MONROE COUNTY, NEW YORK
2016 PROGRESS REPORT

Monroe County Joint Community Service Plan
2014-2016

For Health Systems
Serving Monroe County, including:

- **Rochester General Hospital**
- **Unity Hospital**
- **Strong Memorial Hospital**
- **Highland Hospital**

With collaboration from
Monroe County Department of Public Health
Finger Lakes Health System Agency
Finger Lakes Performing Provider System
UR Medicine – Center for Community Health

MARCH 2016

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
- Highland Hospital

Rochester Regional Health

- Rochester General Hospital
- Unity Health System

These hospitals have jointly filed a community service plan to the New York State Department of Health for the past fifteen years, most recently in November 2013. This partnership assures synergistic, non-duplicative meaningful strategic efforts towards the common goal of improving the population's health in the Monroe County community.

The 2013 Monroe County Joint Community Service Plan (JCSP) builds on a collaborative Community Health Needs Assessment and Community Health Improvement Plan that was developed jointly between the hospitals and the Monroe County Department of Public Health, with the assistance of the Finger Lakes Health System Agency representing several community organizations and initiatives. The Community Health Improvement Plan (CHIP) is based on the NY State Prevention Agenda 2013-2017.

Our CHIP and the JCSP are centered on the State Prevention Agenda 2013's first priority area: Preventing Chronic Disease, a decision based on our Community Needs Assessment. All hospitals and the MCDPH will concentrate on three focus areas within this priority:

1. Reduce Obesity in Children and Adults.
2. Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure.
3. Increase Access to High-Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings.

Our intervention goals, objectives and action steps will be tackled as a community with participation and representation of all hospitals, the health department and FLHSA.

The Monroe County hospitals are pleased and proud to be implementing this Joint Community Service Plan for 2014-2016.

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 both monthly and bi-monthly dependent on the needs of the group and has been doing so, in this format, since May 2012. Each hospital system has at least 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 (Updated March 2016)

Name	Title	Affiliation
Al Bradley	Senior Project Manager, High Blood Pressure Initiatives	Finger Lakes Health Systems Agency
Wade Norwood	Director of Community Engagement	Finger Lakes Health Systems Agency
Catie Horan	Regional Planner and Analyst	Finger Lakes Health Systems Agency
Theresa Green, PhD, MBA	Director of Community Health Policy & Education	Center for Community Health, URMC
Shannon Klymochko	Health Project Coordinator	Center for Community Health, URMC
Kathy Carelock	Manager Division of Epidemiology	Monroe County Department of Public Health
Anne Kern	Public Health Program Coordinator	Monroe County Department of Public Health
Bridget Wiefling, MD	Senior Vice President, Chief Quality and Innovation Officer	Rochester Regional Health
Alida Merrill	Sr. Director, Quality and Innovation Institute	Rochester Regional Health
Kathy Parrinello	Associate VP and COO	Strong Memorial Hospital
Mardy Sandler	Chief Social Worker	Strong Memorial Hospital
Cindy Becker	Chief Operating Officer	Highland Hospital
Lisa Thompson	Director of Public Relations	Highland Hospital
Laura Gustin	Project Manager (Project 4.b.ii)	Finger Lakes Performing Provider System
Tammy Fluitt	Project Manager (Project 4.a.ii)	Finger Lakes Performing Provider System

In addition to the core CHIW Team Members, each hospital has designated a champion for each of the three initiatives.

Roster of Champions (Updated March 2016)

	RRH Unity	RRH RGH	URMC Strong	URMC Highland
Worksite Wellness	Sarah Norton & Bridget Hallman	Sarah Norton & Bridget Hallman	Rachel Carmen	Kim O'Grady Jones
Smoking Cessation	Anthony Minervino	James Sutton	Scott McIntosh	Kathleen McCullough & Bilal Ahmed
Chronic Disease	Anthony Minervino	James Sutton	Steve Judge	Matthew Devine

Previously, The CHIW would meet every third month on the third Monday of the month at the Center for Community Health from 3:30-5:00pm. In order to continue to monitor the progress on the current JCSP while simultaneously developing the new CHIP/JSCP, the group has decided to meet more frequently. Specifically, the workgroup is scheduled to meet every third Monday of every month. Minutes from each meeting are available upon request.

Community Health Improvement Work Team Meetings (2012-2016)

Date	# of Attendees	Date	# of Attendees
June 20, 2012	5	February 10, 2014	10
July 24, 2012	8	April 21, 2014	7
August 22, 2012	6	May 19, 2014	6
October 15, 2012	8	June 16, 2014	9
November 12, 2012	7	August 18, 2014	12
December 17, 2012	6	October 20, 2014	8
January 21, 2013	5	January 12, 2015	11
February 6, 2013	9	March 9, 2015	11
March 25, 2013	8	May 18, 2015	11
April 22, 2013	7	July 20, 2015	7
June 19, 2013	6	September 21, 2015	9
September 16, 2013	8	November 16, 2015	11
October 21, 2013	7	January 11, 2016	12
November 18, 2013	6	February 8, 2016	14
January 13, 2014	11	March 21, 2016	12

Community Health Improvement Workgroup - 2016 Remaining Meetings

Date	Agenda
April 18, 2016	Development of the new CHIP/JCSP
May 16, 2016	Chronic Disease Updates/ Development of the new CHIP/JCSP
June 20, 2016	Development of the new CHIP/JCSP – meet only if need be
July 18, 2016	Smoking Cessation and Chronic Disease Updates/Development of the new CHIP/JCSP
August 15, 2016	Meet only if need be
September 19, 2016	Smoking Cessation and Chronic Disease Updates
October 17, 2016	Meet only if need be
November 21, 2016	Smoking Cessation and Chronic Disease Updates
December 19, 2016	Final Report Due/ New CHIP/JCSP Due

2014-2016 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: By December 31, 2016, reduce the percentage of adults age 18 years and older who are obese by 5%, from 30% (Monroe County AHS, 2012) to below 28.5% among all adults.

Objective 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.

Objective 1.2. By December 31, 2016 increase from 0 to 10 the number of small to medium worksites that complete the worksite wellness index annually and implement at least one improvement.

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

Overarching Goal 2: By December 31, 2016, reduce the percentage of adults ages18 years and older who currently smoke by 5%, from 16% (Monroe County AHS, 2012) to below 15% among all adults. Also, reduce the percentage of adults ages 18 years and older who live in the City and who currently smoke by 7%, from 25% to 23% or less.

Objective 2.1: By December 31, 2016, increase from 0-6 the number of hospitals and primary care practices (including hospital based CMMI practices and/or FHQCs) that have a smoking cessation policy, and which includes linkage to the NYS Quitline Opt-To-Quit Program (Source: Community Health Improvement Work Team/GRATCC).

Priority Area 3: Increase access to high-quality chronic disease preventive care and management in clinical and community settings, especially among high risk (low SES) populations.

Overarching Goal 3: By December 31, 2016, increase the percentage of adults ages 18+ years with hypertension who have controlled their blood pressure (below 140/90) by 10%, from 66.7% (2012) to 73.4% for residents in the blood pressure registry.

Objective 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.

Objective 3.2. By December 31, 2016, expand the practice of meaningful data use to improve the management of patients with chronic disease, especially hypertension.

2016 Joint Community Service Plan Progress Report

Progress on Priority Area 1:
Reduce Obesity in Children and Adults

<table>
<tr><td colspan="4">Goal 1: By December 31, 2016, reduce the percentage of adults age 18 years and older who are obese by 5%, from 30% (Monroe County AHS, 2012) to below 28.5% among all adults.</td></tr>
<tr><td>Measures of success:

Adults who are obese</td><td>Baseline:

30%</td><td>Current (3/16)

Not updated since planned</td><td>Goal (12/16):

< 28.5%

(Reduced by 5%)</td></tr>
<tr><td colspan="4">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.</td></tr>
<tr><td><u>Measures of success:</u>

Overall average score of HOSPITALS on the Monroe County Worksite Wellness Index (all 4 hospitals completed the index by in 2014 and then again in the Fall of 2015)</td><td>Baseline:

H1: 90/117 rank #4

H2: 70/117 rank #20

H3: 55/117 rank #33

H4: 92/117 rank #2</td><td>Current (3/16):

H1: 80/154 rank #10

H2: 105/154 rank #7

H3: 62/154 rank #15

H4: 127/154 rank #3</td><td>Goal (12/16):

Improvement in rank or score (as a %) for each of the hospitals over 3 years</td></tr>
<tr><td><u>Measure of success:</u>

Number of new effective interventions completed</td><td>Baseline:

0</td><td>Current (3/16):

26*

<u>Previous Report:</u>
10</td><td>Goal (12/16):

12</td></tr>
<tr><td>HOSPITAL</td><td colspan="3">INTERVENTION SUCCESSES</td></tr>
<tr><td colspan="4">Strong Hospital (University of Rochester)</td></tr>
<tr><td colspan="4"><u>Recap from Last Report:</u>

● <u>Vending Machines</u> - Efforts made to increase the healthy food options available in vending machines in addition to identifying healthy options in the cafeteria with the tagline “be in balance”.
● <u>Physical Activity</u> – Increased fitness class offerings by 50%. New classes ranged in variety and location.
● <u>Local Healthy Food</u> – Establishment of The University of Rochester Farmers Market.</td></tr>
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Updated Report (3/2015-Present):

Since the 2014 Progress Report, the University of Rochester has launched a variety of new programs that have impacted their wellness program dramatically. Additional efforts have been placed on improving engagement of existing programs; however the newly added programs are highlighted below. In terms of long-term gains from these programs, it is still too early to tell, but the University plans to continue monitoring the effectiveness.

New Lifestyle Management Programs

- Physically Active You – An 8-week lifestyle management program in which an exercise physiologist helps participants improve cardiovascular and muscular fitness, increase strength and flexibility, and prevent injuries.
- Basics for Building a Healthy Lifestyle – A 4-week lifestyle management program that teaches participants how to prioritize health goals and monitor diet and exercise.

YMCA Partnership

- Become a Runner – Become a Runner is a nine-week training program to help new runners safely prepare for a 5k. Interest and enrollment in Become a Runner is strong each session, and as results the University will offer the program in Spring and Fall.
- Discounted YMCA Memberships – The University now offers discounted YMCA memberships to employees. This discount is applicable at all greater Rochester and Canandaigua locations.

Additional New Programs

- FIT1 – FIT1 was added to the fitness class line-up as a result of employee demand for a higher intensity class. FIT1' is a fitness class using body weight and the surrounding environment to get a full body workout, typically held outside. Since its inception, this class has been filled to maximum capacity and had positive participant feedback. As a result the University has added a second FIT1 class.
- Shop with an RD – The Shop with a RD Program provides employees with the opportunity to tour a local grocery store with a registered dietician as they discuss the ways in which to make healthy choices.
- Farmers Market Expansion - According to our Strong Worksite Wellness Champion, the Farmers Market is no longer just a pilot, but is an established program that employees expect, love, and depend on so much that they requested a winter market. In order to accommodate this desire, the University hosted two special winter holiday markets.
- Weekly Wellness Newsletter - This past year, the University improved and enhanced their communications plan to include a weekly newsletter, "Weekly Wellness", highlighting upcoming wellness programs, and a weekly farmers market-specific newsletter.

Highland Hospital (University of Rochester)

Recap from Last Report:

- Vending Machine Improvements - Highland replaced processed and fatty foods with healthy options in all vending machines.
- Cafeteria Improvements – Healthier cafeteria options were made available to employees and visitors alike.
- Good Food Collective Pilot Program – This initiative provided participants with access to healthy local produce.
- Physical Activity Improvements - Beautification of stairways to increase the appeal and use in addition to provided additional opportunities for physical activity including scavenger hunts and fitness classes.

Updated Report (3/2015-Present):

According to the Worksite Wellness Champion for Highland Hospital, the organization set a goal of increasing their fitness class offerings by four in an effort to increase the number and availability of classes from 2014. One class in particular that was added was the 'Yoga Fundamentals Classes' that was held throughout 2015. Initially, this class was well attended and participation was high. However, attendance did continually decline throughout the year. The Worksite Wellness team at Highland attributed these changes in participation to seasonal changes including warm summer and holiday months where employees were busy both professionally and personally which inhibited their ability to attend the class. In an effort to increase participation, additional classes were added at varying times. However, this did not make a substantial difference and eventually this class was cancelled. In order to accommodate for the cancellation of one class, Highland did make it a priority to provide a new programs in its absence including one time workshops titled 'Laughter Yoga' and 'Healthy Heart Relaxation'. Although the new interventions offered to employees had not been as successful as the Worksite Wellness team had planned or hoped, existing programs still continued to be incredibly successful.

Existing Programs that Remained Successful in 2015:

- YMCA Membership Program - This program continued to see success as membership numbers increased to 150.
- Good Food Collective – The Good Food Collective continues to be well received by employees and is a successful intervention at Highland.
- Eat Well, Live Well – Although this was the last year that 'Eat Well, Live Well' will run, it was still very successful at Highland.

Looking to 2016: Every year, Highland Hospital hosts a Wellness Fair – an event that is well attended by employees. During this event, vendors are invited to attend to promote health and wellness. During 2015, there were over 150 employees in attendance. These 150 employees participated in a Worksite

Wellness Survey – the results of which have been used to set goals for 2016 by evaluating the interest in the future activities employees may consider participating in. These activities are listed below.

- Plant-Based Eating Course - This 6 week course taught by Ted Barnett, M.D., allows participants to learn the rationale behind eating a whole-food, plant-based diet. Participants will discover that eating a plant-based diet is abundant as well as optimal for your health. This intervention will be offered on Tuesdays from April 19th - May 24th, 2016.
- Self Defense Classes – Estimated to begin Fall of 2016
- Hike Yoga – Estimated to begin Fall 2016
- Weight Watchers – Although this intervention was not wildly successful in 2015, Highland has recently received interested in the program as a result from their Wellness Fair Survey. they will be holding an information /registration session on April 7, 2016 with a goal of registering a minimum of 12 participants for a 12 week program.
- New Lunch and Learn Workshops – Examples include, "How to beat burnout", and "mindful meditation" and holiday food safety classes.
- Ongoing Annual Initiatives include: Highland Hospital Lilac Run, Highland Spinouts American Diabetes Tour, Corporate Challenge Run, and annual Biometric Screenings.

Rochester General Hospital and Unity Hospital (RRH)

Recap from Last Report:

- Physical Activity - Grand opening of the Riedman Wellness Center that provides space and opportunity for employees and their families to use state of the art exercise equipment.
- Breastfeeding - Integration of newly designed breastfeeding rooms.
- Vending Machine/Cafeteria – "Good 2 U Food" program, removal of fried foods, new smaller entrée options at a lower cost, labeling and identification of good food choices in vending machines.

Updated Report (3/2015-Present):

In July of 2014, Rochester General Hospital and Unity Hospital underwent a merger in which both systems are now are part of the Rochester Regional Health system. As a result, the two organizations spent much of 2015 navigating the new working dynamics of the merger. However, despite the changes happening system wide, the Worksite Wellness Champions for the system as a whole was able to make improvements and expand their wellness programming. These programming efforts are highlighted below.

Get Moving - RRH is increasing their offerings of physical activity programs both inside and outside of work that focus on weight management and exercise.

Eat Healthy – In addition, they are also launching nutrition programs and activities that promote the consumption of fruits , vegetables, whole grains while also educating employees about processed foods, healthy fats, healthy proteins and healthy carbohydrates

Live Well – Additional programs are launching that address not only social, emotional, spiritual, and

financial wellbeing, but also medical self-care and alcohol/tobacco programs.

GRIPA (Chronic Disease Management) – Greater Rochester Independent Practice Association works with RRH to ensure that patients are receiving the best care. Currently, any RRH employee who is recently diagnosed with a chronic disease has the opportunity to work closely with GRIPA's team of nurses and care managers who work to ensure that the patients receives the education and health care needed to manage their disease appropriately.

1.2. By December 31, 2016, increase from 0 to 10 the number of small to medium worksites that complete the worksite wellness index annually and implement at least one improvement.

Measures of success:	**Baseline:**	**Current (3/16):**	**Goal (12/16):**
Number of small to medium sized businesses completing the Monroe County Worksite Wellness Index	35 of the 73 complete WWI were from organizations with less than 100 employees Average score: 36.9%	5 of the 43 completed WWC were from organizations with less than 100 employees Average Score: 44.4%	Improvement in rank or score (as a %) for each the businesses with less than 100 employees
Measure of success:	Baseline:	Current (3/16):	Goal (12/16):
Number (or above) implementing at least one improvement	0	0	10

SUMMARY:

The Healthy Worksite Action Team is comprised of local worksite wellness experts, and is chaired by Dr. Cynthia Reddeck-LiDestri, VP of Health and Wellness at LiDestri Foods. The group meets bi-monthly and was instrumental in the construction, testing and marketing of the Worksite Wellness Index which has since been renamed the Worksite Wellness Checkup.

In addition to the Worksite Wellness Checkup, the group works to identify wellness-related needs of local employers and wellness professionals and develop resources that will help meet those needs. These resources include workplace curriculums on blood pressure management, toolkits for creating a worksite wellness work-plan, email blasts on a variety of wellness topics, webinars on lactation support and the ABCs of cardiovascular health, and workshops. At the workshops, opportunities to network with wellness mentors are priority.

We partner with the Rochester Business Alliance (RBA) to offer the workshops. Following the first workshop held in February 2014, the vast majority of the participants (42) said they would definitely

participate in this type of training again. Our goal for 2015 was to continue to partner with the RBA to determine the best way for the hospital worksite champions to assist small and medium sized businesses in improving their wellness initiatives. Although willing to help, within the last year the hospital systems have not assisted any of these organizations in their worksite wellness endeavors.

The group was able to identify ways in which the hospitals could help local small to medium sized businesses, yet ultimately none of the proposed ideas were viewed as feasible. Specifically, the group explored the idea of mentorship in which the large hospital systems would adopt small to medium sized organizations with the hope of helping them to develop a sustainable worksite wellness initiative. Each hospital felt that they simply did not have the capacity to take on such an undertaking. Although ultimately, the research reinforced the existing hesitation from the hospital by noting that mentorship needed to be meaningful to make an impact. More specifically, that mentorship needed to involve more than just a large organization sharing their successes and failures with a small to medium sized organization in order for smaller organizations to take recommendations and pearls of wisdom seriously.

As we look to the future, the CHIW will continue to monitor the progress each hospital makes with their worksite wellness programming, but we are no longer exploring ways to help small to medium sized business create and/or expand their wellness programming.

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+ who 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 (3/16) 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 (3/16) No new measures since inception	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 NYS 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 (3/16): 4 *<u>Previous Report:</u> 4 (no change noted)*	Goal (12/16): 6
HOSPITAL	**POLICY UPDATES**		
Strong Hospital (University of Rochester)	*<u>Policy Passed</u>* - Strong has developed a policy that includes the use of Opt-to-Quit, and it has been approved by Senior Leadership within the Hospital.		
Highland Hospital (University of Rochester)	*<u>Policy not Passed</u>* - Highland Hospital has developed a policy supportive of the Opt-to-Quit program, and the leadership stands ready to adopt this policy. However, successfully implementation of the opt-to-quit process into the EMRhas not occurred to date. Highland recommends this be completed prior to policy adoption. Once implementation		

	success is inevitable, the draft policy should be approved easily. We are optimistic that it will be a live policy in the future.
Rochester General Hospital (Rochester Regional Health System)	*Policy Passed* - RGH has developed a policy and it has been approved by Senior Leadership within the Hospital.
Unity Hospital (Rochester Regional Health System)	*Policy not Passed* - Unity and RGH have recently finalizing the details of their merger under Rochester Regional Health. As a result of the merger, Unity will begin using RGH's EMR system. Once RGH's EMR system is fully functioning at Unity, Unity will in turn implement an Opt-to-Quit policy; a plan in which senior leadership has already verbally approved.
Oak Orchard Community Health Center (Federally Qualified Health Center)	*Policy Passed* - Oak Orchard has developed a policy and it has been approved by Senior Leadership within the Hospital.
Anthony Jordan Health Center (Federally Qualified Health Center)	*Policy Passed* - Anthony Jordan has developed a policy and it has been approved by Senior Leadership within the Hospital.

SUMMARY OF THE OPT-TO-QUIT INITAITIVE:

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-to-Quit," 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.

In 2014, 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-to-Quit program. During this presentation, Roswell shared model policies, implementation strategies, scripts for patient conversations, and marketing tools among other resources. They also offered an evaluation and reporting plan through Roswell Park Cancer Institute that we have access to and are able to pull reports from.

SUPPLEMENTARY NYSHF GRANT AND THE SMOKING CESSATION SYNERGY MEETING:

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 were used to remove barriers at each of the hospitals around implementation. Additional funds from this grant were used to host a Smoking Cessation Synergy Meeting. The goal of this meeting was to bring a variety of professionals together to join in a robust and action-oriented conversation about the importance of

the Opt-to-Quit™ program and the logistical steps of EMR and policy changes needed in our Hospitals and FQHCs to make the electronic transferal of patient information to the NYS Quitline a reality.

This event was widely successful in bridging the gap between organizations and systems and has helped to push the agenda of this initiative forward. We had 35 attendees, majority of which were EMR Specialists and Program Coordinators but there was also Physicians, Registered Nurses, Counselors, Educators, Nurse Practitioners, Administrators, Quality Improvement Specialists, Physicians Assistants, and Public Health Professionals in attendance. The day consisted of four presentations and two breakout sessions, each of which allowed those from varying organizations with similar goals to comes together to discuss the ways in which push this agenda forward at their respective agency.

Speaker	**Topic**
Rachel Boykan, MD, FAAP Clinical Associate Professor, Department of Pediatrics Stony Brook University School of Medicine Associate Director, Pediatric Residency Training Program Attending Physician, Stony Brook Children's Hospital	Keynote Presentation - *In 2012, Rachel spearheaded a partnership between Stony Brook Children's Hospital and the NYS Opt-to-Quit™ Program – the first implementation of this program at a Children's Hospital. She will join us to discuss the lessons learned from her experience in an effort to help facilitate the necessary policy and IT changes needed in our local Hospitals and FQHC's to make implementing Opt-to-Quit™ a reality.*
Theresa Green, PhD, MBA Director of Community Health Education and Policy Center for Community Health, URMC	Overview of Community Health Needs Assessment and Improvement Planning
Patricia Bax, RN, MS Marketing and Outreach Coordinator Roswell Park Cessation Services NYS Smokers' Quitline - Roswell Park Cancer Institute	Overview of the Opt-to-Quit Program
Marcy Hager, MA Project Director Center of Excellence for Health Systems Improvement for a Tobacco-Free NY	Overview of the Statewide EHR Super User Workgroup
Breakout Session	**Topic**
Breakout Session A	IT Table Discussion
Breakout Session B	Implementation Table Discussion

SUMMARY OF ELECTRONIC MEDICAL RECORD CHANGES:

Strong Hospital and Highland Hospital (University of Rochester): Strong and Highland are currently working together to make the changes to the EMR system. Although Strong has a passed policy and Highland is prepared to do so but prefers that the EMR live transfer be in place before enacting a policy change, the two are partnering because both operate under the University of Rochester Medical Center system and therefore any EMR changes would be applicable system wide. Both organizations seem to

be struggling to identify an EMR champion to spearhead the live electronic transfer in light of several other EMR priorities. However, in recent weeks it does appear that they have identified both a clinical practitioner to inform decisions and an IT specialist to enact the necessary changes. Resources and suggestions with specific emphasis on the importance of working closely with Roswell have been recommended to assist with the implementation. As we move through 2016, it is anticipated that Strong and Highland will be able to make changes to the EMR that make Opt-to-Quit a reality. There are several clinics within UR who are working to implement O2Q within their area, however our goal is system-wide implementation.

Rochester General Hospital (RRHS): RGH was recently able to successfully make changes to their EMR to support the Opt-to-Quit initiative. These changes went live with their EMR in early February and an immediate increase in referrals to the Quitline was captured through Roswell's reporting partner website. Specifically, between January and February, RGH had one referral to the Quitline and immediately after implementation there were 30 referrals between February and March. Currently the initiative has only been rolled out in the inpatient setting. Next steps include developing training to target the Nursing staff in addition to implementing O2Q in the outpatient setting.

Unity Hospital (RRHS): As previously noted, Unity is now part of Rochester Regional Health System (RRHS). Currently, RRHS is focused on implementing Opt-to-Quit within the EMR system used by their affiliate RGH with the goal to implement at Unity once they are also using the same EMR system. Now that RGH has successfully implemented Opt-to-Quit, Unity simply has to wait for their EMR system to switch over to that of RGH and then they too will be impacted by the changed made at RGH allowing them to participate in the Opt-to-Quit initiative.

Oak Orchard Community Health Center (FQHC): In late 2015, Oak Orchard Community Health Center (OOCHC) agreed to make changes within their EMR system (E-Clinical Works) that would electronically submit patient referral information from their EMR to the New York State Smokers Quitline. Although OOCHC does have a location in Monroe County, they first piloted the use of this function at a site outside of Monroe County (Albion). They anticipate that they will be pushing these changes to all of their offices in the very near future and at that point we would anticipate observing an increase in the number of documented referrals to the Quitline among Monroe County residents. Although the process OOCHC has implemented does increase the ease of referral by utilizing an electronic fax model of communication with the Quitline, it is not currently sending patient information via a complete electronic transmission of information. As the work through 2016, we will continue to explore this option with the hopes of successfully integrating an electronic transmission by the end of 2016. OOCHC is currently working with Roswell and the New York State Quitline to discuss the ways in which to make these changes.

Anthony Jordan Health Center (FQHC): Similarly, Anthony Jordan Health Center (AJHC) agreed to participate in this project during the late months of 2015. Luckily, both OOCHC and Jordan operate using the same EMR, E-Clinical Works (ECW). Although, to date AJHC has not implemented the necessary EMR changes that would support Opt-to-Quit, they have been working closely with OOCHC. Specifically, OOCHC shared the way in which adapted ECW to create the changes that allow for the clinician to refer

a patient to the New York State Quitline via a prepopulated electronic fax form. For this and a variety of other reasons, Jordan will also be implementing Opt-to-Quit by utilizing an electronic fax. As we move forward we will continue to explore complete electronic transmission of information.

MONROE COUNTY DATA (2014-Present):

As the data below reflects, the highest numbers of referrals to the Quit Line seen to date occurred during this past month (March, 2016). This increase is assumed to be a result of the EMR changes made at Rochester General Hospital that allow for an easy electronic referral to the New York State Quitline. As continued efforts are made to integrate the necessary EMR changes into the other health systems, it is assumed that these numbers will continue to increase. Supplementary employee training estimated to take place in 2016 about Opt-to-Quit and the associated EMR changes should also help to increase the number of referrals.

Total Call Volume to the NYS Quitline and Total Fax-to Quit Referrals per Month

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
Aug-14	424	28
Sep-14	428	11
Oct-14	352	29
Nov-14	357	12
Dec -14	324	27

Monroe County	Total Call Volume	Fax-to-Quit Referrals
Jan – 15	602	33
Feb -15	348	28
Mar -15	382	24
Apr -15	405	21
May -15	322	19
Jun -15	287	28
Jul -15	506	18
Aug -15	274	24
Sep -15	249	28
Oct -15	252	29
Nov -15	243	20
Dec -15	260	15

Monroe County	Total Call Volume	Fax-to-Quit Referrals
Jan – 16	407	20
Feb -16	445	21
Mar -16	353	84
Apr -16	TBD	TBD
May -16	TBD	TBD
Jun -16	TBD	TBD
Jul -16	TBD	TBD
Aug -16	TBD	TBD
Sep -16	TBD	TBD
Oct -16	TBD	TBD
Nov -16	TBD	TBD
Dec -16	TBD	TBD

New York State Smokers' Quitline

Total Enrolled = 2,478 - Monroe County

Participants Enrolled by Phone and Online. Enrollees are only counted once for the following. If they enrolled more than once, the earliest is used for enrollment data. Missing data is not included in the Totals for each characteristic. Note: Education, Income, Mental Health, and Years Smoked questions are only asked in the phone interview.

From 01/01/2015 To 03/27/2016

01. Age	Count	Percent
Under 18 Years	0	.00
18 to 24 years	158	6.38
25 to 34 years	571	23.04
35 to 44 years	461	18.60
45 to 54 years	600	24.21
55 to 64 years	476	19.21
65+ years	202	8.15
Total	2468	100

02. Gender	Count	Percent
Male	1089	43.95
Female	1387	55.97
Total	2476	100

03. Pregnant or BreastFeeding	Count	Percent
Pregnant	17	1.69
BreastFeeding	5	.50
Women < 55 Not Pregnant or BreastFeeding	985	97.82
Total	1007	100

04. Hispanic / Latino	Count	Percent
Hispanic or Latino	157	6.90
Not Hispanic or Latino	2117	93.10
Total	2274	100

05. Race / Ethnicity	Count	Percent
White	1613	75.69
Black or African American	431	20.23
Native American Indian	19	.89
Asian or Pacific Islander	12	.56
Other & Multiracial	56	2.63
Total	2131	100

New York State Smokers' Quitline

Total Enrolled = 2,478 - Monroe County

Participants Enrolled by Phone and Online. Enrollees are only counted once for the following. If they enrolled more than once, the earliest is used for enrollment data. Missing data is not included in the Totals for each characteristic. Note: Education, Income, Mental Health, and Years Smoked questions are only asked in the phone interview.

From 01/01/2015 To 03/27/2016

06. Language	Count	Percent
English	2461	99.31
Spanish	14	.56
OTHER	2	.08
Turkish	1	.04
Total	2478	100

07. Insurance Status	Count	Percent
Private	915	42.30
Uninsured	192	8.88
Medicaid	815	37.68
Medicare	241	11.14
Total	2163	100

08. Household Income	Count	Percent
Less than $15,000	377	51.15
$15,000 to $30,000	216	29.31
$30,001 to $45,000	85	11.53
$45,001 to $80,000	45	6.11
Over $80,000	14	1.90
Total	737	100

09. Education Level	Count	Percent
Less than grade 9	22	2.09
Grades 9-11	151	14.37
Obtained GED	96	9.13
High School	378	35.97
Technical or Trade school	42	4.00
Some College	232	22.07
Obtained a College Degree	130	12.37
Total	1051	100

10. Chronic Conditions	Count	Percent
Asthma	300	12.83
Cancer	81	3.46

New York State Smokers' Quitline

Total Enrolled = 2,478 - Monroe County

Participants Enrolled by Phone and Online. Enrollees are only counted once for the following. If they enrolled more than once, the earliest is used for enrollment data. Missing data is not included in the Totals for each characteristic. Note: Education, Income, Mental Health, and Years Smoked questions are only asked in the phone interview.

From 01/01/2015 To 03/27/2016

10. Chronic Conditions	Count	Percent
Diabetes	161	6.89
Emphysema / COPD	204	8.73
Heart Disease	60	2.57
Pre-Diabetes	57	2.44
High blood pressure / Hypertension	442	18.91
Kidney Disease	21	.90
Stroke	28	1.20

11. Mental Health	Count	Percent
Anxiety	352	27.78
Depression	363	28.65
Bipolar disorder	114	9.00
Alcohol or Drug abuse	151	11.92
Schizophrenia	32	2.53

12. Amount Smoked Daily	Count	Percent
1 to 9	204	8.84
10 to 19	1008	43.69
20 to 29	833	36.11
30 to 39	151	6.55
40+	111	4.81
Total	2307	100

13. Years Smoked	Count	Percent
Less Than 1 Year	43	3.33
1 to 5 years	99	7.66
6 to 10 years	131	10.14
11 to 15 years	152	11.76
16 to 20 Years	202	15.63
21 or more Years	665	51.47
Total	1292	100

New York State Smokers' Quitline

Total Enrolled = 2,478 - Monroe County

Participants Enrolled by Phone and Online. Enrollees are only counted once for the following. If they enrolled more than once, the earliest is used for enrollment data. Missing data is not included in the Totals for each characteristic. Note: Education, Income, Mental Health, and Years Smoked questions are only asked in the phone interview.

From 01/01/2015 To 03/27/2016

14. Source of Quitline Number	Count	Percent
TV	803	32.41
Called the NYS Quitline before	370	14.93
Clinic/Health Care Provider	316	12.75
Internet/Website/Web Search	228	9.20
Family- Friend who heard about QL	158	6.38
Family- Friend (QL Client)	143	5.77
Other	105	4.24
Radio	95	3.83
Fax-To-Quit	83	3.35
Workplace / Office	58	2.34
NYC Quits	31	1.25
Health Insurance Co.	16	.65
E-mail Message	9	.36
Newspaper	9	.36
Community Organizations / Partners	7	.28
311	6	.24
Pharmacist	6	.24
Cessation Center	5	.20
Flyer	4	.16
211	3	.12
Mailing	3	.12
QuitLine Literature/Materials	3	.12
Billboard	2	.08
Dentist/Dental Hygienist	2	.08
Don't Know	1	.04
Bus Shelter	1	.04
Addiction Program/Services	1	.04
QuitNet	1	.04
School	1	.04
Social Services	1	.04
Taxi	1	.04
Phonebook	1	.04
Prison - Dept. of Corrections	1	.04
Total	2474	100

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, 2016, increase the percentage of adults ages 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:	**Baseline:**	**Current (3/16)**	**Goal (12/16):**
Adults with hypertension who have controlled their blood pressure	66.7% As of Dec 2012 (JNC7) Of the 104,300 patients in the registry	71.3% As of June 2015 (JNC7) Of the 121,337 patients in the registry *Previous Report: 70.1% of the 114,500 patients in the registry as of June 2014 (JNC7)*	73.4% (Increased control by 10%)

Several years ago, Finger Lakes Health System Agency in partnership with the Rochester Business Alliance, now the Greater Rochester Chamber of Commerce, 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.

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.

Recap from Last Report:

- Development of the Diabetes Prevention Program Resource Directory
- Preliminary distribution of the Resource Directory

Updated Report (2015-Present):

The Diabetes Coalition* continues to meet regularly as they work to update the Diabetes Prevention Program (DPP) Resource Directory for 2016. The currently version of the Resource Directory is available on the Monroe County Department Public Health website. In addition, the Resource Directory can be found on the Monroe County Medical Society's website and the YMCA's webpage. To view a

copy of the DDP Resource Directory, please refer to the link below.

http://www2.monroecounty.gov/files/health/DataReports/Greater%20Rochester%20Diabetes%20Guide-.pdf

Unfortunately, the group has been struggled to make much progress on identifying and implementing a means of sharing the DPP Resource Directory through the Electronic Medical Record system. Although, the Diabetes Coalition does continue to meet to network and share strategies for driving referrals to the Diabetes Prevention Program. In addition, The American Diabetes Association has a grant through June to also identify ways in which to increase referrals to the Diabetes Prevention Program. Collectively, it is anticipated the work of all involved parties will help to move this agenda.

*The following organizations are all represented on the Diabetes Coalition: Rochester Regional Health System, University of Rochester's Center for Community Health, the YMCA, the Office for The Aging, Anthony Jordan Health Center, Excellus, Interdenominational Health Coalition, Visiting Nurse Services, the American Diabetes Association, and the Monroe County Department of Public Health.

3.2. By December 31, 2016, expand the practice of meaningful data use to improve the management of patients with chronic disease, especially hypertension.

Updated Report (2015-Present):

Since our last progress report, the group has continued to monitor and improve upon our ability to integrate meaningful use of data to enhance the way we manage patients with chronic conditions. Particularly, Monroe County is interested in using the local registry data of patients diagnosed with hypertension to monitor and prompt interventions designed at increasing the control of blood pressure among these patients.

Prominent business members of the city's Chamber of Commerce, in collaboration with a primary community collaborating organization developed the High Blood Pressure Collaborative after deciding to target hypertension as a major barrier to community health. The hospitals in our county have been instrumental in several key Collaborative initiatives to achieve these goals. Four key components, that are dependent on hospitals continued participation, will be highlighted: Overall Metrics and Measurement, Blood Pressure Advocate Program, Practice Improvement Consultants and Worksite Wellness.

Overall Metrics and Measurement: The High Blood Pressure Collaborative collects patient information on those diagnosed with hypertension in our region. Extensive EMR data is systematically shared (with obvious required patient protection safeguards in place) from each of the HANYS health systems primary care practices. Information includes diagnoses, provider, latest blood pressure readings, race and ethnicity, demographic and quality data among others. Information is collected into a centralized Blood Pressure Registry which enables the Collaborative to assess control rates over time, and where

disparities across race and ethnicity, as well as, socio-demographic dimensions exist. In turn, this information is shared with the practices and informs strategy for the Collaborative and for the hospitals and clinics.

Blood Pressure Advocate Program: Established in 2013, the Blood Pressure Advocate Program is managed by one of the 4 HANYS hospitals and employs four full-time community health advocates embedded into five community health care clinics led by the HANYS hospital partners. Advocates are community members who's roles and responsibilities include conducting an initial health intake with the hypertensive patient (1 hour), providing education and identifying barriers to successful BP control and creating a list of personal goals and actions the patient can use to make healthier choices, reviewing progress on goals/actions regularly with the patient and establishing community and clinical connections for the patient. In addition the Advocates enter appropriate data into the electronic medical record and provide feedback to the patient's provider(s) while following up with patients who have graduated out of the program.

Practice Improvement Consultants: In an effort to improve the effectiveness of local practices' ability to manage blood pressure control rate, the Practice Improvement Consultant (PIC) Program was created. Representatives from the local hospitals are trained as PICs for high blood pressure management through an academic detailing initiative. These specially trained physicians provide one-on-one training to other physician on the best practices and new evidence-based approaches to treating high blood pressure. In addition, practices that are deemed high performers through the Registry data were visited to explore how they were able to be successful. Materials were collected from these practices to support practice improvement visits to the other practice sites. As of June 2015, seven Practice Improvement Consultants work with 20 practices that have a total of 24,700 hypertensive patients.

Additionally, all practices associated with the hospital systems as well as most community practices are certified Patient Centered Medical Homes, a nationally recognized reporting structure that guides quality care. In addition to the hospital initiatives, the collaborative utilizes very robust community engagement programs centered on churches, barber shops, beauty salons and Community Based Organizations to promote peer to peer counseling, heightened awareness and monitoring.

UPDATED MEASURES AND METRICS FOR THE REGISTRY:

The method of calculating control rates has been amended to be more consistent with health plan and system methodology and now follows HEDIS guidelines. The most important component of that change is related to patients who had not had a blood pressure reading in the past year. In the past we removed those patients from the denominator and reported that as a separate metric. Under HEDIS, that group is considered "not controlled." By definition this has the effect of reducing the overall control rate.

For June 2015 the control rate was 69.4% using the HEDIS calculation. (Under the previous JNC7 system the rate would have been 71.3% as reported above). It should be noted that the group has observed a plateau effect in control rates which have stayed flat over the last three registry reports.

Summary of INTIATIVES FOR BLOOD PRESSURE CONTROL

Blood Pressure Registry: Two times a year, in June and December, practices submit high blood pressure data to FLHSA to support the creation of a community-wide registry in addition to individual a system specific practice reports. Calculations include control rate and no blood pressure reading in the past 13 months. Data received represents approximately 65% of hypertensive adults in Monroe County.

Highland	RGH	Strong	Unity	Community
Highland Family Medicine submits data to 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 from several community practices including FQHC's

Blood Pressure Advocate Program: Community Members are trained to work in clinics and meet with hypertensive patients to help them change behavior and navigate with their providers and social services. Also the name of the Blood Pressure Advocate Program has been updated to "HEART Advocate Program" to more accurately reflect their work.

Highland	RGH	Strong	Unity	Community
Highland Family Medicine	Genesee Internal Medicine	Eastridge Family Medicine	Unity Parkway Unity Cornerstone	-

Practice Improvement Consultants: Consultants were trained in an academic detailing model designed to examine practice procedures and systems that lead to the best chronic care outcomes.

Highland	RGH	Strong	Unity	Community
Highland Family Medicine has two trained MDs	RGH has one trained MD and two trained PharmDs	Strong does not participate in the PIC program – they use their own internal program	Unity has two trained MDs and one trained PA – growing	n/a