Rockland County Community Health Improvement Plan

2022 - 2024

Revised – 12/28/2022

Data compiled and reviewed in a collaboration between the Rockland County Department of Health, Good Samaritan Hospital, and Montefiore Nyack Hospital

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And the evaluation of local health concerns was conducted in collaboration with representatives from:

- AARP
- American Lung Association
- ARC of Rockland
- Bikur Cholim
- BRIDGES
- CANDLE
- Catholic Charities
- Center for Safety and Change
- Community Collaboratives of Western Ramapo, Spring Valley, & Haverstraw
- Dominican University
- Epilepsy Society of Southern New York
- Fidelis Care
- Friends of Recovery
- Good Samaritan Hospital
- HACSO Community Center
- Helen Hayes Hospital
- Hudson River Healthcare
- Hudson Valley Perinatal Network
- Immigration Coalition of Rockland
- Independent Living, Inc.
- Jawonio, Inc
- Konbit Neg Lakay
- Legal Services of the Hudson Valley
- Lexington Center for Recovery
- Lower Hudson Valley Perinatal Network
- Maternal-Infant Services Network
- Meals on Wheels
- Mental Health Assoc. of Rockland
- Montefiore Nyack Hospital
- NAMI Rockland
- People to People
- PFLAG Rockland
- Planned Parenthood Hudson Peconic
- POW'R Against Tobacco
- Refuah Health Center
- Rehabilitation Support Services, Inc.
- Rockland Alliance for Health
- Rockland County Dept of Mental Health
- Rockland County Dept of Social Services
- Rockland County Office for the Aging
- Rockland County School Nurses Assoc.
- Rockland Pride Center
- United Hospice of Rockland
- United Way of Rockland
- VCS, Inc.

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INTRODUCTION

The purpose of this Community Health Improvement Plan (CHIP) is to outline a course of action that attempts to address the underlying factors influencing health conditions among Rockland County residents as a cooperative group of local organizations. Using the current New York State Department of Health (NYSDOH) Prevention Agenda 2019-2024 as a guide, the two most significant health concerns impacting the county were identified through a collaborative data assessment and review process that began in 2021. This CHIP is the culmination of that procedure and was developed through the joint efforts of the Rockland County Department of Health (RCDOH), Good Samaritan Hospital (GSH) and Montefiore Nyack Hospital (MNH); in partnership with the varied community partner organizations who comprise in the local community collaboratives, namely the Spring Valley Collaborative, the Haverstraw Collaborative and the Western Ramapo Collaborative (acknowledged on the previous page). It is the hope of this collective public health workgroup that the utilization of evidence-based approaches with predetermined goals, improvement strategies, and measurable objectives will advance overall health and reduce health disparities. The chosen priority areas for this three-year CHIP cycle (2022 - 2024) are: **Prevent Chronic Diseases**; and **Prevent Communicable Diseases**. The specific goals and objectives to be addresses within these two topic areas are outlined on pages 6-7.

This CHIP document is intended to serve as the underlying framework for the collaborative efforts being conducted in Rockland County and is expected to be re-evaluated and updated regularly over the multi-year improvement cycle to reflect changes. It is expected that essential feedback from partners will be garnered at future workgroup meetings on the specific issues being addressed, the data points being collected, and to assist in evaluating progress towards the designated goals. It is anticipated that any decisions to make midstream adjustments to the chosen priority goals and measures will occur as a result of these events. The working version of this document, and the Community Health Assessment (CHA) that was utilized to inform this planning process, can be found on the Rockland County Department of Health website at: (www.rocklandgov.com/departments/health/statistics-and-data/) for ease of public access.

EXECUTIVE SUMMARY

Every three years, the New York State Department of Health requires Local Health Departments to submit Community Health Improvement Plans (CHIP) and hospitals to submit Community Service Plans (CSP) which require a thorough Community Health Assessment (CHA) to be completed. In addition, the IRS requires all non-profit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years and to adopt an implementation strategy to meet the identified community health needs. These assessments and subsequent action plans are meant to meet several requirements outlined by both the Affordable Care Act (ACA) and New York State public health law. The overarching purpose of these documents is to identify and address unmet health needs in local communities.

In recent years, the New York State Department of Health has encouraged local hospitals and health departments to collaborate in the creation of joint CHIP/ CSP documents in order to better serve the populations served. To that end, beginning in 2021, the seven Local Health Departments and community hospitals in the Mid-Hudson Region, (Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester Counties), along with the Rural Health Network formed the Hudson Valley Public Health (HVPH) Collaborative with the purpose of issuing an updated Regional Community Health Assessment for the Mid-Hudson Region. The assessment incorporated information from a diverse set of secondary sources (CDC, US Census Bureau, NYSDOH, County Health Rankings), and was further supplemented with primary data collection in the form of a broad resident level health opinion survey, plus a targeted community-service provider survey.

The agencies involved in the CHA process contributed both funding and staff members to join the Collaborative in a contract with Siena College Research Institute (SCRI) who developed and implemented the resident level health assessment survey. The survey conducted by SCRI was a random digit dial community health survey designed to supplement the Regional Community Health Assessment. In order to gauge the perception of residents surrounding health and resources in their communities, responses from 765 residents of Rockland County (5,699 in total for the M-H region) were collected. To further enhance the data collected, members of the HVPH Collaborative deployed a community service provider survey to understand the needs of specific communities and populations, and the barriers they face to achieving optimal health among their clientele. There were 66 provider surveys completed among providers that offer services locally to Rockland residents.

Implementation of the 2019-2021 Community Health Improvement Plan in Rockland County requires a coordinated effort between healthcare, public health, and non-government community-based organizations especially from the lead agencies of Good Samaritan Hospital, Montefiore Nyack Hospital, and the Rockland County Department of Health. It was evident from the survey results that enhanced collaboration is required to reduce the disparities observed along racial and ethnic lines for the incidence and prevalence of various conditions like heart disease, stroke, diabetes, and vaccine hesitancy. The themes identified as having the greatest influence on health disparity in Rockland were housing, transportation, and nutrition. The most influential barriers to care that were identified included lack of knowledge about existing resources, low health literacy and increased substance abuse. It is extremely difficult to address such broad social determinants as individual organizations, so developing stronger interagency bonds that limit the impact of these barriers is critical for success. Intervention plans have been drafted that will foster increased referrals between participating organizations and hopefully enhance partnerships that allow residents to overcome existing obstacles.

Moving forward the RCDOH intends to arrange annual Public Health Summit meetings, and to provide progress reports towards achieving the specific objectives with feedback from stakeholders. It is expected that during these meetings, input from participants will be obtained through open forum, Q&A, and survey format. The collected feedback will be used as a guide to determine if modification of interventions is necessary and to ultimately aid in making any midcourse adjustments deemed necessary. The process measures listed in the workplan will be tracked continuously and shall be the basis of impact evaluation. It is hoped that a broader set of organizations will become involved as a result of this organizational engagement, and an expansion of cross cutting collaborations will be made possible.

The plan recommends several strategies to improve health and well-being across the lifespan for all Rockland County residents. All agencies involved will maintain their commitment to improving health outcomes related to goals in all 5 of the NYS Prevention Agenda priority areas, but the expressed mission at this time is to concentrate on health objectives related to Preventing Chronic Diseases and Preventing Communicable Diseases. These areas were chosen collectively in data assessment review sessions held during 2022. The evidence-based interventions to be implemented in these areas are outlined in the attached workplan grids. This 'living document' is a plan for community members, designed to be implemented by health agencies, community organizations, collaborative partners, and

residents across the county. Working together we envision a safe, healthy community in which to live, work and play where everyone has equal opportunity for a healthy productive life as we aspire to make Rockland the healthiest county possible.

Improvement Plan - 2022-2024

Rockland County is located approximately 30 miles north of Manhattan on the western side of the Hudson River. The county is the smallest by area and third most dense in the state, outside of New York City, at only 115,000 total acres which includes more than 35,000 acres of preserved open space parkland.

Due to its proximity to New York City, Rockland has continued to experience a steady population growth over the past several years within all incorporated towns and 19 villages. The most recent population estimates from the 2020 ACS 5-year estimates indicate that Rockland County grew by 19,752 people (6.5%) between 2010 and 2020, up to 325,213. The statewide growth rate over the same period was 1.5%. Between 2010 and 2020, all five Rockland County towns increased in number, led by the Town of Ramapo (11.3%), Stony Point (3.7%), Clarkstown (3.5%), Haverstraw (3.4%), and Orangetown (2.4%). The county is home to an ever-expanding diverse population, comprised of 69.9% Caucasian, 12.2% Black or African American, 17.9% Hispanic or Latino, and 6.0% Asian residents according to the US Census. Most notable in this round of the decennial census is the large rise in the percentage of individuals who self-identify as either 'other' or as 'more than 2 races,' each category has increased dramatically over the last 10 years.

Consistent with what has been seen at both the state and national level, there continues to be growth in the proportion of elderly county residents since the 2010 census. The most significant increases to date have been in those older than 65, with the largest expansion among the 70–74-year-old age group with a 25.1% increase. The recent population estimates also indicate steady increase in the proportion of residents speaking languages other than English, with the estimated percentage of Spanish speakers up to 14.0% and those speaking 'Other Indo-European' languages up to 21.8% in 2020. When compared against the other MARO counties, Rockland has the lowest percentage of residents identifying as English-Only speakers at 58.6%. Together this indicates that as a group public health needs to prepare to address the broad of health issues that concern older adults with more diverse, inclusive measures than ever before.

HEALTH IMPROVEMENT PLANNING PROCESS

Beginning in late 2021, the 7-County Mid-Hudson partnership convened once again to develop a Regional Community Health Assessment (CHA). The process was organized by the Epidemiologists and Public Health Educators from each of the Local Health Departments in the Metropolitan Area Region (MARO); Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester. With input and assistance from the participating local hospitals this cooperative developed the Regional Community Health Assessment Survey for the purposes of collecting primary data from residents that is comparable across the region and could inform future health improvement decisions within each county. This survey was designed to include questions that collect information around several initiatives and priorities put forward by the New York State Department of Health and the NYS Prevention Agenda 2019 -2024.

Survey data collection, analysis, and charting were provided by a team from Siena College Research Institute (SCRI). SCRI administered a randomized telephone survey which took place between February and June of 2022, utilizing both landline and mobile phone numbers to reach respondents. Results were then weighted by gender, age, race, and region according to the U.S. Census 2020. The 2022 survey is the second iteration of this regional CHA project and contained many of the same questions previously offered in 2018 to allow for assessment of changes over a timeline that includes the COVID-19 pandemic.

The Regional Community Health Assessment Survey ultimately collected responses from a random sample of over 5,699 Hudson Valley residents, with 765 of those being from Rockland. It was determined that certain populations could have been missed through this survey technique and unaccounted for in the survey findings. Some of these under-represented populations include those who are low-income, veterans, seniors, people experiencing homelessness, LGBTQ members, and people with a mental health diagnosis. In order to ensure that the needs of these special populations were met, a separate survey was conducted with the community providers that serve these populations by offering mental health support, vocational programs, nutritional and educational programs, and family and community support. This survey covered several topics, including the populations the providers serve; the issues that affect health in the communities they serve; barriers to people achieving better health; and interventions that are used to address social determinants of health. Throughout the

seven counties in the Mid-Hudson Region, 84 surveys were completed by service providers, 26 of which from providers who serve Rockland.

The overall process culminated with meetings between the 3 primary agencies involved, namely Good Samaritan Hospital, Montefiore Nyack Hospital and Rockland County Department of Health. In conjunction with the data from the stakeholder Interview forms and the resident survey mentioned above, other primary and secondary data compiled from local, state, and federal partners for purposes of the CHA were reviewed. These included the US Census Bureau, NYSDOH (disease rates, eBRFSS responses, Hospital Discharge data), the NYSDOH Prevention Agenda Dashboard, the New York State Opioid Data Dashboard, and the County Health Rankings website. Using the NYSDOH 5 Prevention Agenda Focus Areas as a guide, the team considered which health issues were most pressing and most likely to influenced by implementing collaborative interventions. Consideration was also given to what evidence-based programs could be put into place that will align and bolster the initiatives each organization may already be operating throughout the region.

PRIORITIES SELECTED FOR 2022-2024

As mentioned previously, the two Prevention Agenda priority areas chosen through the local selection process in 2021 were **Prevent Chronic Disease** and **Prevent Communicable Disease.** The activities planned under each of these main areas also include an emphasis on the reduction of health disparities associated with transportation, housing and nutrition by supporting interventions in the communities with the greatest documented health inequities.

Under the priority area of **Prevent Chronic Disease**, the following focus areas and goals were designated for inclusion in the workplan (*numbering corresponds to the New York State Prevention Agenda*):

Focus Area 1: Healthy Eating and Food Security

Goal 1.1 Increase access to healthy and affordable foods and beverages

Focus Area 4: Preventative Care and Management

Goal 4.1 Increase cancer screening rates

Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity

Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity

Under the priority area of **Prevent Communicable Disease**, the following focus areas were designated for inclusion in the workplan (*numbering corresponds to the New York State Prevention Agenda*):

Focus Area 1: Vaccine Preventable Diseases

Goal 1.1: Improve vaccination rates

Goal 1.2: Reduce Vaccination coverage disparities

Focus Area 2: Human Immunodeficiency Virus (HIV)

Goal 2.1: Decrease HIV morbidity (new HIV diagnoses)

Goal 2.2: Increase viral suppression

Focus Area 3: Sexually Transmitted Infections

Goal 3.1: Reduce the annual rate of growth for STIs

CHOSEN PRIORITY FOR 2022-2024: PREVENT CHRONIC DISEASE

Caring for healthy people through prevention efforts is an important component of public health. Educating all residents about health and promoting health-seeking behaviors can assist in postponing or preventing illness and disease. In addition, detecting health problems at an early stage increases the chances of effectively treating them, often reducing suffering and costs. Even when preventive care is ideally implemented, it cannot entirely avert the ultimate need for acute care. Delivering optimal treatments for acute illness can help promote quicker recovery and reduce the long-term consequences of disease.

Chronic illnesses by nature cannot simply be remedied in response to a singular episode but must be carefully monitored and controlled over time. Management of chronic illness often involves promotion and maintenance of lifestyle changes and regular contact with a provider to monitor the status of disease progression. For patients, effective self- management of chronic diseases can mean the difference between normal, healthy living and frequent medical problems or disability. However, for

many individuals, appropriate preventive services, timely treatment of acute illness and injury, and meticulous management of chronic disease can positively affect mortality, morbidity, and quality of life.

The leading causes of death for Rockland residents continue to be heart disease (138.9/100k) and cancer (121.6/100k). Leading a healthy lifestyle (avoiding tobacco use, being physically active, and eating well) greatly reduces a person's risk for developing chronic disease. Access to high-quality and affordable prevention measures (including screening and appropriate follow-up) are essential steps in saving lives, reducing disability, and lowering costs for medical care. The collaborative authors of this CHIP (Rockland County Department of Health, Montefiore Nyack Hospital, and Good Samaritan Hospital) fully understand this concept and plan to maintain and enhance their outreach and educational services internally and externally with the assistance of the local Federally Qualified Health Centers (Sun River Healthcare and Refuah Healthcare Center) and through their provider networks. The development and initiation of evidence based self-management programs (EBSMP) enhanced disease prevention and maintenance courses like the National Diabetes Prevention Program (NDPP), Diabetes Self-Management Program (DSMP), and Chronic Disease Self-Management Program (CDSMP), are scheduled to be given in additional formats, at more locations, and in multiple languages in the coming years. These and other concerted efforts are planned to continue throughout this implementation cycle utilizing staff, funds and other resources provided from each engaged partner mentioned above.

A wide array of educational services and interventions spanning the life spectrum are planned from childcare center nutritional and school physical activity programs, to farmer's market and CSA initiatives, to senior citizen physical activity and disease education programs. Using the current health statistics as a guide, the collaborative partners aim to curb troubling trends in several important indicators. The current data indicates that approximately 27.0% of the adults in Rockland County are classified as obese. Although this percentage is slightly above the NY Prevention Agenda goal of 24.2% and below the national target of 30.5%, there exists an increased percentage of adults who are classified as being overweight or obese (59.4%) than what was identified at the regional and state levels. Additionally, the number of school-aged children and adolescents who are overweight or obese in Rockland County at 33.9% is more than double the Healthy People 2030 goal of 15.5%. The partners included in this portion of the plan have committed themselves to preventing and addressing the impact of chronic illnesses by attacking the issues at several levels along the life path, from direct patient care interventions to the development and adoption of broader public health policies in schools, workplaces, and public spaces.

CHOSEN PRIORITY FOR 2022-2024: PREVENT COMMUNICABLE DISEASES

The public health partners in Rockland also expressed significant concern for several of the designated goals within this prevention area. In the forefront was the ever-increasing trend in the annual incidence of Sexually Transmitted Infections that has been observed locally, regionally, and nationally. The available 2018 age-adjusted incidence rates of Chlamydia (383.5), Early Syphilis (13.6) and Gonorrhea (47.3) per 100,000 women aged 15-44 continue to show upward trends among Rockland residents since 2015. It has also been evident from disease reporting data that the infections are impacting a much younger age range of the population than seen in decades prior. While the measured burden for each fall below the designated NYSDOH Prevention Agenda 2024 targets, the community-based organizations in Rockland are determined to effect change on these diseases. Plans have been made to increase access to care among the high school aged population through school and community outreach, as well as through creating a presence at public events that appeals to younger residents. This cohort has also been targeted in an intervention by Montefiore Nyack Hospital and RCDOH to widely offer free condoms, making prevention options more readily available. The revised county workplan will also tap into available Disease Intervention Services grant funds for an upgraded ability to provide chlamydia and gonorrhea rapid testing to known contacts of cases in an attempt to offer immediate expedited partner therapy (EPT) that will more effectively limit disease transmission. Along the same lines Rockland also continues to experience an elevated rate of new HIV diagnoses (8.5/100k), with the second highest rate in the MARO region behind Westchester County (10.1/100k). Since HIV is preventable, there will be enhanced efforts by the CHIP health partners to further educate the public on the benefits of pre-exposure prophylaxis (PrEP) and to increase access to those medications for those at risk throughout the county.

The other priority objectives chosen within this focus area center on addressing the well documented low local vaccination rates which have contributed to multiple, avoidable outbreaks like measles, pertussis, and polio since the last iteration of the CHIP. In response to the single case of paralytic polio in a Rockland resident during 2022, a series of initiatives were launched in coordination with NYSDOH and CDC. The main goal of which were to evaluate and remedy low pediatric vaccination rates for the overall primary series (4:3:1:3:3:1:4) and for polio vaccine alone. These efforts are multi-faceted and rely on conducting reminder outreach to patients, working closely with providers to ensure vaccine registry data integrity, confronting vaccine hesitancy, and assessing school and daycare enrollment records to gain compliance and a better understanding of the core issues surrounding any deficiencies.

This will continue throughout the CHIP cycle and will be enhanced in 2023 as additional staff are being dedicated by RCDOH to evaluate quarterly progress towards increase immunizations in target areas with substandard rates. Apart from mandatory school immunizations the CHIP partners will also work together to increase vaccine coverage rates for diseases like influenza, pneumonia, and meningitis across all ages where appropriate.

ADDITIONAL AREAS OF CONCERN FOR 2022-2024

As stated earlier, the CHIP process is devoted to identifying and taking measurable action around 2 New York State Prevention Agenda priority areas. This is of course not the full extent of community health improvement work planned for this three-year period. Other areas of concern identified during the 2021 planning phase that fall under the remaining 3 state prevention agenda areas will be addressed as well. The main difference being that these additional interventions will not be officially tracked and reported out upon along the workplan that is associated with this version of the CHIP. Given below are brief descriptions of the local health issues identified and the intended actions planned for the three remaining prevention agenda priority areas.

PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

In Rockland County there is an independent Department of Mental Health (RCDOMH) which spearheads the coordination of programs aimed at increasing the well-being and behavioral health of Rockland residents across the spectrum. The Department of Health works in collaboration with the RCDOMH to aid and assist their efforts as much as possible. A major concern identified through the coordinated assessment process was the impact that depression and substance abuse, mainly opioids, is having on Rockland residents. Over the past few years this issue has come to the forefront across New York State and elsewhere in the wake of the isolation and stress of the COVID-19 pandemic. According to the CHA data reviewed, Rockland showed an increasing trend in the number of unique naloxone administrations by EMS agencies, coupled with higher rates of overdose deaths involving heroin, opioids, and methadone. Collaborative work is planned between the Department of Mental Health, Emergency Medical Services, Law Enforcement, and the local hospitals to better assess risks, link patients to mental health providers, and act quickly to prevent opioid related hospitalizations and deaths. Now that many

of the COVID-19 restrictions placed on services have been lifted, it is expected that the interventions planned in the prior 2019-2021 CHIP that could not be completed will be renewed.

Organizations working to reduce substance abuse have often expressed their difficulty in gathering and sharing the information they collect in a standardized format that can be used to inform prevention and response efforts. Several long-standing data measures are available that clearly support the need for concern, such as drug overdose deaths involving any opioid, where in Rockland that crude rate has risen steadily from 5.0 per 100,000 in 2014 to 14.1 per 100,000 in 2019. The issues contributing to substance abuse cross many sectors and require a multi-layer approach between mental health providers, emergency services, law enforcement, public health, and social services to initiate change. Continued grant funding is being sought for the unified Opioid Task Force that aims to increase collaboration through pooled resources, referral systems, and data sharing. In conjunction there will be continued expansion of educational efforts to provide residents the tools they need reduce overdose incidence, like expansion of Naloxone administration training and kits, drug take back events and locations, and peer to peer recovery and counseling opportunities.

PROMOTING HEALTHY WOMEN, INFANTS AND CHILDREN

Enhancing the health of the youngest generation, ultimately increases the overall chances that a population will attain its healthiest state. This important goal can only be reached by focusing strategic interventions at all levels of the lifepath associated with childbearing; from preconception and interconception health, to healthy pregnancies and births, to ultimately ensuring the well-being and healthy opportunities throughout childhood. Many of the interventions developed over the years will remain in operation or be expanded further during the next three years. A major concern that continues to be a focus moving forward is reducing the health disparity that has been observed among babies born to African American and Hispanic mothers with regards to low birthweight and preterm birth. Rockland has the highest birth rate in the Mid-Hudson region at 17.3 per 1,000, and both Montefiore Nyack Hospital and Good Samaritan Hospital are dedicated to minimizing the existing racial and ethnic health inequities related to birth outcomes. Community outreach and education that has been conducted by community-based organizations (LHVPN, HACSO) for many years will continue with to occur in the communities most affected, mainly Spring Valley and Haverstraw. Additionally, Montefiore Nyack Hospital has expressed a commitment to this particular prevention agenda in the past

with interventions aimed at increasing the percentage of infants being exclusively breastfed. They worked to improve education and support systems that promote breastfeeding among pregnant women and post-partum mothers, as well as established policies to increase early skin-to-skin contact birthing practices inhouse.

PROMOTING A HEALTHY AND SAFE ENVIRONMENT

Ensuring that natural and built environments throughout Rockland are safe is an important factor in promoting and preserve health. To that end there are both public health enforcement and private sector and community cooperative initiatives in place that are committed to monitoring conditions and responding to emerging concerns. The environmental conditions that were identified to be of most concern in the coming years were improved water quality oversight, reduction of lead hazards causing elevated blood lead levels, and prevention of conditions that contribute to Legionella. Increased need for improvement efforts in these areas stems from upcoming changes to state regulation that will once again lower the blood lead action level from 5 to 3 mg/L. This seemingly minor change has the potential to significantly increase the volume of new lead poising cases and the associated follow up required by environmental workers and medical providers. In that regard plans are in place to bolster the existing RCDOH programs with enhanced education and outreach to new mothers. RCDOH aims to provide prevention tips and reminders for testing of children via mail and phone calls. It is hoped that through the development and usage of more advanced technology resources the partners will be capable of preventing new cases earlier in their lifespan.

EVALUATION

The following grids outline the designated goals, objectives, and process measures for 2022-2024 and is meant to act as the framework for tracking progress towards improvement in the two chosen priority areas. In addition to reviewing advancement towards these goals on a quarterly basis, annual public health summit meetings will be scheduled for 2023 and 2024 to reinforce all collaborative efforts. Progress in attaining the predetermined goals will be discussed at future Collaborative and DOH/Hospital meetings. This type of community engagement is a recent addition to the RCDOH CHIP process and is anticipated to enhance effectiveness of the partnerships in place. It is expected that during these meetings input from participants will be obtained through data exchange, open discussion,

and survey format. The assembled group will be asked to recommend guidance concerning the appropriateness of the interventions in place. Collected responses will then be used as a barometer to gauge if fine tuning of interventions should occur or midcourse adjustments should be made. Meeting dates and times will be made available to the public through social media, the Rockland County website, and through traditional press releases. Similarly, this full Community Health Improvement Plan will be made available on the Rockland County main page, and the Rockland County Department of Health website in early 2023. http://rocklandgov.com/departments/health/

Prevent Chronic Diseases Strategic Plan					
Priority Area: Prevent Chronic Diseases					
Focus Area 1: Healthy Eating and Food Security					
Goal 1.1: Increase access to healthy and affordable foods and beverages **Objective 1.2:** *Decrease the percentage of children with obesity (among public school students in NYS exclusive of New York City [NYC])* **Disparity Addressed:** Creating Healthy Schools and Communities (CHSC) work is being performed in the North Rockland School District					
Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/ Result
1.0.4, multi-component school-based obesity prevention interventions, which include: Completion the Creating Healthy Schools and Communities grant deliverables in the North Rockland School District Collaboration with additional daycare centers and parent-teacher organizations to support policy, and environmental changes that target nutrition before, during or after school by providing healthy eating learning opportunities. Supporting and co-leading efforts to create healthier school environments	Complete the CHSC deliverables for the North Rockland School District, as per the grant Collaborate with additional school districts and parent-teacher organizations to support policy, and environmental changes that target nutrition before, during or after school by providing healthy eating learning opportunities. Supporting and co-leading efforts to create school meal policies that ensure that school breakfast and/or lunches meet	RCDOH (CHSC), Montefiore Nyack Hospital (MNH) school nutrition outreach program to advise North Rockland School District, Creating Healthier Schools and Communities (CHSC) Wellness Committees to implement	January 2022-December 2024	# of NRSD schools that implement at least two actions to comply with Smart Snacks in School Standards for competitive foods/beverages #of schools that participate in the programs and employ improved nutrition standards # of strategies implemented to increase Smart Snacks compliance of competitive foods and beverages # of schools that have no violations in the Smart Snacks Standards for fundraising. # of educational activities offered to students, staff and/or parents	The NRSD facilities will implement at least two actions to comply with Smart Snacks in School Standards for competitive foods/beverages (this includes a la cart, vending, school stores, snack or food carts, food-based fundraising). Increased number of school districts and individual schools that revise school nutrition policies and strategies to comply with the Smart Snacks in School standards

school meal policies that ensure that school breakfast and/or lunches meet specific nutrition requirements. based on the premises of Alliance for Healthier Generation.	specific nutrition requirements. based on the premises of Alliance for Healthier Generation.			# of nutrition education workshops provided in public schools: prior year / current year # of children participating in taste tests and/or educational workshops that want to switch to lower calorie drinks and water / total number of children participating in taste tests and/or educational workshops	

Prevent Chronic Diseases Strategic Plan					
Priority Area: Prevent Chronic Diseases					
Focus Area 4: Chronic Disease Preventative Care and Management					
Goal 4.1 Increase cancer screening rates **Objectives 4.1.1 to 4.1.4**: *By December 31, 2024, increase the percentage of adults receiving breast cancer, cervical, and colorectal cancer screenings based on the most recent screening guidelines for Breast Cancer Screening by 5% from 78.8% to 82.7%; for Cervical Cancer Screening by 5% from 88.8% to 93.2% and for Colorectal Cancer Screening by 5% from 61.7% to 64.8%. (Data source: NYS Behavioral Risk Factor Surveillance Survey, 2018)* **DISPARITIES ADDRESSED**: Low SES; concentrating on areas with higher populations of racial/ethnic minorities					
Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/ Result
4.1.5, Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammography vans, flu clinics), offering on-site translation, transportation, patient navigation and other administrative services and working with employers to provide employees with paid leave or the option to use flex time for cancer screenings	Good Samaritan Hospital (GSH) to develop a system for directly referring patients without primary care when presenting to the emergency department	Good Samaritan Hospital will engage with network and local primary providers	January 2022 – December 2024	Number of referrals made to primary care	Increased number of patients presenting to the emergency department that identify as having a primary physician.
4.1.6, Ensure continued access to health insurance to reduce economic barriers to screening.	Develop a system to connect insurance patient navigators to patients waiting for care in the emergency department	Good Samaritan Hospital and NY Cancer Services	January 2022 – December 2024	Number of patients signed up for health insurance	Higher insurance coverage rates for the local Hospital Service Areas. Decreased number of patients presenting to

	Work with NYS Cancer Services Program to provide free/low-cost breast, cervical and colorectal screening and treatment to uninsured or underinsured patients				the emergency department that identify as being under- or uninsured.

Prevent Chronic Diseases Strategic Plan					
Priority Area: Prevent Chronic Diseases					
Focus Area 4: Chronic Disease Preventative Care and Management					
Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity. **Objective 4.2.1:** *Increase the percentage of adults 45+ who had a test for high blood pressure within the past three years by 5% from baseline* **DISPARITIES ADDRESSED**: Heart attack mortality rate is the second highest for Rockland County compared to the rest of Hudson Valley at 36/100k in 2019, affecting non-Hispanic white people at 105/100k, followed by Non-Hispanic Blacks and Hispanics at 98.2/100k and 93.2/100k respectively.					
Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/ Result
4.2.1, Promote strategies that improve the detection of undiagnosed hypertension in health systems.	Montefiore Nyack Hospital (MNH) will start offering blood pressure checks at all community events for adults and educate/refer individuals with blood pressure above 130/90 to follow up with their PCP or will help patients without a PCP to identify one for follow up. This involves the creation of a community policy to offer BP checks at community events and public places as requested, including food pantries,	MNH will engage physicians for the referral process, and with community-based organizations who can assist with planned community outreach and education efforts	January 2022 – October 2024	# of policies to identify patients with undiagnosed HTN over time # of adult patients screened with policies in place over time # of adult patients identified with HTN during screening over time # of adult patients referred to PCP for diagnosis and treatment over time	Increases in documented BP readings performed during all patient visit types, and offered/provided during public events Decreases in cardiovascular disease hospitalization and mortality rates, coronary heart disease hospitalization and mortality rates, and heart attack hospitalization and mortality rates

	libraries, churches, etc. MNH will: design a form for patients with high blood pressure to follow up with PCP; Increase number of events where blood pressure is being checked; Apply for grants to purchase blood pressure monitors to give to individuals with high blood pressure at screenings encouraging them to check BP regularly and share readings with their doctor.				

Prevent Chronic Diseases Strategic Plan					
Priority Area: Prevent Chronic Diseases					
Focus Area 4: Chronic Disease Preventative Care and Management					
Goal 4.4: In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity **Objective 4.4.1**: *Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition* **DISPARITIES ADDRESSED**: Strategies are concentrated in areas with persons with low socioeconomic status and with minority majorities.					
Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/ Result
4.4.2, Expand access to evidence-based self-management interventions for individuals with chronic disease (arthritis, asthma, cardiovascular disease, diabetes, prediabetes, and obesity) whose condition(s) is not well-controlled with guidelines-based medical management alone. Increase availability of and referrals to Chronic Disease Self Management Programs (CDSMP) and Diabetes Self Management Programs (DSMP) in Rockland	Delivery of the Chronic Disease Self-Management Program (CDSMP), and the Diabetes Self-Management Program (DSMP) by MNH and RCDOH Create database to track referrals, number of participants and completions Promote program among medical practices in the area Invite eligible discharged patients from MNH to join programs	Montefiore Nyack Hospital (MNH) , RCDOH,	January 2019-December 2021	# of CDSMP/DSMP programs delivered; # of patients who participate in each program type; percentage of enrollees who complete courses; # of health systems that have policies/practices for identifying and referring patients to National DPP programs; # of individuals accessing group diabetes education services / # of individuals diagnosed with pre-diabetes at MNH;	Increase the number of courses offered in the county Decreases in the hospitalization and mortality rates for cardiovascular disease and diabetes

	Increase the number of community providers making referrals and the number of individuals reached Analysis and review of progress made to expand or adjust the interventions selected			# of referrals received by MNH Diabetes programs / total # referrals to Diabetes programs; # of individuals accessing one on one pre-diabetes education services / total # referrals for individual services for patients diagnosed with pre-diabetes; Initial vs last A1c among hospital patients enrolled in program; Yearly change of prevalence and incidence of pre-diabetes among Nyack Hospital patients	
4.4.3, Expand access to the National Diabetes Prevention Program (National DPP), a lifestyle change program for preventing type 2 diabetes.	MNH to expand NDPP courses from 1 to 3 programs per year, offer a new program every 4 months, starting in February ‘23 Delivery of the NDPP for participants in English, and in languages other-than-English (Spanish, Creole, etc.) for populations at risk	MNH and RCDOH as lead agencies CBO’s and medical providers to refer their patients and educate	January 2019-December 2021	# of NDPP courses delivered in community settings #of patients referred to NDPP # of patients who participate in NDPP Percentage of patients who complete NDPP by type of course	Increase the number of courses being offered in the county, in multiple formats (live, video conference, phone) Provide greater opportunity for residents to receive training from peers in languages and settings they prefer

	Promote programs at community events, through the RCDOH clinics, MNH e-mail list, and social media to increase referrals Obtain data of completed programs and analyze results				

Prevent Communicable Diseases Strategic Plan					
Priority Area: Prevent Communicable Diseases					
Focus Area 1: Vaccine Preventable Diseases					
Goal 1.1: Improve vaccination rates **Objective 1.1.1**: *Increase the rates of immunization among NYS 24-35-month-olds with the 4:3:1:3:3:1:4 series (4 DTaP, 3 polio, 1 MMR, 3 Hep B, 3 Hib, 1 varicella, 4 PCV13) by 10% to 70.5%* **Objective 1.1.3:** *Increase influenza immunization rates of New Yorkers aged 6 months and older by 10% to 54.8%.* **Objective 1.1.4:** *Increase the age-adjusted pneumococcal vaccination rate of New Yorkers aged 65 years and older by 10% to 76.2%.* **DISPARITIES ADDRESSED**: This effort is intended to assist those with low SES, limited access to healthcare, and a lack of education					
Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/ Result
1.1.1, Ensure and enforce strong immunization requirements for childcare, school and post-secondary institution entry and attendance.	Conduct assessments reviewing vaccine records at Head Starts, daycare centers and school facilities to ensure that enrolled students are adequately immunized for their age as is expected by law. Work directly with the daycares and schools to update and correct any NYSIIS or school based record discrepancies through the audit process to increase registry data integrity.	K-12 schools, childcare and daycare centers NYSDOH and CDC will assist with NYSIIS data analysis	January 2022 – December 2024	# of schools and daycares engaged # of audits conducted to ensure EMR and NYSIIS accuracy, and compliance to state vaccination law Percentage of children, per school, who are found to be under vaccinated Year to year comparison of changes over time by school, district, and in total for the county	To have all daycares, schools and school districts meet the Prevention Agenda objective of having 70.5% of students fully vaccinated for the 4:3:1:3:3:1:4 series which is mandatory for K-12 school enrollment

	Work closely with schools that remain out of compliance with the student vaccine regulations.				
1.1.2, Maximize use of the New York State Immunization Information System (NYSIIS) and the Citywide Immunization Registry (CIR) for vaccine documentation, assessment, decision support, reminders and recall. Increased use of the registries can better inform assessments of vaccine coverage, missed vaccination opportunities and help address disparities in vaccine coverage including those for specific age groups.	Evaluate provider level progress on the primary series through AFIX Product reports. Reach out to providers to review patients that are behind to determine if they are truly not getting vaccinated, or if the providers are vaccinating but not adequately reporting to NYSIIS Send reminder recall letters for those patients who are under-or un-vaccinated for the 4:3:1:3:3:1:4 series.	RCDOH will engage with all local pediatricians to evaluate and assist in correcting provider practice EMR issues NYSDOH and CDC to consult	January 2022 – December 2024	# of providers engaged and evaluated per year # of meetings held with providers to ensure EMR and NYSIIS accuracy Quarterly review of the percentage of under- and unvaccinated children per pediatrician via AFIX product Analysis of ZIP Code level vaccination rate changes over time	To have the electronic medical records (EMR) of each engaged provider match what has been reported to NYSIIS Overall increased vaccination coverage rates in areas with documented poor initial rates in 2022
1.1.3, Implement and promote use of standing orders for vaccine administration.	Offer influenza vaccine at GSH when medically appropriate during inpatient hospitalizations for ages 6 months and older	GSH is the lead org, will work closely with network providers	August 2022 – December 2024	# of influenza vaccines given year to year # of pneumococcal vaccines given year to year	Increased use of standing orders for influenza and pneumococcal vaccines during hospitalization at Good Samaritan Hospital

	Offer pneumonia vaccine at GSH when medically appropriate during inpatient hospitalizations for ages 65 and older				

Prevent Communicable Diseases Strategic Plan					
Priority Area: Prevent Communicable Diseases					
Focus Area 1: Vaccine Preventable Diseases					
Goal 1.2: Reduce Vaccination coverage disparities **Objective 1.2.1**: *Reduce the disparity measured by the difference in the 4:3:1:3:3:1:4 vaccine series coverage between NYS 19-35-month-olds living in households below the federal poverty level compared with those living in households at or above the federal poverty level by 50% to 4.90%.* **DISPARITIES ADDRESSED**: A large percentage of households in the target area above fall below the federal poverty line. According to the US Census 14.4% of persons in Rockland are in poverty, and in Monsey and Spring Valley those percentages are estimated at 46.1% and 24.2% respectively					
Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/ Result
1.2.2, Offer vaccines in locations and hours that are convenient to the public including pharmacies, vaccine only clinics, and other sites that are accessible to people of all ages.	RCDOH will coordinate with FQHC's and community-based organizations to arrange for expanded POD offerings (mobile unit or other) within Ramapo communities that have well documented low pediatric vaccination rates	RCDOH to collaborate with local municipalities, FQHCs and CBOs to roll out additional clinic times	October 2022 – December 2024	Number of Point of Distribution (POD) offered by type and location number of attendees at each, number of vaccines given by type and location	Increased pediatric primary series vaccination rates in target ZIP Codes with poor initial rates in 2022 Reduced disparity in the vaccination rates between those above and below the poverty line

Prevent Communicable Diseases Strategic Plan					
Priority Area: Prevent Communicable Diseases					
Focus Area 2: Human Immunodeficiency Virus (HIV)					
Goal 2.1: Decrease HIV morbidity (new HIV diagnoses) **Objective 2.1.1**: *Reduce the number of new HIV diagnoses by 70% to 1,020 diagnoses or 5.2 per 100,000 population.* **DISPARITIES ADDRESSED**:					
Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/ Result
2.1.1, Facilitate access to Pre-Exposure Prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) for high-risk persons to keep them HIV-negative. Access can be facilitated by the following: -Statewide education campaign on PrEP and nPEP; -Expanding funded programming for PrEP -Creating a statewide mechanism for persons to access PrEP and nPEP -Determining a method for measuring the number of New Yorkers on PrEP and nPEP	Conduct outreach to all high traffic STI providers and clinics locally, ensuring that information on PrEP is widely available to all patients, and is provided in multiple languages	RCDOH and local providers running PrEP programs will track patient progress and share data. The same facilities will promote services and refer where necessary	January 2022 – December 2024	# of patients screened for PrEP treatment at RCDOH clinic #of patients appropriately placed on PrEP by providers in Rockland (RCDOH, Sun River and Pride Center # of educational outreach visits to inform providers and the public about PrEP services # of outreach visits to underserved communities where language barriers are a known barrier to PrEP services	Increase the number of patients enrolled in and being followed up within PrEP medication programs

Prevent Communicable Diseases Strategic Plan

Priority Area: Prevent Communicable Diseases

Focus Area 2: Human Immunodeficiency Virus (HIV)

Goal 2.2: Increase viral suppression

Objective 2.2.1: *Increase the percentage of all persons living with diagnosed HIV infection (PLWDHI) who receive care with suppressed viral load to 95%.*
Objective 2.2.2: *Increase the percentage of African American persons living with diagnosed HIV infection (PLWDHI) who receive care with suppressed viral load to 95%.*
Objective 2.2.3: *Increase the percentage of Hispanic persons living with diagnosed HIV infection (PLWDHI) who receive care with suppressed viral load to 95%.*

DISPARITIES ADDRESSED: Montefiore Nyack Hospital opened the Jacob's Family Pride Wellness Center (JFPWC) in November 2021, a safe space for individuals from the LGBTQ+ community to do HIV and STI testing and receive treatment by experienced professionals and specialists that understand the needs of this high risk community.

Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/ Result
2.2.1, Link and retain persons diagnosed with HIV in care to maximize virus suppression so they remain healthy and prevent further transmission. MNH aims to expand the JFPWC to be able to offer services Monday thru Saturday and improve the health and quality of life of persons with HIV/AIDS by increasing linkage to care, improving retention in care, and promoting adherence to ART. We will also promote the message that individuals with a sustained undetectable viral load will not sexually transmit	Increase hours of operation of the Jacob's Family Pride Wellness Center (JFPWC) from 8 hr/week to 16 or more hr/week. Seek approval to expand JFPWC from 1 to 3 exam rooms; add 2 counseling rooms to increase capacity; hire new staff specializing in infectious disease to increase effectiveness Participate in campaigns that help	MSH as lead agency, with RCDOH and college staff supporting the education and awareness campaign	January 2022 – December 2024	# of patients testing for HIVs by race and ethnicity # of patients positive for HIVs by race and ethnicity # of patients diagnosed with HIV who receive treatment by race and ethnicity	A reduction in the rate of new HIV diagnosis for Rockland residents in 2023 and 2024

HIV to encourage individuals to seek treatment.	to reduce stigma around HIV/AIDS and offer 1-2 webinars to the community at large on HIV, encouraging prevention, testing and treatment. Partner with Rockland School Health Coalition and community colleges to bring at least one educational session per year on HIV prevention, testing and treatment				

Prevent Communicable Diseases Strategic Plan					
Priority Area: Prevent Communicable Diseases					
Focus Area 3: Sexually Transmitted Infections					
Goal 3.1: Reduce the annual rate of growth for STIs **Objective 3.1.1:** *Reduce the annual rate of growth for early syphilis by 50% to 10%.* **Objective 3.1.2:** *Reduce the annual rate of growth for gonorrhea by 50% to 4%.* **Objective 3.1.3**: *Reduce the annual rate of growth for chlamydia by 50% to 1%.* **DISPARITIES ADDRESSED**:					
Evidence Based Strategy	Activity	Community Implementation Partner	Timeframe	Evaluation Measure	Intended Outcome/Product/ Result
3.1.2, Increase STI testing and treatment: Ensuring that all persons at risk for STIs have access to affordable, accessible, convenient, and culturally responsive STI testing and treatment services is the bedrock of any STI prevention and control strategy. STI testing should be offered in venues and at times that are convenient for population groups most affected by STIs. Providers should ask their patients about which body parts they and their partners use during sex and offer STI testing of the throat and rectum (in addition to genitals) as appropriate.	Increase hours of operation of the Jacob's Family Pride Wellness Center (JFPWC) from 8 hr/week to 16 or more hr/week Seek approval to expand JFPWC from 1 to 3 exam rooms and add 2 counseling rooms, increasing capacity Apply for CON and permits for expanded JFPWC and seek funding for expansion Offer 1-2 webinars to the community at large on prevention	MNH as lead agency, RCDOH to support by promoting the services during clinic hours and at community events	January 2022 – December 2024	# of patients testing for STIs # of patients positive for STIs # of patients diagnosed with an STI who receive treatment # of visits at the expanded JFPWC over time to analyze patient use of services	A decrease in the disease incidence trends for chlamydia, gonorrhea, and early syphilis per 100 thousand population

	and treatment of STIs encouraging prevention, testing and treatment Partner with Rockland School Health Coalition and community colleges to bring at least one educational session per year on STI prevention and treatment Train providers to ensure that they ask their patients about which body parts they and their partners use during sex and offer STI testing of the throat and rectum (in addition to genitals) as appropriate				
3.1.3, Promote distribution of Condoms: While new methods for preventing HIV have garnered attention over the last several years, the foremost primary prevention method for sexually active people remains condoms. New approaches for increasing condom utilization, and making condoms a regular part of sexual health, will be	Strategize best ways to bring condoms to the community to make them widely available Create a policy for the Community Health Department at Montefiore Nyack Hospital regarding distribution of	MNH as lead agency, to collaborate with NYSDOH, RCDOH, local colleges, and food pantries	January 2022 – December 2024	# of condoms distributed Percentage of sexually active people who report using condoms through MNH evaluations	A decrease in the disease incidence trends for chlamydia, gonorrhea, and early syphilis per 100 thousand population

important for reducing STI impact in NYS. Providers of sexual health services can partner with the NYS Condom program to make condoms more available within their local community.	condoms in public events Obtain policy approval and condoms from DOH Distribute condoms to medical offices and adult community organizations, including colleges and food pantries Expand distribution of condoms to new sites Data analysis and program evaluation				
3.1.4, Promote Expedited Partner Therapy: Expedited Partner Therapy (EPT) is a practice that allows health care providers to provide a patient with either antibiotics or a written prescription, intended for the patients' sexual partner(s). In New York State, EPT is used for treatment of exposure to chlamydia. Broad implementation of EPT across multiple provider types will be an important population-level intervention for chlamydia control, given this STI's	Obtain lab equipment and associated testing supply kits to offer next generation Chlamydia and Gonorrhea Rapid Testing to contacts of known cases at the RCDOH clinic Expand the availability of CT and GC rapid testing outside of the set RCDOH clinic hours on Tuesday and Thursday afternoons to offer convenient	RCDOH as lead agency	January 2022 – December 2024	# of patients who receive EPT annually # of DIS partner calls, and percentage where EPT was successfully provided # or Rapid tests provided to known contacts	A decrease in the disease incidence trends for chlamydia, gonorrhea, and early syphilis per 100 thousand population

prevalence in the state (with over 110,000 diagnoses annually it is the most commonly reported communicable disease). Providers of sexual health services should take steps to ensure EPT is offered to patients who they diagnose with chlamydia.	testing to all contacts; and recommend EPT to those contacts who are eligible Communicate and partner with key local providers to increase public awareness of the expanded rapid testing options and the EPT program				

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