open annually from 3-6pm on Wednesdays, March 4 through October 28. In addition, Well-U will offer onsite pickup for employees wishing to purchase food shares from the Good Food

Progress on Priority Area 2: Reduce illness, disability and death related to tobacco use

Goal 2: By December 31, 2016, reduce the percentage of adults 18+ who currently smoke by 5%, from 16% to below 15% among all adults. AND reduce the percentage of adults 18+ live in the city and who currently smoke by 7%, from 25% to 23% or less.			
Measures of success: Adults who currently smoke	Baseline: 16% (Monroe County Adult Health Survey)	Current (12/14) No new measures since inception	Goal (12/16): <15% (reduced by 5%)
Measures of success: Adults who live in the city and who currently smoke	Baseline: 25% (Monroe County Adult Health Survey)	Current (12/14) No new measures sinceinception	Goal (12/16) <23% (reduced by 7%)
2.1 Increase from 0-6 the number of hospitals and primary care practices (including FQHCs) that have a smoking cessation policy that includes YES Quitline Opt-to-Quit			
Measures of success: Number of hospitals and primary care practices (FQHC) that have a smoking cessation policy that includes Opt-to-Quit	Baseline: 0	Current (12/14): 4	Goal (12/16): 6
HOSPITAL	Intervention Successes		
Highland – URM	Highland has developed its smoking cessation opt-to-quit policy (very strong and well written) which will shortly be sent for board approval. URM is updating its electronic medical records (EMR) system to automatically send referrals to the quit-line. Focus is on the outpatient aspects of the		

	with Highland to develop similar language for a system-wide smoking cessation opt-out-quit policy. Highland's policy language is stronger, and the Strong policy board (Clinical Council) has encouraged stronger language to be submitted. URM is updating its electronic medical records (EMR) system to automatically send referrals to the quit-line. Focus is on the out-patient aspects of the EMR and procedures, which will then be moved to the in-patient side. A pilot program will be conducted at four sites system-wide between Strong and Highland, including the Solid Organ Transplant Clinic and the Cancer Center.
	With the merger between Unity and Rochester General, Unity has worked with Rochester General to develop and implement a shared policy. The implementation team includes represent [(U)3(n)5(i2T0 1 Tf -5(l)-3(u)-1(d)-58 0 Td [(m)-fcas)-

Unity - RHHS

SUMMARY

In order to increase smoking cessation in the communities of Monroe County, the hospital systems agreed to each pass and implement a policy that included "Opt-Out," a system of referral for patients within the hospital systems. Patients are all asked their smoking status, and current tobacco users are automatically enrolled in the NY State Quit Line program unless they "opt out" of the enrollment. This is a more aggressive version of the "fax-to-quit" or "refer-to-quit" iterations of enrollment.

To begin the process, Patricia Bax from the Roswell Park Cancer Institute was invited to present to the Community Health Improvement Workgroup and to the Smoking Cessation champions from each hospital about the Opt-Out program. Ms. Bax shared model policies, implementation strategies, scripts for patient conversations, and marketing tools among other resources. She also offered an evaluation and reporting plan through Roswell Park Cancer Institute that we will employ. The CHIW took an inventory of everyone's current cessation policy for patients and had each hospital champion develop a plan for policy intervention. All four hospitals have made significant progress, and several have adopted Opt-Out policies. In order to facilitate implementation, the Center for Community Health applied for and was awarded a grant from the New York State Health Foundation to advance the Prevention Agenda. Funds are being used to remove barriers at each of the hospitals around implementation. The greatest barriers appear to be inconsistencies in the various EMR systems and the ability of a given EMR to track smoking and to send referrals to the Quit Line. Through the CHIW, all four hospitals are able to discuss this process and work collaboratively to address common problems and compatibility issues.

Copies of all four current Opt-Out policies have been collected, along with policies from three unique health clinics in Rochester. Policies will be strengthened and/or adopted within the next six months in all circumstances. IT specialists are working with cessation champions to transform the EMR to be able to collect appropriate data and make automatic referrals.

Discussion with Roswell is ongoing around reporting and evaluation of the impact of adopting Opt-to-Quit. -

Some baseline data has been collected, including the demographics for Monroe County callers and referring physician/clinic information from fax-to-quit referrals. The demographic information is included as an attachment to this report.

Call volume to the NYS Quit line from Monroe County (March 2015)

Monroe County	Total Call Volume	Fax-to-Quit Referrals
Jan-14	315	22
Feb-14	472	38
Mar-14	640	41
Apr-14	540	29
May-14	601	29
Jun-14	665	30
Jul-14	811	35
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Progress on Priority Area 3: Increase access to high-quality chronic disease preventive care and management in clinical and community settings

Goal 3 By December 31, 2017, increase the percentage of adults 18+ years with hypertension who have controlled their blood pressure (below 140/90) by 10% from 66.7% (2012) of residents in the blood pressure registry to 73.4%.		
Measures of success: Adults with hypertension who have controlled their blood pressure	Baseline: 66.7% (JNC7)	Current:
System Agency in partnership with the Rochester Business Alliance developed a registry to track all patients in the area that are diagnosed with hypertension, in order to track control rates and to measure the impact of community interventions. Both hospital systems endorse the use of the registry and have shared patient data in a private and secure manner so that accurate community information could be gathered. Registry data is evaluated twice a year to measure control rates. The most recent control rates for December 2014 are expected to be reported in April 2015		
3.1. By December 31, 2016, develop a central repository for community-based resources that is sustainable and user-friendly, and link the repository to health care providers, including care managers and community health workers.		

Narrative:

- Anne Kerr from the MCDPH convened a team (MCDPH, HEART, FLSAHEC, the Community Wide Systems to Deliver Evidence Based Interventions to Address Chronic Disease Several ideas were discussed at the meeting to inform our next steps in intervention.

onto establish a resource guide especially geared to the diabetic

3.2. By December 31, 2016, expand the practice of meaningful data use to improve the management of patients with chronic disease, especially hypertension.
Narrative: There are several community initiatives underway to increase the rate of control among hypertensive patients. The Greater Rochester Health Foundation funded a variation project that involved RGH, Unity, Jordan and Culver that focused on provider transparency against peers in order to provide a consistent standard of care. HPIG plans to implement this program in all primary care sites. Unity is also rolling the process into other areas. There is the Practice Improvement Consultants PIC program that involves academic detailing. Also there is the NCQA, a patient centered medical home reporting structure that guides quality care. During 2014, while these initiatives continued to grow, the CHIW developed a way to catalog the interventions as well as where they were taking place. Next steps are to work with the RBA and the hospital systems to see where each hospital can grow and drill down to implement HTN control interventions. In addition to the hospital initiatives, it is important to note that we have a very robust community engagement program for HTN control. A high blood pressure ambassador program run by the FLHSA functions in churches, barber shops, beauty salons and Community Based Organizations to promote peer to peer counseling, heightened awareness and monitoring.

Initiatives for Controlling Blood Pressure in People Diagnosed with Hypertension

Initiative	Description	Highland	RGH	Strong	Unity	Community
Blood Pressure Advocate Program	Community members trained to work in clinics to meet with HTN patients to help them change behavior and navigate with their providers and social services	Highland Family Medicine	Genesee Health Services		Parkway	
Blood Pressure Registry	Twice per year (June and December) practices submit high blood pressure data to FLHSA for creation of a community-wide registry an addition to individual and system specific practice reports. Calculations include control rate and no BP reading in the past 13 months. Data received represents approximately 65% of hypertensive adults in Monroe County.	HFM submits data for the registry.	RGH submits data for all primary care practices.	Strong submits data for most primary care practices.	Unity submits data for all primary care practices.	Data is received ,A áB ÆAff¾Þ í* ± ! z/
[redacted]		trained MDs	RGH has one trained MD and two trained PharmDs	Strong does not participate in PIC program. They use their own internal program.	Unity has two trained MDs and one trained PA - growing	N/A