Community Health Improvement Plan (CHIP)

2019 to 2021

For Genesee-Orleans-Wyoming Counties

ROCHESTER REGIONAL HEALTH
United Memorial Medical Center

ORLEANS Community Health

WCCHS
Wyoming County Community Health System

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Project Dates:

- Original Community Health Improvement Plan (CHIP) shared with New York State Department of Health (NYSDOH) by December 31, 2019
- Approved by the New York State Department of Health: October 2020
- Modification of Document Layout for Easier Public Sharing: February 1, 2022

Summary of Community Health Improvement Plan Focus Areas and Goals, 2019-2021

Priority A: Promote Well-Being and Prevent Mental and Substance Use Disorders
Focus Area 1: Prevent Mental and Substance User Disorders • Goal: Prevent opioid overdose deaths

Priority B: Prevent Chronic Diseases
Focus Area 1: Tobacco Prevention • Goal: Promote tobacco use cessation
Focus Area 2: Preventative care and management • Goal: Increase cancer screening rates • Goal: In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity

Priority A:
Promote Well-Being and Prevent Mental and Substance Use Disorders

Focus Area 1:

Prevent Mental and Substance Use Disorders

Goal:

- Prevent opioid overdose deaths

Objectives:

- Decrease the rate in opioid overdose deaths by 7% by the end of year 3 (2024).
- Increase knowledge of the Peer Support/Recovery Coaches program among hospital Emergency Department (ED) staff and community members.

Disparities:

- Location - Rural communities with limited service providers available.
- Access - to primary care providers in a rural setting.
  - Population to primary care providers ratio in our counties are:
    Genesee: 2520:1
    Wyoming 2400:1
    Orleans: 13780:1
  - Our Population to Mental Health provider ratios are:
    Genesee: 650:1
    Wyoming: 500:1
    Orleans:1860:1

(Source: 2019 Robert Wood Johnson County Health Rankings- Health Outcomes Data)

  - 80% stated they use their doctor as their main source of health information. 2019 Robert Wood Johnson County Health Rankings- Health Outcomes Data
  - In 2018, there were a total of 37 reported opioid overdose deaths in the GOW region with the following per 100,000; 26.1, 29.5, and 24.9 as compared to New York State **(Source: Monroe County Medical Examiner).**

Priority A:

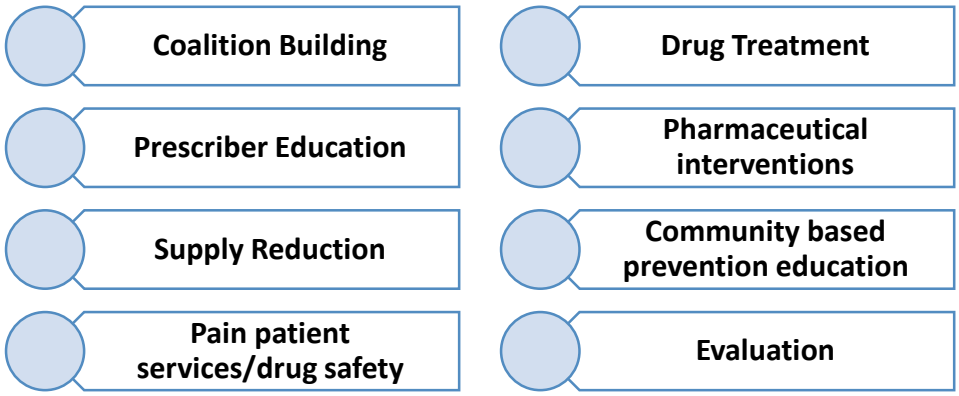
Promote Well-Being and Prevent Mental and Substance Use Disorders

Focus Area 1:

Prevent Mental and Substance Use Disorders

Interventions:

- We support the public health model for the prevention of drug overdose. Model Components may include:



Family of Measures

- # Of organizations represented on Opioid Prevention Task Force.
- # Of individuals receiving treatment in tri-county region.
- # Of pounds of drugs / sharps disposed of at permanent drug drop sites and / or National Drug Take Back Day events.
- # Of referrals to Peer helpline and service.
- # Of Narcan Trainings

Implementation Partner: Type: Other

Partner Role(s) and Resources:

- Opioid Prevention Task Force. Partnerships through the Genesee, Orleans and Wyoming (GOW) Opioid Task Force continue to develop and/or strengthen. Task Force members serve on workgroups to address data, community education, access to care and Narcan training/distribution. These workgroups are made up of a cross section of the 3 counties and provides quarterly updates to the public as well as updates to the core Mental, Emotional, Behavioral Steering Committee which reviews the updates and assists with the planning of the quarterly meetings.
- Genesee/Orleans Council on Alcoholism and Substance Abuse (GCASA) has had a strong role in securing grant funding to provide the Task Force Coordinator as well as bring in much needed services to the tri-county region.
- Wyoming County has provided a web site for agencies and community members to seek out services.
- Each of the 3 counties has a growing Peer support community to reach out to hospitals and law enforcement to assist with securing aid to those who are in need of recovery services.

Priority A:
Promote Well-Being and Prevent Mental and Substance Use Disorders

Focus Area 1:

Prevent Mental and Substance Use Disorders

GOAL: Prevent opioid overdose deaths.

Projected (or completed) **Year 1** **Intervention**	○ Provide Narcan trainings to 150 individuals throughout the GOW region. ○ Hold conversations with key stakeholders to establish and implement policies and protocols at United Memorial Hospital, Orleans Community Health and Wyoming Community Hospital for contacting Peer/Recovery Coaches when patient arrives to ED due to opioid related Health complications. ○ Maintain 13 permanent drug drop off sites throughout the GOW region. ○ Hold 2 Drug Take Back Events throughout region.
Projected **Year 2**	○ Provide Narcan trainings to 150 individuals throughout the GOW region. ○ Provide education and marketing related to Peer Support Program to address the knowledge gap impacting referrals. ○ Maintain 13 permanent drug drop off sites throughout the GOW region. ○ Hold 2 Drug Take Back Events throughout region.
Projected **Year 3** **Interventions**	○ Provide Narcan trainings to 150 individuals throughout the GOW region. ○ Consistently deploy Peer Support providers/Recovery Coaches to hospital ERs for 90% of the patients who arrive due to opioid-related health complications. ○ Maintain 13 permanent drug drop off sites throughout the GOW region. ○ Hold 2 Drug Take Back Events throughout region.

Priority B:
Prevent Chronic Diseases

Focus Area 1:

Tobacco Prevention

Goal:

- Promote tobacco use cessation

Objectives:

- The GOW Hospitals and Local Health Departments will utilize Refer-to-Quit or Opt-to-Quit programs in an aim to increase the percentage of smokers who are referred to the NYS Quitline by 13.1% across the GOW region by December 31, 2024.
- New York State Prevention Agenda (NYSPA) Objective: Decrease cigarette use for all adults to 11%.

Disparities:

- Location - Rural communities with no smoking cessation support outside of the NYS Quitline.
- Access - to primary care providers in a rural setting.
  - Population to primary care providers ratio in our counties are:
    Genesee: 2520:1
    Wyoming 2400:1
    Orleans: 13780:1
  - Our Population to Mental Health provider ratios are:
    Genesee: 650:1
    Wyoming: 500:1
    Orleans:1860:1

(Source: 2019 Robert Wood Johnson County Health Rankings- Health Outcomes Data)

- 22% of respondents surveyed in GOW region smoke or use nicotine products. 84% stated they use their doctor as their main source of health information
  (Source: GOW Community Health Survey 2019)

Priority B:
Prevent Chronic Diseases

Focus Area 1:
Tobacco Prevention

Interventions:

- United Memorial Medical Center, Orleans Community Health, Wyoming County Community Hospital will implement/maintain a smoking cessation policy and utilize the Electronic Medical Record (EMR) platform for direct referral process to NYS Smokers Quitline for those self-reporting tobacco/nicotine use.
- Genesee and Orleans County Health Departments will continue implementation of the 'Tobacco Dependence Treatment/Smoking Cessation Program: Refer-to-Quit Policy' adopted in 2017

Family of Measures

- The GOW Hospitals and Local Health Departments will set the baseline in year one (2020). The goal is to increase smoking/nicotine cessation Quitline referrals to 13.1% at the end of year 3 (2024).

Implementation Partner: Type: Other

Partner Role(s) and Resources:

- NYS Quitline and Smoke FREE NY will provide support through hotline and program information

Priority B:
Prevent Chronic Diseases

Focus Area 1:
Tobacco Prevention

GOAL: Promote tobacco use cessation.

Projected (or completed) **Year 1** **Intervention**	○ Epic EMR go-live at United Memorial Medical Center February 2020. ○ Orleans Community Health will implement the Electronic Referral System (EMR) Opt-to-Quit program at Orleans Community Health, Medina Hospital and will continue existing program at the Albion Healthcare Center. ○ The Genesee and Orleans County Health Departments will review if changes are needed to the Refer-to-Quit policy and retrain staff. ○ The GOW Hospitals will distribute 200 NYS Quitline and smoking/nicotine cessation packets to hospital departments and outpatient providers for patients who self report tobacco/nicotine use. ○ Referrals made to the NYS Smokers Quitline by the Genesee and Orleans County Health Departments will increase by 1% annually.
Projected **Year 2**	○ Complete Smoking/Nicotine Cessation policy and EMR automated Opt-to-Quit referral process at the GOW Hospitals. ○ Referrals made to the NYS Smokers Quitline by the Wyoming, Genesee and Orleans County Health Departments will increase by 1% annually.
Projected **Year 3** **Interventions**	○ Maintain Smoking/Nicotine Cessation policy and EMR automated Opt-to-Quit referral process at the GOW Hospitals. ○ Referrals made to the NYS Smokers Quitline by the Wyoming, Genesee and Orleans County Health Departments will increase by 1% annually.

Priority B:
Prevent Chronic Diseases

Focus Area 2:

Preventative Care and Management

Goal #1: Increase cancer screening rates

Goal #1:

- Increase cancer screening rates

Objectives:

- Increase percentage of women, with an annual household income less than $25,000 receiving breast cancer screening based on most recent guidelines, by 5% by December 31, 2024.

Disparities:

- Gender - Women age 40-64 who are under or uninsured and/or have not had a mammogram. The percentage of women ages 50-74 that had a mammogram in the past 2 years for all three of the tri-county regions was under the Healthy People 2020 target of 81.1% with Genesee County and Orleans County at **71%** and Wyoming County at **79.9%**

  (Source: BRFSS 2016)
- Race - Native American women living on local reservation in Genesee County.
- Location - Women living in rural areas with limited access to providers. **141.2** rate of breast cancer incidence in Genesee County; **114.4** rate of Breast Cancer incidence in Orleans County and **166.6** rate of breast Cancer incidence in Wyoming County

  (Source: National Cancer Institute 2011-2015).

Priority B:
Prevent Chronic Diseases

Focus Area 2:

Preventative Care and Management

Goal #1: Increase cancer screening rates

Interventions:

- Conduct one-on-one (phone or in-person) and group education (presentation or other interactive session) in a church, home, senior center or other setting; with a focus on communities where zip codes reflect under/uninsured and/or low screening rates.
- Remove barriers to cancer screening by offering flexible clinic hours, cancer screenings in non-clinical settings (mobile mammography, flu clinics), on-site translation, transportation, patient navigation and other administrative services.

Family of Measures

- Percentage of compliant patients screened quarterly.
- Percentage of non-compliant patients contacted and educated tracked quarterly.
- Report Number of uninsured / underinsured clients in the tri-county region who accessed Cancer Services Program (CSP) for mammography each quarter.
- Record attendance and location of education sessions, clinics and mobile mammography events.
- Report non-traditional hours for mammography offered at United Memorial Medical Center, Orleans Community Health, and Wyoming County Community Hospital.

Implementation Partner: Type: Other

Partner Role(s) and Resources:

- Local healthcare office provides space for the Patient Navigator and access to patient screening records. The patient navigator collaborates with staff to contact patients who need appointments, scripts for screening, and reminder calls.
- Work in partnership with community organizations, businesses and churches to provide education and outreach regarding the importance of mammography and cancer screenings. Specifically partner with the Peer Education program within Genesee County to assist with these education opportunities.
- Windsong's Mobile Screening Mammography will partner with the CSP and Peer Education program to schedule events throughout the GOW region.
- Hospital administration to ensure hours of operation to include nontraditional hours for mammography services.

Priority B:
Prevent Chronic Diseases

Focus Area 2:

Preventative Care and Management

Goal #1: Increase cancer screening rates

GOAL: Increase cancer screening rates.

Projected (or completed) **Year 1** **Intervention**	○ Collaborate with one local health care office/provider to offer patient navigation services through the CSP. ○ Generate baseline patient data and create a patient list based on disparity criteria for the CSP Navigator to work from. ○ United Memorial Medical Center, Orleans Community Health and Wyoming County Community Hospital will offer nontraditional hours of operation for mammography services
Projected **Year 2**	○ Provide 3 group and/or 1:1 breast cancer screening education sessions per quarter (12 per year) using NYS Department of Health approved program information. ○ Offer three (3) Mobile Mammography events throughout the tri-county region; to include the Tonawanda Indian Reservation. ○ Provide weekly navigation services via Genesee, Orleans, Wyoming and Niagara Counties (GOWN) CSP at one (1) provider office to improve patient screening compliance 5% by 2024
Projected **Year 3** **Interventions**	○ Provide 3 group and/or 1:1 breast cancer screening education sessions per quarter (12 per year) throughout TriCounty region using NYS Department of Health approved program information. ○ Offer Four (4) Mobile Mammography events throughout Tri-County region; including the Tonawanda Indian Reservation. ○ Initiate collaboration with another local health care office/provider within the tri-county region to expand navigation services with the CSP while continuing to meet the 5% screening compliance by end 2024.

Priority B:
Prevent Chronic Diseases

Focus Area 2:

Preventative Care and Management

Goal #2: In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity

Goal #2:

- In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity

Objectives:

- The GOW Hospitals and Local Health Departments will collaborate to increase participation in Diabetes Self-Management Education (DSME)/ Diabetes Prevention Program (DPP) 5%. Achieve NYSPA Objectives 4.4.1 and 4.4.2 by 2024

Disparities:

- Location - Rural communities with limited programming and high adult obesity rates. **37.8%** of adults in Genesee County; **36.2 %** of adults in Orleans County and **39.8%** of adults in Wyoming County are obese. **(Source: BRFSS 2016)**; 2018 NYSPA goal 23%.
- Self-reported diabetes diagnosis - **11%** **(Source: GOW Community Health Needs Assessment 2019)**.
- Race - Native American population living on local reservation in Genesee County.

Priority B:
Prevent Chronic Diseases

Focus Area 2:

Preventative Care and Management

Goal #2: In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity

Interventions:

- The GOW Hospitals and Local Health Departments will expand access to evidence-based self management interventions for individuals with chronic disease whose condition(s) is not well controlled with guidelines-based medical intervention alone. (i.e. arthritis, asthma, cardiovascular disease, diabetes, prediabetes, and obesity).

Family of Measures

- Number of individuals and/or support persons attending evidence based Diabetes Self Management or Chronic Disease self management classes.
- Number of Individuals attending Diabetes Prevention Programs.

Implementation Partner: Type: Providers

Partner Role(s) and Resources:

- Assist with identifying and referring potential qualified program participants.
- Tonawanda Indian Reservation Family Health Center program that will assist with identifying and referring qualified participants from their facility and work with UMMC to develop an independently run program.
- Independent Living provides evidence based Chronic Disease Management and Diabetes Self-Management programs.

Priority B:
Prevent Chronic Diseases

Focus Area 2:

Preventative Care and Management

Goal #2: In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity

GOAL: In the community setting, improve self-management skills for individuals with chronic diseases, including asthma,

Projected (or completed) Year 1 **Intervention**	○ The GOW Hospitals and Local Health Departments: initiate conversations with hospital department and practice leaders to develop a referral system for DPP and DSME classes. ○ Offer 1 annual CDC Diabetes Prevention Program and a minimum of 1 DSME or Chronic Disease Management class per year within the GOW region.
Projected Year 2	○ United Memorial Medical Center to: Develop contracts and billing mechanism for Medicare Part B, Medicaid and other insurance providers to increase referral and participation of insured participants in DPP. ○ Build relationships, through conversations, with staff and leaders residing on the Tonawanda Indian Reservation. Hold conversations with Reservation leaders and health clinic staff about training two (2) resident and or professional DPP lifestyle coaches. ○ Develop and implement new policy and EMR referral process for providers to utilize with patients who qualify for DSME or DPP based on individual risk/health data. ○ Offer 1 annual Diabetes Prevention Program and a minimum of 1 DSME or Chronic Disease Management class per month within the county through United Memorial Medical Center and Independent Living.

Priority B:
Prevent Chronic Diseases

Focus Area 2:

Preventative Care and Management

Goal #2: In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity

GOAL: In the community setting, improve self-management skills for individuals with chronic diseases, including asthma,

Projected Year 3 Interventions	○ United Memorial Medical Center to: Enroll new DPP class participants promoting use of contract insurances. Orleans Community Health to: Develop contracts and billing mechanism for Medicare Part B, Medicaid and other insurance providers to increase referral and participation of insured participants in DPP. ○ Work with hospital revenue cycle team to create a self-pay fee schedule with appropriate discounts for participants without insurance coverage. ○ Continue to expand on the referral program with nonhospital employed practices/providers. Expand relationships with the Tonawanda Indian Reservation and Family Health Clinic staff to start examining the possibility of CDC evidence based Native American specific DPP program. ○ Offer a minimum of 1 DSME or Chronic Disease Management class per month within the county through United Memorial Medical Center and Independent Living.