# 2025-2027
# 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

# 2025 - 2027
# 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, improvement strategies with a detailed work plan, and a distribution plan for these efforts.

## Identified Health Priorities

After review of the 2025 NYS Prevention Agenda framework, identification of relevant population health data for Monroe County and after extensive important community engagement, the following areas were selected as the primary health challenges of focus for the Monroe County Joint Community Health Improvement Plan:

### Monroe County health priorities and goals for the 2025-27 CHNA and CHIP

| **VISION** | Every individual in Monroe County has the opportunity, regardless of background or circumstances, to attain their highest level of health across the lifespan | |
|---|---|---|
| **DOMAIN** | **PRIORITIES** | **GOAL by Dec 2027** |
| Economic Stability | Economic Wellbeing<br>Decrease Poverty, a driver of health | Reduce the percentage of people living in poverty in Monroe County from the baseline of 13.1%, with special attention to Rochester residents (29.1%) (ACS 2019-2023). PA2030 Goal of 12.5%. |
| Social and Community Context | Mental Wellbeing and Substance Use<br>Reduce Anxiety and Stress | Decrease the percentage of adults in Monroe County who experience frequent mental distress from 13.5% (BRFSS 2021) PA2030 Goal of 12% |
| Health Care Access and Quality | Insurance Coverage and Access to Care<br>Prevent Maternal Mortality | Decrease the rate of maternal mortality in Monroe County from 26.5 per 100,000 Live Births, specifically reduce black maternal mortality and morbidity, currently 3 times worse than that of white birthing persons. (National Vital Statistics 2020-22) PA2030 Goal of 16.1 per 100K |

## Model and Timeline for Community Health Improvement Planning

The Community Health Improvement Workgroup (CHIW) followed the American Hospital Association's (AHA) Association for Community Health Improvement's (ACHI) Community Health Assessment Model for needs assessment and improvement planning, The CHIW meets monthly to discuss all phases of the assessment and planning process.


| Planning Step | Specific Implementation |
|---|---|
| 1. Map the CHNA/CHIP process.<br>2. Build Relationships | The CHIW has been meeting for over 20 years and has well-established relationships. The process was outlined in the July 2024 CHIW meeting. |
| 3. Community Profile including data to demonstrate inequities | Description of Monroe County's demographics for the CHNA was created with Common Ground Health. Health outcomes were collected and reported on. |
| 4. Deepen understanding.<br>5. Prioritize community health needs and assets. | Community Engagement by reviewing reports, meeting with community-based groups, AmeriCorp PhotoVoice, meetings with hospital/health dept leadership: August – December 2024 |
| 6. Document and communicate the results. | Present to the four hospital boards and the health department board in May and June 2025. Write the CHNA and CHIP according to IRS and NYS guidelines. |
| 7. Plan strategies for equity.<br>8. Jointly develop an action plan | Review evidence-based interventions, preliminary prevention agenda framework. Select feasible strategies, identify partners and metrics for evaluating progress. |
| 9. Evaluate Progress | July 2025 – June 2027 Implement the CHIP action plans and track metrics. Report and discuss progress with the CHIW |

## 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 2024, the CHIW began the 2025 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 discussed in relation to the 2025 NYS Prevention Agenda focus areas as well as needs identified by the Monroe County Department of Public Health and the community.

In late summer 2024, before engaging in data analytics or community outreach, the CHIW members developed a structured set of criteria to guide the prioritization of health needs identified through the CHNA. The CHIW created the criteria to promote equity and feasibility.

The criteria identified as key factors in prioritizing needs included:

- The capacity of hospital systems and partners to provide resources and leadership.
- The potential for measurable and sustainable impact.
- Whether the issue addressed root causes of health inequities.
- The severity and magnitude of the issue in Monroe County.
- Whether the issue filled a gap not already addressed.
- And whether it has been identified by the community as a key concern.

In August 2024, CHIW conducted a prioritization poll among its members to weigh these factors. "Community need" emerged as the top consideration, followed by magnitude and severity of the problem. This community- and data-informed process led to the final selection of the Monroe County CHIP priority areas within the CHIW meetings.

Next, several sources of data were examined to determine the top community health needs for Monroe County. Common Ground Health, a community planning agency for the Finger Lakes Region, were instrumental in updating, analyzing, and sharing data for the CHIW members to examine.

Data was collected from several detailed resources in the 2025 Monroe County CHNA, including:

- US Census Bureau and the American Community Survey
- NYS Vital Statistics Mortality Data
- NYS Department of Health Statewide Planning and Research Collaborative (SPARCS)
- NYS Prevention Agenda Tracking Dashboards
- Finger Lakes Regional Perinatal Program

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. This data was cross walked with community-raised concerns and mapped to the NYS Prevention Agenda 2025–2030 domains. The final priorities reflect the convergence of quantitative data and qualitative community voice, selected through a transparent, equity-focused process.

## Community Engagement

Community engagement was central to the prioritization process and helped ensure that the CHIP is both data-driven and responsive to lived experiences across Monroe County.

Throughout fall 2024 the CHNA process engaged hundreds of community members and stakeholders through listening sessions, focus groups, and review of county survey results. Feedback was gathered from diverse communities across the City of Rochester and Monroe County and included representation from groups historically underserved by the health care system.

Throughout the needs assessment process, representatives from the CHIW met with several community groups for feedback on the focus areas. The Commissioner of the Monroe County Department of Public Health and several other public health experts were instrumental in the prioritization process. The meeting dates for some of the most significant groups input sessions are shown below in Table 1.

*Table 1: Significant Group Input Sessions for Monroe County 2025-24 CHIP Development*

| Group | Date |
|---|---|
| Community Advisory Council | July 23, 2024 |
| African American and Latino Health Coalitions | September 2024 |
| Rochester Flower City AmeriCorps | October 25, 2024 |
| Monroe County Board of Health | November 4, 2024 |
| Maternal Child Health Advisory Group | November 17, 2021 |

Common Ground Health conducted the "My Health Story" survey of the nine-county Finger Lakes Region. The survey of a convenience sample of 3,747 individuals asked several questions, including "Currently, what is your biggest concern for your own health and well-being?" Results of the survey were analyzed by Common Ground Health and disseminated in a brief report: Spotlight: Self-Reported Health Concerns. Results were considered in the community engagement.

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. See Monroe County 2025 CHNA for a full description of this process.

**Summary of Community Engagement**: Community input was invaluable and further confirmed the information discovered in the data. From the solicited community input, identified priorities include:

- Mental and emotional health and well-being, stress relief
- Access to care – wait times, dental care, language interpretation
- Diversity and cultural understanding among health care workers
- Preventive care and health education
- Social drivers, especially housing
- Aging of the population
- Maternal and Infant health
- Opioid addiction and overdose
- Obesity and overweight, lack of physical activity, safety, and poor nutrition

## Significant Needs Not Addressed

When comparing the community-identified needs and the analyzed population health data, ten priority areas emerged. Unfortunately, resources do not support the CHIW working on all ten priority areas, so the prioritization criteria of the CHIW were invoked to help in the selection process. Community demand was our top prioritization criteria, and the community identified maternal/infant health outcomes as well as stress/anxiety more often and with stronger concern than any other topic.

Choosing a third priority proved more difficult, as many of the ten identified community needs are vital and interconnected. To address this, the CHIW combined several key focus areas—social drivers of health, access to care, preventive care and health education, and cultural competence among health care providers—into a broader effort to tackle poverty in our community. This integrated approach supports the top four community-highlighted priorities and recognizes the overlapping nature of these issues.

While all these needs are important and deserve attention, the Community Health Improvement Workgroup (CHIW) selected three priorities for focused CHIP action:

- **Poverty and Economic Stability**
- **Mental and Emotional Health (Stress and Anxiety)**
- **Maternal and Infant Health (Maternal Morbidity, Decreasing gaps in outcomes)**

While additional areas also demonstrate significant need, limited resources require strategic focus. Fortunately, many other community stakeholders are actively working in those unaddressed areas. The hospital systems remain committed to supporting all public health initiatives for the greater good. By focusing on social determinants of health and upstream interventions, the CHIW aims to create sustainable, system-wide improvements, including areas not currently prioritized.

**The priorities not selected for action include** aging of the population, opioid addiction and overdose, obesity and overweight, lack of physical activity, safety, and poor nutrition, and falls and assaults.

*Aging Population (Dementia and Elder Care)*
The aging population is a growing concern; however, several outstanding programs exist in our community including Lifespan of Greater Rochester that work specifically with that population. The CHIW will continue to support partnerships with Lifespan while focusing CHIP efforts on broader upstream drivers like stress and poverty.

*Opioid Addiction and Overdose*
Although substance abuse remains a significant public health issue in Monroe County and nationwide, this remains a high priority area for the Monroe County Department of Public Health and the Office of Mental Health (OMH). They lead several harm reduction programs including significantly increasing Narcan access and coordinated behavioral health responses with the IMPACT Team.

*Falls and Assaults (Including Gun Violence)*
Although not raised as a major concern in community engagement sessions, population health data show that violence remains a persistent issue. The City of Rochester has an Office of Violence Prevention with several new initiatives, and the Monroe County Department of Public Health recently received a CURE Violence Prevention grant.

The CHIW acknowledges the importance of each identified health need and remains committed to collaborative, cross-sector work that supports broader public health goals. The CHIP aims to advance upstream solutions to generate long-term community benefits, including indirect impact on many unaddressed areas.

## Community Health Improvement Plan

After identifying the prioritized needs for health in Monroe County, alignment was sought with the 2025-2030 NYS Prevention Agenda. The framework for the NYS Prevention Agenda has been released and is modeled after the CDC 2030 Prevention Agenda. The current NYS Prevention Agenda includes suggested evidence-based interventions and recommended state metrics.


## 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 2025-2027 Monroe County Joint Community Health Improvement Plan. All four hospitals and the health department as well as advising 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 collaboratively involved in the planning and implementation of all intervention strategies, from their selection to their completion.

**Vision:** Every individual in Monroe County has the opportunity, regardless of background or circumstances, to attain their highest level of health across the lifespan.

| **Objective 1: Reduce the percentage of people living in poverty in Monroe County from the baseline of 13.1%, with special attention to Rochester residents at 29.1%. (ACS 2019-2023). The PA2030 goal is 12.5%.** | |
|---|---|
| Domain | Economic Stability |
| Priority | Economic Wellbeing; Poverty |
| **Evidence-Based Interventions** | |
| 1.1 Support educational programs that enhance recruitment for needed positions while mitigating disparities in recruitment efforts. | |
| Measure for Intervention 1.1:<br>• Employment rate by age group and industry | |
| **Existing work** | **Lead Organization** |
| Transformational Community Care Coordination (TC3): healthcare initiative focused on addressing the barriers to discharging complex care patients from hospitals to skilled nursing facilities (SNFs). Workforce Development component: investing in long term care training programs for healthcare professionals including certified nursing assistants, home health aides, and nurses. | FLPPS, Common Ground Health, RRH, URMed, and several others |
| RRH Employee Care Fund can assist employees who are struggling with financial hardships (utility shut off, funeral services, unexpected home repairs, etc.). | RRH |
| RRH Life Coach program helps current employees with stressors/issues that can negatively impact an individual's ability to retain employment (i.e. transportation, a fiscal crisis, childcare, etc.) | RRH |
| The UR Career Pathways program focuses on placing individuals in high-demand positions and supporting them by identifying a career pathway within the University of Rochester, leading to opportunities for higher earning potential. High-demand positions include several in lab, nursing and other patient-care areas. | University of Rochester |
| Health systems have pipeline programming for high schoolers interested in health careers. | RRH, URMed, RCSD |
| Finger Lakes Performing Provider System (FLPPS) is leading regional implementation of the 1115 Waiver NYS Department of Health Career Pathways Training (CPT) Program across the Finger Lakes as the designated Workforce Investment Organization (WIO). The CPT Program provides a powerful opportunity through tuition and educational expense support for individuals to launch or advance careers in health, behavioral health, and social care. | FLPPS, URMed, RRH |
| The Office of Mental Health prioritized mitigating workforce concerns for behavioral health providers in their most recent Local Service Plan (LSP). | OMH |
| Rochester General College of Health Careers: evidence-based healthcare education that equips adult students with the knowledge, skills, and competencies for successful health careers, advanced study, and lifelong learning. | RRH |
| Isabella Graham Hart School of Practical Nursing: two 10-month, full-time programs delivering comprehensive, evidence-based theory and clinical training to prepare students to provide compassionate, high-quality nursing care and succeed on the Practical Nursing License Exam. | RRH |

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|---|---|
| Certified Nursing Assistant Program: Free CNA training program that immerses students in healthcare and fast-tracks them into unit assistant roles at nursing and rehabilitation centers. | RRH |
| **CHIW work** | **Collaborators** |
| Learn about workforce initiatives in Monroe County, then share with CHIW partners by creating a health career workforce educational program guide for social workers and other direct support professionals. | RochesterWorks! / CCHP / FLPPS |
| Find ways to share resources and information with communities experiencing high levels of poverty. Support employment programming for high need healthcare positions as appropriate. | Existing programs |
| Engage the Regional Consortium on Health Care Workforce which brings together decision makers and subject matter experts to address the workforce challenges faced by health care providers in the Rochester-Finger Lakes Region. | The Workforce Consortium (CGH) |
| 1.2 Engage in multi-sector collaborations that highlight the health burden of unemployment and under-employment. | |
| Measure for intervention 1.2<br>• Employment rate by age group and industry | |
| **CHIW Work** | **Lead Organization** |
| Invite new and consistent membership representatives from the Rochester-Monroe Anti-Poverty Initiative (RMAPI) to the CHIW and get more involved in supporting RMAPI's work. | RMAPI |
| Invite representatives from employment programs to the CHIW including TC3 and Rochester Works! To explore ways to build collaborations. | TC3, RochesterWorks!, FLPPS WIO, and ABC |
| Share success stories from current existing programs and consider starting an advisory group of graduates from workforce development programs. | URMC / RRH |
| 1.3 Screen for social determinants of health (SDOH) and connect patients to resources through (1115) Social Care Network (SCN) or 211 for resources. | |
| Measure for intervention 1.3<br>• Healthcare Effectiveness Data and Information Set (HEDIS) measure: Social Need Screening and Intervention (SNS-E) – (DOH has this measure) | |
| **Existing work** | **Lead Organization** |
| Health systems are currently screening for social determinants of health and connecting patients to resources. | RRH, URMed |
| Food pantry at URMC, RRH (RRH has pantries for patients, surrounding community and employees). | URMed, RRH |
| Inpatient SW SDOH program @ RGH – specific initiative to collect data on and identify/address SDOH barriers/needs of hospitalized patients that impact their risk of readmission and/or length of stay. | RRH |
| EMR interoperability enhancement projects are underway to track closed loop referrals to community resources. | RRH, URMed |
| **CHIW work** | **Lead** |
| Work with FLIPA to learn more about social care network referrals and agencies (1115 work). | CHIW |
| Invite RTS and other public transportation programs to the CHIW to learn more about their programs and how they can support those in poverty. | CHIW |
| Explore hospital processes and access to data around referrals to social supports from RRH / URMC. | RHIO – CGH, RRH, URMed |

| **Objective 2: Decrease the percentage of adults in Monroe County who experience frequent mental distress from 13.5%** (BRFSS 2021) PA2030 Goal of 12% | |
|---|---|
| Domain | Social and Community Context |
| Priority | Mental Wellbeing and Substance Use: Anxiety and Stress |
| **Evidence-Based Interventions** | |
| 2.1 Promote evidence-based mindfulness resources to reduce the negative impact of stress and trauma. | |
| Measure for Intervention 2.1<br>• Manner of outreach and data re: reach of intervention | |
| **Existing work** | **Lead Organization** |
| Common Ground Health provides a 42-hour training for capacity building of mental health providers currently at RRH and URMC around antiracist mental health treatment. Both systems have contributed funding to support the training of over two hundred providers. | Common Ground Health |
| Healthy Living programs in the Center for Community Health and Prevention lead mindfulness programs for stress management. | URMed |
| URMC Mindful Practice for providers | URMed |
| Robust EAP programs to help employees and their families find social resources for well-being. | RRH, URMed |
| Health systems provide mindfulness resources throughout behavioral health clinics and are focused on staff wellness. | RRH, URMed |
| RRH Life Coach program helps current employees with stressors/issues that can negatively impact an individual's ability to retain employment (ie transportation, financial crisis, childcare, etc). | RRH |
| **CHIW work** | **Lead** |
| Create or identify a resource guide of evidence-based mindfulness resources and find creative ways to share with community members. | CHIW |
| Schedule at least 2 presentations annually to CHIW membership to learn more about resources providing evidence-based mindfulness programming. | CHIW |
| 2.2 Social prescribing: Connecting individuals with local community resources and activities that address their social needs and promote well-being. | |
| Measure for intervention 2.2:<br>• Surveys tracking participation in social and community programs | |
| **CHIW Work** | **Lead Organization** |
| Connect with the 1115 SCN and 211 to discover community resources to address social needs and promote well-being. | FLPA, NAMI, MHA, VA |
| Create or locate a resource guide of evidence-informed social support in the community to share with community members. | CHIW |
| Schedule at least 1 presentation annually to CHIW membership to learn more about social prescribing and options. | CHIW |
| Highlight outstanding social programs like the ENCORE program. Assist with recruiting and dissemination when possible. | ENCORE |
| Art Therapy – educate and share resources on how to bill for art therapy services and activities. | Eastman Performing Arts Medicine (URMC) |
| Market and share social prescribing within FQHCs and hospitals. Learn and share best practices. | CHIW |
| EMR interoperability enhancement projects are underway to track closed loop referrals to community resources. | RRH/ URMed |

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| **Objective 3: Decrease the rate of maternal mortality in Monroe County from 26.5 per 100,000 Live Births**, specifically reduce black maternal mortality and morbidity, currently 3 times worse than that of white birthing persons. (National Vital Statistics 2020-22) PA2030 Goal of 16.1 per 100K | |
| Domain | Health Care Access and Quality |
| Priority | Health Insurance Coverage and Access to Care: Prevention of Maternal Mortality |
| **Evidence-Based Interventions** | |
| 3.1 Implement community-based Doula programs - Establish policies and practices to support doula care and Services. | |
| Measures for tracking 3.1:<br>• Number of hospitals that institute doula-friendly policies, number of births involving doula care, utilization of doula Medicaid benefit. | |
| **Existing work** | **Lead Organization** |
| Pregnant people looking for a doula can contact several local organizations and communities that are supportive. Beautiful Birth Choices and the Doula Collective of Rochester work to connect doulas with people searching for them. | Beautiful Birth Choices<br>Doula Collective |
| The Community Doula Program is an initiative that provides free doula services for people of color who have Medicaid, are Medicaid-eligible, or are uninsured in the 13 counties surrounding Monroe County. Funded through a multi-year Finger Lakes Performing Provider System (FLPPS), services are provided by Finger Lakes Community Health and the Healthy Baby Network. | Health Connect One<br>Healthy Baby Network<br>Finger Lakes Community Health |
| **CHIW work** | **Lead** |
| Work with the Maternal Child Health Advisory Group (MCH-AG), hospital leaders, Community-based doula programs and other experts to remove barriers, including hospital barriers, to Doula care. | CHIW |
| Create an informational campaign to ensure that all birthing people in Rochester and Monroe County are aware of Doulas, what they are, what they do, and how to access them for care. | CHIW |
| 3.2 Connect birthing people at high-risk to evidence-based or evidence-informed home visitation programs. | |
| Measures (options) for tracking 3.2:<br>• Number of people served by home visitation programs, number of home visits per patient, number of screenings performed for medical or social care needs, number of successful referrals made for medical or social care needs. | |
| **Existing work** | **Lead Organization** |
| Nurse Family Partnership is a free, voluntary program that provides first time, income-eligible pregnant women with home visits from specially trained nurses through pregnancy until their child turns two. | MCDPH |
| ROC Family Teleconnect is a program designed to improve health outcomes for new mothers and infants, reduce unnecessary emergency department visits, enhance the postpartum experience for families, and increase satisfaction among pediatric and family medicine providers through telehealth. | RRH, URMed, Jordan Health, FLPPS |
| The Healthy Moms program empowers pregnant and parenting moms in Monroe County with personalized support to achieve physical health, emotional well-being, and self-sufficiency through services like prenatal education, mental health counseling, job training, and home visits. | RRH |

| | |
|---|---|
| Baby Love is a program in which community health workers enroll patients during pregnancy as identified with social risk factors that negatively impact pregnancy outcomes for both mother and baby and follow through birth and beyond for support. | URMed |
| Building Healthy Children since 2007 providing evidence-based home visits to teen parents (to mid-20s) through partnership with URMC Social Work, Department of Pediatrics and Mt. Hope Family Center. | Mt. Hope Family Center |
| **CHIW Work** | **Lead Organization** |
| Continue to coordinate the MCH-AG which serves as the community advisory board for the Roc Family Teleconnect and assist the program whenever possible. | CHIW |
| Monitor and improve the 211 New Families Resource Navigation Tool by overseeing personal use observations and marketing the tool to community members and perinatal navigators. | CHIW |
| 3.3 Collect and stratify clinical data by race, ethnicity, and language (REAL) data to analyze and identify drivers of inequity and targets for quality improvement. | |
| Measure for tracking 3.3:<br>• Number of reports analyzed, intermediate findings of likely drivers contributing to inequities | |
| **Existing work** | **Lead Organization** |
| Health systems, the Finger Lakes Perinatal Network and the NYS DOH monitor birth outcomes and complete reports. | RRH, URMed, Perinatal Network, NYSDOH, and Common Ground Health |
| FLPPS is leading a planning process to identify drivers of maternal and infant outcome disparities to develop an action plan for the immediate future. | FLPPS, CGH |
| **CHIW work** | **Lead** |
| Translate collected data into a platform or report that stakeholders can easily find and use. | CHIW, with CGH |
| Survey, or read collected survey reports, about the experiences of recently birthing people to identify underlying drivers of inequity and targets for quality improvement. | CHIW, with CGH |

**Evaluation Plan for Monroe County 2025-2027 Community Health Improvement Plan**

Future State: Every individual in Monroe County has the opportunity, regardless of background or circumstances, to attain their highest level of health across the lifespan.

| Long-Term Outcome | Medium Term Outcomes | Short Term Outcomes | Baseline/metrics | Goal |
|---|---|---|---|---|
| 1. Reduce the % of people living in poverty in Monroe County | | | • 13.1% of MC residents in poverty<br>• 29.1% of Rochester residents in poverty | • 12.5% (PA2030 Goal) |
| | 1.1 Increase employment in the health sector by supporting educational programs that enhance recruitment for needed positions while mitigating disparities in recruitment efforts. | | • Unemployment rate in MC = 3.4%*<br>• Unemployment rate in Roc = 4.6%*<br>• 1 YR Job gains in Private Ed and Health Services = 400 | Decrease |
| | | 1.1a. Rochester residents are more aware of high-need healthcare positions and programs to fill them through the CHIW and its member organizations. | • Research high-need healthcare positions and programs, and enrollment | Increase from baseline |
| | | 1.1b. The CHIW is more connected with the Regional Consortium on Health Care Workforce and aware of their agenda and initiatives. | • Number of meetings with CHIW and Consortium | At least 2 meetings annually with CHIW and Consortium |
| | 1.2 Engage in multi-sector collaborations that highlight the health burden of unemployment and underemployment. | | • Unemployment rate in MC = 3.4%*<br>• Unemployment rate in Roc = 4.6%*<br>• 1 YR Job gains in Private Ed and Health Services = 400 | Decrease |
| | | 1.2a. The CHIW is more connected with the Rochester Monroe Anti-Poverty Initiative (RMAPI). | • Identify areas of overlap between CHIP and RMAPI goals | Collaborative partnership with RMAPI |
| | | 1.2b. The CHIW is more familiar with the high need healthcare positions and programs in Monroe County. | • Presentations to CHIW members | At least 3 presentations annually from programs |
| | 1.3 Screen for social determinants of health (SDH) and connect patients to resources through (1115 social care networks or 211 for resources). | | • HEDIS measure of Social Need Screening and Intervention (SNS-E) | Increase from baseline |
| | | 1.3a. Health systems will continue to screen for SDH and connect patients to resources with the goal of closed loop referrals. | • % of patients at each health system screened for SDOH<br>• % of patients receiving resources | Increase from baseline |
| | | 1.3b. Health systems will continue to provide short-term support to address the social needs of patients. | • Number of patients using short-term supports for SDOH | Increase from baseline |

*Labor Market Briefing Finger Lakes June 2025 **

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| Long-Term Outcome | Medium Term Outcomes | Short Term Outcomes | Baseline/metric | Goal |
|---|---|---|---|---|
| 2. Decrease the % of adults in Monroe County who experience frequent mental distress. | | | • 13.5% (BRFSS 2021) frequent mental distress during the past month among adults (age adj)* | 12%<br>(PA 2030 Goal = 13.4&) |
| | 2.1 Promote evidence-based mindfulness resources to reduce the negative impact of stress and trauma. | | • Number of residents engaged in selected mindfulness programs | Increase from baseline |
| | | 2.1a. The CHIW members are more familiar with resources providing evidence-based mindfulness programs. | • Number of presentations | At least 2 presentations annually from programs |
| | | 2.1b. Monroe County residents are more aware of mindfulness resources through the CHIW and its member organizations. | • Number of educational and informational efforts to share mindfulness resources | At least 3 efforts |
| | 2.2 Social prescribing: Connecting individuals with local community resources and activities that address their social needs and promote well-being. | | • Number of residents engaged in selected programs addressing social connectedness and promoting well-being | Increase from baseline |
| | | 2.2a. CHIW members are more familiar with social prescribing and local programs addressing social needs and promoting well-being. | • Number of presentations to the CHIW | At least 2 presentations annually about social prescribing and/or programs |
| | | 2.2b. Monroe County residents are more aware of social programs to address well-being through the CHIW and its member organizations. | • Number of educational and informational efforts to share social support and well-being resources | At least 3 presentations annually from programs |

*BRFSS 2021

Future State: Every individual in Monroe County has the opportunity, regardless of background or circumstances, to attain their highest level of health across the lifespan.

| Long-Term Outcome | Medium Term Outcomes | Short Term Outcomes | Baseline/metric | Goal |
|---|---|---|---|---|
| 3. Decrease the rate of maternal mortality in Monroe County, specifically reducing Black maternal mortality and morbidity. | | | • Monroe County maternal mortality = 26.5 per 100,000 live births**<br>• Black maternal morbidity = 151/10K* | 16.1 per 100,000 goal of PA2030 |
| | 3.1 Support the implementation of community-based Doula programs. Establish policies and practices to support doula care and services. | | • Number of hospitals that institute doula-friendly policies<br>• number of births involving doula care<br>• utilization of doula Medicaid benefit | 4/4 hospitals<br>Increase in doula births and Medicaid benefit usage |
| | | 3.1a. Work through the Maternal Child Health Advisory Group (MCH-AG) to support community-based Doula programs by removing barriers, including hospital barriers, to Doula care. | • Number of MCH-AG meetings where Doula's are discussed<br>• List of barriers and potential solutions, tracking removal | At least 2 MCH-AG meetings annually<br>Database of barriers |
| | | 3.1b. Rochester residents are more aware of doulas and how to access them - through the CHIW and its member organizations. | • Number of educational and informational efforts to teach about doulas | At least 3 annually |
| | 3.2 Connect birthing people at high-risk to evidence-based or evidence-informed home visitation programs. | | • Number of people served by home visitation programs (NFP, RFTC, Healthy Moms, Baby Love, BHC) | Increase from baseline |
| | | 3.2a. Roc Family TeleConnect, and other home-visitation based programs are supported and discussed at Maternal Child Health Advisory Group. | • Number of MCH-AG meetings where home visitation programs are discussed | At least 2 meetings annually |
| | | 3.2b. The 211 New Families Resource Navigation Tool is a useful tool for community members seeking support for pregnancies and new babies. | • Number of views in the New Family Resource Navigation Tool (from 211) | Increase 20% from baseline |
| | 3.3 Collect and stratify clinical data by race, ethnicity, and language (REAL) data to analyze and identify drivers of inequity and targets for quality improvement. | | • Summary and findings of likely drivers contributing to inequities from at least 2 planning initiatives | Summarize at least 2 planning initiatives |
| | | 3.3a. Develop a useful website for Maternal Health information increasing the visibility of data, disparities. | • Number of views at the newly developed Maternal Health site | Site developed, 500 views annually |
| | | 3.3b. Collect and share results of Rochester and MC planning and formative evaluation efforts to identify underlying drivers of inequities. | • Report results from Mothers and Babies Health Survey 3.0, FLPPS planning, etc. | Summary report |

*SPARCS Common Ground Health, **NYS PA Dashboard

## Community Engagement & Evaluation for 2025-2027 Implementation

The Community Health Improvement Workgroup will continue to meet monthly throughout the implementation period of the 2025-27 CHIP. Representatives from all hospitals, the local health department, the local office of mental health, and the advising 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 needed. Some of our process measures involve community-wide meetings through the Maternal Child Health Advisory Group, and those gatherings 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 formed website for community health improvement.

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:

| **Community-Based Organization** | **Brief Description of the Organization** |
|---|---|
| Monroe County Medical Society | Professional organization composed of 1,200 physicians, residents, and medical students that aims for the betterment of the medical profession and the health of the community. |
| Common Ground Health | A health research and planning organization bringing together 9 Finger Lake counties to create strategies for improving health, through data analysis, resident engagement and solution implementation. |
| Rochester Regional Health Information Organization (RHIO) | An organization serving as a secure, electronic health information exchange for authorized medical providers in the Finger Lakes and Southern Tier regions. To improve timely access to clinical information and improve decision making for communities. |
| Finger Lakes Performing Provider System | A network of hundreds of clinical and community-based provider organizations aiming to create and provide partnerships with valuable and innovative tools. Originally established for DSRIP implementation. |
| Jordan Health | A system of federally qualified health centers throughout the neighborhoods of the city of Rochester to provide comprehensive healthcare to those living in underinsured, low-income communities. |
| Action for a Better Community (ABC) | A Community Action Agency charged with creating opportunities for low-income individuals and families in the Greater Rochester Area to become self-sufficient. |
| City of Rochester | The government body for the city municipality, run by the mayor whose goals are to promote systemic and structural change through leadership collaboration, providing equitable access to essential municipal services, creating productive partnerships, and improving quality of life through neighborhood and employment investments. |

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| United Way of Greater Rochester | Connects 30,000 donors, 14,000 volunteers, 500 workplace and corporate partners, and over 1,000 nonprofit partners to co-create solutions to address the communities' needs. |
| African American and Latino Health Coalitions | Community-based groups working to improve health equity for the African American and Latino communities in the Rochester and Finger Lakes region. The coalitions work to improve the collection of data on race and ethnicity, advocates for policies that support healthy behaviors, and fights for better quality and accessibility of health services for African American and Latino residents. |
| 211 Lifeline | A free, confidential 24-hour phone, chat, and text service, as well as an online database, providing information, referrals, and crisis/suicide prevention services. |
| Cornell Cooperative Extension | Utilizes Cornell University's research from the College of Agriculture & Life Sciences and the College of Human Ecology to enrich and empower neighborhoods' economic vitality, ecological sustainability, and social wellbeing. |
| Center for Tobacco-Free Finger Lakes | Serves 11 counties of the Finger Lakes region by providing partners with evidence-based resources and strategies to assist health care systems in the design and implementation of policies and guidelines to identify and treat nicotine addiction. |
| Regional Health Reach | Provides comprehensive primary medical care, including resources for social drivers, to the homeless population in the city of Rochester, as well as the greater Rochester area free of charge. |
| Trillium Health | A Community Health Center offering primary and specialty medical care services to all, ensuring equitable, judgement-free and affordable care, specializing in care for the LGBTQ+ community |
| Ronald McDonald House | Provides a "home-away-from-home" to families while their children receive necessary medical care. Families are provided with transportation, lodging, meals, and companionship. |
| Rochester Monroe County Anti-Poverty Initiative (RMAPI) | RMAPI is a coalition of strong-willed individuals and organizations working together to tackle the systematic root causes that create and perpetuate poverty in Rochester. |

## 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 2025-2027 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.