



# NATHAN LITTAUER

*Hospital & Nursing Home*

## 2014 Community Service Plan Summary Report Update

*Nathan Littauer Hospital and Nursing Home and its Family of Health Services is committed to providing safe, high-quality health and wellness services and improving the health of our communities in a caring, contemporary environment. Our mission is accomplished not only through the efforts of our own dedicated employees, services and programs, but in cooperation with countless community partners.*

Following a Community Health Needs Assessment (CHNA), completed in 2013 in coordination with our local health department and with input from local health and human service providers, a three year Community Service Plan (2013 – 2015) was developed. We were tasked by the New York State Department of Health (as were all NYS hospitals and local health departments) to cooperatively prioritize our community needs and identify focus areas to address over the next three years.

Our Community Service Plan is our guide to the future and our compass. The priorities we identified for action over the next three years were to “increase access to high-quality chronic disease preventive care and management in clinical and community settings” and “increase the use of comprehensive well child care.” As described under each priority you will see a summary of the area of focus and progress we have made, as well as the challenges we have encountered.

**Priority #1** - Increase access to high-quality chronic disease preventive care and management in clinical and community settings, specifically, **to increase the percentage of adults 18 years and older who are tested for high blood sugar or diabetes.** By improving diabetes awareness and screening more people, we will also be addressing an identified disparity: access to care.

According to NYS DOH data, an estimated 8% Fulton County adults have been diagnosed with diabetes, this equates to more than 3,400 people. While determining an accurate number of **undiagnosed** persons is not possible, we know that diabetes is more common in the elderly and those with a BMI of > 35. Earlier identification and treatment of diabetes may actually

increase our incidence rate, but will reduce the chance of developing harmful and costly complications. Activities associated with increasing screening rates will also bring attention to the potential complications of poor diabetes control and the need for careful diabetes management.

### **Accomplishments**

- Littauer Primary Care Centers (PCC) are seeking out and identifying those at risk for developing diabetes within their patient populations, and encouraging them to be tested
- HealthLink & Fulton County Public Health are:
  - working to increase community awareness of risk factors and need for testing by targeted outreach (ex, to senior centers & clubs and large employers) and through social media.
  - using the American Diabetes Association “Diabetes Risk Test” at outreach sites and community events as an awareness tool, and referring at risk persons for follow up
- The Diabetes Resource Center at Littauer continues to provide an ADA recognized “Diabetes Self-Management Education” program and support
- HealthLink continues to offer ongoing community health & wellness education and referral, including cholesterol, glucose, blood pressure and BMI screening
- Registered dietitians provide outpatient nutrition counseling (as requested by provider) as well as nutrition specific community education programs

### **Challenges include**

Not having dedicated staff time to plan, implement, evaluate and track activities

Engaging target population.. to accept that this is a serious problem for our community and that each person has the ability to do something about it

Little access to practical, research based interventions and monitoring/tracking /process strategies

**Priority #2** – Increase the use of comprehensive well child care, **specifically increase the proportion of NYS children who receive lead screening** (as a key recommended preventive health services) as part of routine well-child care. **Fulton County has extremely high rates of child lead poisoning.** Increasing screening rates will allow at risk children to be identified and treated, reducing the number of children diagnosed with lead poisoning and its life changing long term effects. Providing POC (point of care) testing will improve access, a disparity identified in our CHNA. Activities associated with increasing screening rates will also bring attention to older housing stock and other causes of lead poisoning.

### **Accomplishments**

- Coordinated efforts with Fulton County Public Health (FCPH), which has identified lead poisoning as an agency priority and has received a grant to help address it
- Established a baseline number of tests using DOH Lead Web data and monitored over time
- Established a baseline level of awareness of lead poisoning risk and dangers by e-survey

- Expanded POC lead testing in our pediatric primary care offices from two sites to four in 2014
- In coordination with FCPH carried out: Media campaign including: billboards, social media, postcards mailed to all new moms, infomercial for public access, web sites peds waiting rooms Targeted outreach education at events such as home shows, rabies clinics or car seat checks; and to WIC, Day Care Centers, and Head Start sites, Navigators.
- Worked to establish a broad based community task force comprised of health care, local government and business stake holders.

**Challenges include**

- Difficulty engaging target population
- Difficulty engaging community leaders
- Little access to practical, research-based interventions and monitoring/tracking /process strategies

**Submitted 4/3/15**